

**STATE FAILURES
AND THE ‘INCLUSIVE SUBSIDIARITY’ OF THE MARKET
IN HEALTHCARE AT THE TIME OF THE ECONOMIC
RECESSION**

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1. INTRODUCTION: THE RELATIONSHIP BETWEEN SPENDING CONTROL AND COMPETITION IN HEALTHCARE

This article contains some reflections on the relationship between spending control and competition in healthcare.

It is actually a synthesis of another, more detailed, study¹.

However, in this case the study will focus on a slightly different point of view, which is the role of the basic level of benefits related to healthcare in its difficult relationship with the carrying out of fiscal federalism (if it still exists?²), also in the light of: a) the possible relationship between this carrying out and the recentralization of financial policies due to the economic recession; b) the constitutional reform regarding the budget balance, applicable as from 2014.

¹ See M. D'ANGELOSANTE, *Strumenti di controllo della spesa e concorrenza nell'organizzazione del servizio sanitario in Italia*, Rimini, Maggioli, 2012.

² The question is due to the need to verify whether fiscal federalism is compatible with the recentralization of financial policies due to the economic recession and with the constitutional reform regarding the budget balance. This point will be better developed later.

It is first of all necessary to explain why we begin from the assumption that there is a double relationship, sometimes in conflict, between spending control and competition in healthcare.

However, before that, it is necessary to explain the meaning of the expressions spending control and competition as used in this essay.

The article refers to public spending (including that coming from private accredited healthcare trusts, but limited to those healthcare services which are covered by public financing). Moreover the ‘spending control’ mentioned in this essay is that kind of spending control related to a macro-economic perspective, and not that related to the tools which each healthcare trust can adopt to reduce (or control) its costs (the micro-economic perspective).

Furthermore the ‘competition’ mentioned in this article is a kind of competition with a double meaning: a) on the one hand, the competition between stakeholders (funders, buyers and/or providers of healthcare services) in each healthcare system; b) on the other hand, the competition between different healthcare systems (local, regional, national, with a meaning that will be specified later).

Now we can go back to the relationship between spending control and competition.

The idea that the promotion of competition between stakeholders of the healthcare system could be useful to improve the quality of the healthcare services and could also reduce spending has influenced some reforms of the National Healthcare System in the United Kingdom³. This system – like the Italian and Spanish ones, which have taken the

³ See S. NERI, *La regolazione dei sistemi sanitari in Italia e Gran Bretagna*, Milano, Franco Angeli, 2006; S. CIVITARESE MATTEUCCI, *La riforma del NHS inglese. Evoluzione o rivoluzione?*, in A. PIOGGIA A. – S. CIVITARESE MATTEUCCI – G. RACCA – M. DUGATO (a cura di), *I servizi sanitari: organizzazione*,

English NHS as a model – is the paradigm of the so called ‘universalistic healthcare systems’, which are the most equitable both from a subjective and from an objective point of view⁴, but are also those kinds of systems in which the public spending is higher and difficult to control⁵. However, in the UK the development of the reforms of the NHS has fluctuated, because sometimes they have pursued the goal of implementing the competition

riforme e sostenibilità. Una prospettiva comparata, Rimini, Maggioli, 2011; ID., *Quadrare il cerchio tra efficienza, qualità e accesso universale alla sanità. La riforma Tory del National Healthcare System inglese*, in *Munus*, n. 2, 2011, 381.

⁴ According to the subjective point of view, the equity is due to the very large number of recipients (all citizens) that can benefit from healthcare services funded by public spending (and this is the reason why these systems are defined as ‘universalistic’), without any limitation related to the need to belong to specific categories of citizens, such as workers or their families (as in German or French systems, in which healthcare services are funded mainly by social health insurance). According to the objective point of view, the equity is, on the contrary, due to the very large number of healthcare services covered by public financing which are provided for the recipients, and to the fact that there are fewer exclusions (such as some dental or aesthetic healthcare services). For a comparison between different healthcare systems, see A. PIOGGIA – S. CIVITARESE MATTEUCCI – G. RACCA – M. DUGATO (edited by), *I servizi sanitari: organizzazione, riforme e sostenibilità. Una prospettiva comparata*, quot.; F. TOTH, *Le politiche sanitarie – Modelli a confronto*, Bari, Laterza, 2009; ID., *Is there a Southern European Healthcare Model?*, in *West European Politics*, n. 33-2, 2010, 325; ID., *Le politiche sanitarie tra riforme e contro-riforme*, in *saluteinternazionale.info*, 2010; ID., *Le riforme sanitarie in Europa: tra continuità e cambiamento*, in *Riv. it. pol. pubb.*, n. 2, 2009, 69; E. JORIO, *Il percorso legislativo della riforma sanitaria di Barack H. Obama, prima che venga approvata dal Congresso USA*, in *www.astrid-online.it*, 2010.

⁵ One of the reasons is that users tend to overestimate their real need for healthcare services, first of all because they do not pay directly for them. The universalistic healthcare systems have, however, introduced some tools that can avoid this overestimation. The first one is the so called ‘gatekeeping’, according to which each citizen asking for non-urgent hospital or specialist healthcare services covered by public financing has to obtain a specific prescription from his primary care physician. The second is the so called ‘ticket’, which is a mechanism of cost-sharing, according to which each citizen asking for non-urgent hospital or specialist healthcare services (or some kind of medicines) covered by public financing has to pay a part (generally not very high) of their cost. This point will be better developed later.

between stakeholders in healthcare (believing that this kind of competition could reduce public spending and implement the quality of the healthcare services), while on other occasions they have pursued an opposite goal (after verifying that competition which was too strong and not well managed would give rise to the implementation of the so called ‘transaction costs’, which are those coming from the management of the contractual or non-contractual relationships between the stakeholders involved).

It is now necessary to add two more reflections.

The first one is related to the propensity of the different national healthcare systems to converge, so that each one tries to borrow features from the others in order to overcome its limits. And in fact neither of them can be considered ‘absolute’, because each one has many prevailing features (on the basis of which the system can be traced back to one of the existing models), but also some additional features (borrowed from one or more of the other models)⁶.

The second reflection is related to the role of the European Union in this framework. It is true, in fact, that each healthcare system has the propensity to borrow some features from the others, and that it happens even if the different systems concerned do not belong to one of the State Parties of the EU. However, if the different systems concerned belong to one of the State Parties of the EU, the propensity of these systems to converge

⁶ See A. PIOGGIA – S. CIVITARESE MATTEUCCI – G. RACCA – M. DUGATO (edited by), *I servizi sanitari: organizzazione, riforme e sostenibilità. Una prospettiva comparata*, quot.; F. TOTH, *Le politiche sanitarie – Modelli a confronto*, quot.; ID., *Is there a Southern European Healthcare Model?*, quot.; ID., *Le politiche sanitarie tra riforme e contro-riforme*, quot.; ID., *Le riforme sanitarie in Europa: tra continuità e cambiamento*, quot.; E. JORIO, *Il percorso legislativo della riforma sanitaria di Barack H. Obama, prima che venga approvata dal Congresso USA*, quot. See moreover M. D’ANGELOSANTE, *Strumenti di controllo della spesa e concorrenza nell’organizzazione del servizio sanitario in Italia*, quot.

seems to be accelerated for two reasons, related to the common aim of building a single model of ‘Social Europe’.

For some years now it has in fact been possible to find a further double propensity in the EU perspective.

On the one hand, this propensity, especially since the Maastricht Treaty (i.e. since the beginning of the 90’s), proceeding in a ‘vertical direction’, has determined the enlargement of community policies beyond the original core of the economic and monetary union (and so also to some policies that in the beginning were completely excluded from the competences of the European economic community, such as health, education, and welfare in general).

On the other hand, the above mentioned propensity, especially since 2006, proceeding in a ‘horizontal direction’, has determined that social services (including healthcare services) have sometimes been considered services of general economic interest and, as a consequence, subject to the rules contained in the Treaties regarding competition (unless the application of these rules hinders the particular task assigned to them). The combination of these two kinds of propensity is playing an important role in the building of the so called ‘European social model’⁷.

⁷ On the ‘European social model’ see: S. CIVITARESE MATTEUCCI, *Servizi sanitari, mercato e “modello sociale europeo”*, in A. PIOGGIA - M. DUGATO - G. RACCA - S. CIVITARESE MATTEUCCI (edited by), *Oltre l’aziendalizzazione del servizio sanitario*, Milano, Franco Angeli, 2008; ID., *Servizi sanitari, mercato e «modello sociale europeo»*, in MCR, n. 1, 2009, 179; W. STREECK, *Il modello sociale europeo: dalla redistribuzione alla solidarietà competitiva*, in *Stato e Mercato*, n. 1, 2000, 3; A. KACZOROWSKA, *A Review of the Creation by the European Court of Justice of the Right to Effective and Speedy Medical Treatment and its Outcomes*, in *European Law Journal*, n. 12-3, 2006, 365; R. CAVALLO PERIN, *Crisis del Estado de bienestar. El papel del derecho administrativo*, in <http://uspceu.es/pages/congresos/italo-espanol/presentacion.html>, 2012; J. HENRY - M. CHAUVIERE, *Quel statut pour les services sociaux dans l’union européenne? Arguments pour des*

Starting from this framework in the next pages we will try to answer the following questions.

The first is about the effect of spending control (in a macro-economic perspective, as we have said) on the competition between stakeholders of the healthcare system (on the one hand) and between different healthcare systems (on the other hand): in this case we will speak mainly about a) the Italian legal system and the role of the basic level of benefits related to healthcare in the carrying out of fiscal federalism, b) the recentralization of financial policies due to the economic recession, c) and the constitutional reform regarding the budget balance.

The second question is about the effect of the actions adopted to promote competition between stakeholders of the healthcare system (on the one hand) and between different healthcare systems (on the other hand) on spending control: in this case we will also discuss the international perspective and mainly the role of the user's freedom to choose (which is one of the most important tools in order to open the study to an international perspective), with some references also to the role of the separation between funders, buyers and/or providers of healthcare services (already considered in answer to the first question).

Finally, in the last part of the article, we will try to imagine the future consequences of the propensities examined and the arguments supported, with a focus on the relationship between the possible market and State failures (or achievements) in healthcare.

services sociaux non économiques d'intérêt général, in *Revue du droit sanitaire et social* (RDSS), n. 6, 2011, 1043.

2. DOES SPENDING CONTROL LIMIT THE COMPETITION BETWEEN STAKEHOLDERS IN HEALTHCARE AND BETWEEN HEALTHCARE SYSTEMS? SOME REFLECTIONS ABOUT THE ROLE OF THE BASIC LEVEL OF BENEFITS RELATED TO HEALTHCARE IN ITS RELATIONSHIP WITH FISCAL FEDERALISM, WITH THE RECENTRALIZATION OF FINANCIAL POLICIES DUE TO THE ECONOMIC RECESSION, AND WITH THE CONSTITUTIONAL REFORM REGARDING THE BUDGET BALANCE

Spending control in healthcare consists mainly in controlling demand (on the one hand) and supply (on the other hand)⁸.

In Italy the main tools used for spending control with the aim of monitoring the demand are: a) the choice of services to be paid with public funds; b) the mechanism of the so called gatekeeping (according to which citizens asking for non-urgent hospital or specialist healthcare services which are covered by public financing have to obtain a specific prescription from their primary care physician); c) the use of the so called ‘ticket’, which is a mechanism of cost-sharing, according to which each citizen asking for non-

⁸ The most important legislative references are the following: law 833/78, l. 421/92 and delegated decree 502/92; d.d. 517/93; l. 724/94; l. 549/95; l. 662/96; l. 449/97; l. 419/98; d.d. 112/98; d.d. 517/99; l. 133/99; d.d. 229/99; il d.d.. 56/00; law decree 347/01; d.d. 288/03; l. 311/04; l. 266/05; d.d. 159/07; l.d. 98/11; l.d. 52/12; l.d. 95/12; l.d. 174/12; l.d. 158/12.

urgent hospital or specialist healthcare services (or for some kind of medicines) covered by public financing has to pay for a part (generally not very high) of their cost.

The National Healthcare System, like the other universalistic models, guarantees to all citizens, almost completely free of charge, the same quality and quantity of healthcare services. However, some of them are not included in those covered by public financing: these are the so called out of pocket services (such as some dental or aesthetic healthcare services), and users must pay for them directly or through a private insurance policy, if they have one.

The choice of healthcare services which will be covered by public funds concerns first of all the determination of the basic level of benefits related to healthcare: so, according to art. 117 par. 2 lett. m) Const., it is a legislative competence of the State and is both a political and ethical choice. However regions can provide for additional levels of benefits related to healthcare covered by regional funds⁹. It is clear that the above mentioned choices can both influence public spending.

Moreover each citizen asking for non-urgent hospital or specialist healthcare services covered by public financing has to obtain a specific prescription from his primary care physician¹⁰ (except in some cases, such as urgent healthcare services). This is another tool used in spending control with the aim of monitoring market demand, and in particular filtering it: market demand is in fact verified at source (gatekeeping) in order to avoid users asking for healthcare services which are not really necessary.

⁹ See, *ex multis*, Tar Lazio, Roma, sez. III ter, may 26 2003, n. 4690, in www.giustizia-amministrativa.it; Tar Lazio, Roma, sez. III ter, July 10 2002, n. 6252, in www.giustizia-amministrativa.it.

¹⁰ In fact, first of all, each citizen has to register on the list of a primary care physician.

This tool is reinforced by the so called tickets, which represent another mechanism of spending control applicable often as a result of gatekeeping, but with a double aim: on the one hand, the aim (common to gatekeeping) of avoiding users asking for healthcare services which are not really necessary; on the other hand, the aim of determining a cost-sharing system, according to which each citizen asking for non-urgent hospital or specialist healthcare services (or some kind of medicines) covered by public financing has to pay a part (generally not very high) of their cost.

At this point we can examine the controlling of market supply. The main tools used in spending control with the aim of monitoring market supply are the following: the mechanism based on institutional accreditation and contractual agreements (used to control the entry into the market of potential providers)¹¹; the introduction of spending limits for

¹¹ In order to benefit from public funds healthcare trusts need in fact to receive the so called accreditation from the competent authority (the region). However, even though accreditation is necessary, it is not sufficient, because after that the competent authority and the healthcare trust concerned have to sign a specific contractual agreement. The agreement provides the quantity and the quality of the healthcare services covered by public financing that the healthcare trust can supply and, if the limits established are exceeded and public funds cannot cover, fully or partially, the healthcare services provided, the accreditation could be overruled. The consequences of exceeding the spending limits are better described by G. Corso, *Pubblico e privato nel sistema sanitario*, in G. CORSO - P. MAGISTRELLI (edited by), *Il diritto alla salute tra istituzioni e società civile*, Torino, Giappichelli, 2009, 17, with many case law references; more specifically on accreditation: M. CONSITO, *Accreditamento e terzo settore*, Napoli, Jovene, 2009.

healthcare services covered by public financing¹²; the possibility of starting new forms of organization in healthcare (with the participation of public and private parties), in order to increase the quality of the services provided and at the same time raise private funds¹³; plans to eliminate the healthcare deficit, the violation of which (such as the failure to ensure basic level of benefits related to healthcare), gives the Government the power to act in

¹² The spending limits are determined by the region and the accredited healthcare trust concerned on the basis of the healthcare needs defined in accordance with the current regional planning. However, even though they are set through a contractual agreement between the above mentioned parties, the agreement is just the external form of the act, because its contents are determined mainly in a unilateral way by the region. A similar procedure (in the meaning of ‘unilateral’) is used to define the so called ‘system spending limits’, which refers to the quantity of accreditations that can be granted in the region or in the province as a whole. See G. FERRARI, *Determinazione dell’aggregato provinciale di spesa per l’assistenza ospedaliera prestata da strutture private accreditate*, in *Giorn. dir. amm.*, n. 4, 2011, 431; M. CONSITO, *Accreditamento e terzo settore*, quot., 63.

¹³ We have said that institutional accreditation and the introduction of spending limits for healthcare services covered by public financing are useful tools for spending control through supply control. The same effects can be determined by the so called ‘management experimentations’, which are new forms of healthcare trust deriving from a possible partnership between a public and private party. They have been introduced for the first time by art. 9 bis of delegated decree 502/1992 (as amended by delegated decrees 517/93 and 229/99). In this case spending control is due mainly to the fact that the setting up of ‘management experimentations’ can introduce private capital into the National Healthcare System, so reducing significantly the need for public resources. Regarding ‘management experimentations’, see, ex multis, R. ROTIGLIANO, *Le società di sperimentazione gestionale nel quadro della tutela della concorrenza*, in G. CORSO - P. MAGISTRELLI (edited by), *Il diritto alla salute tra istituzioni e società civile*, quot., 12; C. DE VINCENTI - R. FINOCCHI GHERSI - A. TARDIOLA (edited by), *La sanità in Italia. Organizzazione, governo, regolazione, mercato*, Bologna, il Mulino, 2010; S. CIVITARESE MATTEUCCI - M. DUGATO - A. PIOGGIA - G. RACCA (edited by), *Oltre l’aziendalizzazione del servizio sanitario*, quot.; M. CONTICELLI, *Privato e pubblico nel servizio sanitario*, Milano, Giuffrè, 2012; M. D’ANGELOSANTE, *Strumenti di controllo della spesa e concorrenza nell’organizzazione del servizio sanitario in Italia*, quot.; G. CORSO - P. MAGISTRELLI (edited by), *Il diritto alla salute tra istituzioni e società civile*, quot.; R. BALDUZZI (edited by), *La sanità italiana tra livelli essenziali di assistenza, tutela della salute e progetto di devolution*, Milano, Giuffrè, 2004; C. BOTTARI, *Tutela della salute ed organizzazione sanitaria*, Torino, 2009.

substitution of the regions concerned¹⁴; the adoption of the policies of the spending review in healthcare, with the main aim of controlling the intermediate costs of healthcare trusts (such as costs related to public tenders)¹⁵; the implementation of fiscal federalism, but just with the limitations and meaning that will be better explained later.

¹⁴ The combined application of all the above mentioned tools has not been able, in fact, either to restrain or to reduce, in the necessary measure, the excessive healthcare deficit. So paragraph 180 of the only article of financial law n. 311/04 states that, in the cases provided in par. 174 (such as management of deficit) and 176 (non compliance with the duties disciplined in par. 173 – such as those related to planning – so that the possibility of using State additional financing is denied), the region concerned had the duty of draft and approving a plan, with a duration of no longer than three years, containing rules and programs about the reorganization, redevelopment and strengthening of regional healthcare service. In order to achieve this aim, the State and the regions signed an agreement on March 23 2005 concerning spending control, on the basis of the provisions contained in article 8, par. 6, l. 131/03. After that the discipline of the Plans to eliminate the healthcare deficit was supplemented and refined, mainly to allow the management of the deficit which had not yet been paid off on the expiry of the first three years (see, *ex multis*, the agreement between the State and region signed on March 23 2005; art. 1, p. 1 bis, l.d. 23/07; art. 1, p. 2, l.d. 154/08; art. 6 bis, p. 1, l.d. 185/08; art. 4, l.d. 159/07; art. 5 and 6, d.d. 68/11; l.d. 23/07; art. 2, par. 46 and 49, of the financial law for the year 2008; the Health Agreement signed in 2006 between the Ministers for Health and the Economy and the regions and autonomous provinces; art. 11, l.d. 78/10; art. 2, p. 77, l. 191/09; l.d. 95/12; art. 1, p. 274 and following, l. n. 266/05; art. 1, p. 1 bis and 1 ter, l.d. 206/06; art. 1, p. 796, lett. b, l. 296/06; the Health Agreement between the State and regions, signed on December 3 2009; d.d. 149/11; see, moreover; E. JORIO, *I Piani di rientro del debito sanitario ed i rischi della legislazione dell'emergenza*, in *San. pubb. e priv.*, n. 5, 2009, 13; M. MENEGUZZO - G. FIORANI, *I Piani regionali di rientro. Analisi dinamica sistemica*, in *Mecosan*, n. 68, 2008, 27; R. ARRIGONI, *La "manovra correttiva" dei conti pubblici*, in *Giorn. dir. amm.*, n. 11, 2010, 1179). The Plans to eliminate healthcare deficit normally determine a limitation of regional autonomy, both legislative and administrative, but also a limitation of regional autonomy regarding expenditure (see Const. Court, 23 April 2010, n. 141, in *www.giurcost.org*). The violation of the Plans by the regions concerned can moreover determine their substitution by the State government (according to art. 120, p. 2, Const.), through the nomination of a special commissioner (the same procedure can be applied if the basic level of benefits related to healthcare is not ensured).

¹⁵ More recently measures adopted against the economic recession and to reduce the public deficit (such as l.d. 52/12, confirmed by l. 94/12, and l.d. 95/12, confirmed by l. 135/12) have introduced an important spending review in healthcare, with the main aim of controlling the intermediate costs of the healthcare trusts

It is clear that the tools aimed at controlling supply are more numerous and complex. In fact they can be classified on the basis of different criteria. One of them is the distinction between structural measures (which mainly regard the organization of the stakeholders in healthcare: for example ‘management experimentations’) and functional measures (which on the contrary mainly regard the discipline of the activity of the stakeholders in healthcare: for example spending limits for healthcare services covered by public financing). Another one is the distinction between ordinary measures (which always apply: for example the mechanism based on institutional accreditation and contractual agreements) and extraordinary measures (which, on the contrary, apply just in some special cases: for example Plans to eliminate the healthcare deficit). Finally, a third one is the distinction between measures aimed at spending control (for example plans to eliminate the healthcare deficit and the policies of the spending review in healthcare) and those aimed at optimizing spending (even though the spending will not be reduced in absolute terms), so

(such as costs related to the contracts that they have signed to buy goods and no core services). These measures are mainly related to the need to adopt new ordinary rules to discipline certain activities in order to ensure that they are well managed. In other words, the economic recession represents just an opportunity for the adoption of these measures, but real aim goes beyond the need to cope with the crisis (regarding the ordinary, and not extraordinary, character of the above described spending review, see R. PEREZ, *Prime osservazioni sulla spending review*, in www.astrid-online.it; regarding the relationship between the economic recession and the crisis of the Welfare State in Spain see J. TORNOS MÀS, *Crisis del Estado de bienestar. El papel del derecho administrativo*, in <http://uspceu.es/pages/congresos/italo-espanol/presentacion.html>, 2012). However it is also possible to find, among the recent policies on spending review, some measures applicable for a limited period to cope with urgent needs for a reduction in public spending (such as measures regarding the creation of extraordinary organs). Moreover these measures also have a functional impact (reflecting on the discipline of the actions of the parties concerned), as well as a structural one (reflecting on their organization). Thus all the above mentioned actions are related both to the ordinary reduction in costs and the need to eliminate the healthcare deficit, and also represent one of the most important tools of this need (regarding the relationship between spending review, distribution of financial resources and the gradual phasing out of the so called ‘past spending’ see R. PEREZ, *La manovra d’estate, il patto interno di stabilità e la spesa sanitaria*, in www.astrid-online.it, 2008).

preferring optimization in the use of resources (for example the implementation of fiscal federalism, if and when completed).

The distinction between ordinary and extraordinary measures (on the one hand) and measures aimed at spending control and at optimizing spending (on the other hand) requires further reflection. Regarding the first, it is necessary to make clear that the distinction between ordinary and extraordinary measures seems to be even more difficult, because as the extraordinary measures are quantitatively and qualitatively highly significant, the ordinary ones often seem to be dismissed. The emergency tends in fact to become permanent and endemic, like the ongoing economic and financial recession. Some examples of emergency becoming permanent are the frequent exceptions to the sanctions established for the violation of the Plans to eliminate the healthcare deficit, or the many agreements signed in derogation of some fiscal regulation. Here it is necessary to clarify that the reform regarding the financing of healthcare is made up not only of the implementation of fiscal federalism (starting with law 42/2009 and carrying on with d.d. 68/2011), but, first of all, also of l.d. 56/2000 and the subsequent measures related to it (which some years before 2009 began to use the concept of ‘standard cost’ in addition to the traditional notion of ‘past spending’): however, since the beginning of the new Century, as we have already noticed, the extraordinary measures have been so many and so frequent that it is difficult to distinguish them from the ordinary ones. This tendency has never stopped, and, on the contrary, it has been made worse by the economic recession. In fact, starting from the beginning of this recession, which began as an extraordinary event, important measures have been introduced, but with the aim of setting up ordinary tools for the governance of certain situations (such as the economic crisis) and to prevent them happening again. Some of these measures are the constitutional reform regarding the budget balance (const. law 1/2012, implemented by l. 243/2012), in accordance with the international Treaty about Fiscal compact; but, in a wider meaning, also all the measures regarding the recentralization of financial policies. These reforms, however, need to be coordinated with the implementation of fiscal federalism, but trying to understand, first of all, if this implementation is still ongoing or if it has been abandoned as a consequence of the above mentioned measures.

The answer may be found going back to the distinction between measures aimed at spending control and measures aimed at optimizing spending: in this perspective the implementation of fiscal federalism as requested by article 119 of the Italian Constitution could optimize spending, for the following reasons. On the basis of article 119 of the Italian Constitution, law n. 42/2009 was approved. In turn, law n. 42/2009 was implemented through some delegated decrees: one of them (d.d. 68/2011) contains provisions about healthcare financing. In all these sources the basic level of benefits related to healthcare are disciplined as a tool of fiscal equalization, in order to avoid the implementation of a kind of federalism which is too competitive and inequitable .

The financial autonomy of the regions is in fact balanced by the possibility, for those which are not able to ensure the basic level of benefits related to healthcare in the measure corresponding to the ‘standard need’, to draw from a State fund, in order to achieve all the financial resources necessary: a) to provide the basic level of benefits related to healthcare according to the quality and quantity standard required (if this basic level is not ensured, but the budget is balanced); b) or to reach the budget balance for the healthcare spending (if the basic level of benefits related to healthcare is ensured, but the budget is not balanced); c) or, finally, to achieve both the goals listed in the previous points (if the basic level of benefits related to healthcare is not ensured, and the budget is not balanced).inequitable¹⁶.

¹⁶ For some references about fiscal federalism and the basic level of benefits related to healthcare, see, ex multis: A. MASSERA, *Uguaglianza e giustizia nel Welfare State*, in *Dir. amm.*, n. 1, 2009, 24; R. BALDUZZI, *Equità ed efficienza nei livelli essenziali in sanità*, in G. CORSO - P. MAGISTRELLI (edited by), *Il diritto alla salute tra istituzioni e società civile*, quot., 81 ss.; E. BALBONI, *Diritti sociali, sanità e prospettive del federalismo*, in G. CORSO - P. MAGISTRELLI (edited by), *Il diritto alla salute tra istituzioni e società civile*, quot., 95; E. BORGONOVÌ, *Verso il federalismo fiscale*, in *Mecosan*, n. 67, 2008, 3.; C. TUBERTINI, *Pubblica amministrazione e garanzia dei livelli essenziali delle prestazioni. Il caso della tutela della salute*, Bologna, BUP, 2008; A. BRANCASI, *Uguaglianze e disuguaglianze nell’assetto finanziario di una repubblica federale*, in *Dir. pubbl.*, 2002, 922; C. PINELLI, *I livelli essenziali delle prestazioni e fabbisogni standard*, in www.astrid-online.it,

The financial autonomy of the regions is in fact balanced by the possibility, for those which are not able to ensure the basic level of benefits related to healthcare in the measure corresponding to the ‘standard need’, to draw from a State fund, in order to achieve all the financial resources necessary: a) to provide the basic level of benefits related to healthcare according to the quality and quantity standard required (if this basic level is not ensured, but the budget is balanced); b) or to reach the budget balance for the healthcare spending (if the basic level of benefits related to healthcare is ensured, but the budget is not balanced); c) or, finally, to achieve both the goals listed in the previous points (if the basic level of benefits related to healthcare is not ensured, and the budget is not balanced).

However it is now necessary to say a little more about the concept of ‘standard need’. The ‘standard need’, according to delegated decree 68/2011, seems to be the result of multiplying the basic level of benefits related to healthcare by the standard costs of the healthcare services, as registered in the ‘virtuous’ regions: so the ‘standard need’ seems to represent, together with the ‘standard costs’, the parameter which should bring about the abandoning of the criterion of ‘past spending’ in the financing of healthcare. According to d.d. 68/2011, the ‘virtuous’ regions are those which have a balanced budget and are not

2011; C. PINELLI, *Sui “livelli essenziali delle prestazioni concernenti i diritti civili e sociali”* (art. 117, comma 2, lett. m) Cost.), in *Dir. pubb.*, 2002; F. PALLANTE, *I diritti sociali tra federalismo e principio di uguaglianza sostanziale*, in *Dir. pubb.*, n. 2, 2011, 258; G. DELLA CANANEA, *Autonomie e perequazione nell’art. 119 della Costituzione*, in *Idf*, 2005, 134; E. INNOCENTI, *Il finanziamento della spesa sanitaria nella recente giurisprudenza costituzionale: tra tutela della salute, coordinamento della finanza pubblica e (in)attuazione dell’art. 119 Cost.*, in *Le Regioni*, n. 3, 2008, 580; F. BASSANINI - G. MACCIOTTA, *I principi della delega per l’attuazione del federalismo fiscale – Commento all’art. 2 della legge n. 42 del 2009*, in www.astrid-online.it; F. SAITTO, *La legge delega sul “federalismo fiscale”: i livelli essenziali delle prestazioni come misura economia dell’eguaglianza*, in *Giur. cost.*, n. 3, 2010, 2817; R. BIFULCO, *Osservazioni sulla legge n. 42 del 2009 in materia di federalismo fiscale*, in www.astrid-online.it; E. CARUSO - N. DIRINDIN, *Costi e fabbisogni standard nel settore sanitario: le ambiguità del decreto legislativo n. 68 del 2011*, in www.astrid-online.it, 2011; M. SICLARI, *Il “federalismo sanitario”* (Appunti preliminari), in www.astrid-online.it, 2011; F. TOSI, *Il federalismo fiscale a due anni dalla legge delega*, in www.astrid-online.it, 2011.

subject to the Plans to eliminate the healthcare deficit. However, if the regions responding to both these requisites do not exist in the number required by the above mentioned delegated decree, it is possible to apply the supplementary parameter of the best economic result. The identification and choice of the ‘virtuous’ regions are the preconditions to determine the standard costs of the healthcare services: first of all these costs have to be identified in the regions chosen with the above mentioned procedure, and then they have to be multiplied by the basic level of benefits related to healthcare to be ensured in each region, but adapting the result on the basis of the demographic characteristics of the regional population concerned¹⁷. The above mentioned procedure is aimed at the identification of the ‘regional standard need’ to be covered by public financing. As we have already said, the introduction of these mechanisms requires understanding if and how they will be influenced by the constitutional reform regarding the budget balance (applicable as from 2014) and by the many measures related to the recentralization of financial policies due to the economic recession. It is too soon to give a complete answer, but the interpretation of the many reforms which have recently been approved suggests that autonomy will not be abandoned, and that, on the contrary, it will become a kind of ‘prize’ for the regions which will be able to achieve certain goals. Furthermore these goals do not seem to be too different from those related to the reform about fiscal federalism: first of all

¹⁷ Regarding the limits related to the use, in the ‘non virtuous’ regions, of the data collected in the virtuous ones, see T.E. FROSINI, *The Gamble of Fiscal Federalism in Italy*, in *Italian Journal of Public Law*, n. 1, 2011, 138; G. LEONE, *Per un federalismo competitivo e solidale*, in *Idf*, n. 3-4, 2009, 538; G. MACCIOTTA *Semplificazione istituzionale e risorse finanziarie*, in F. BASSANINI - L. CASTELLI (edited by), *Semplificare l’Italia, Città di Castello*, Passigli, 2008, 135; G. VIESTI, *Il federalismo difficile*, in *Il Mulino*, n. 5, 2010, 734; F. PUZZO, *Prime considerazioni intorno alla legge delega di attuazione dell’art. 119 della Costituzione*, in www.astrid-online.it, 2009; F. PAMMOLLI - N.C. SALERNO, *Alla ricerca di standard per la sanità federalista. Una proposta per l’attuazione della Legge n. 42-2009*, Fondazione Cerm, note n. 1, 2010, in www.cermlab.it; ID., *Le differenze regionali nella governance della spesa sanitaria*, in www.astridonline.it, 2011; G. PITRUZZELLA, *Sanità e Regioni*, in *Le Regioni*, n. 6, 2009, 1177. Cfr. G. MACCIOTTA, *La standardizzazione dei costi, dei fabbisogni e dei prelievi*, in www.astrid-online.it, 2011. See, moreover, the Health National Plan 2011/13.

this conclusion can be reached, for example, by thinking of the double role of the budget balance, which represents both a precondition to consider a region ‘virtuous’ according to the fiscal federalism reform and a principle now established in the Constitution above all as a consequence of constraints coming from the EU legal order. So it does not seem that autonomy is going to be sacrificed in the name of the economic recession: in other words, the recession should not lead to the waiver of autonomy¹⁸.

Something different can be said regarding the relationship between autonomy and liability of regional-local government. However, in this case, this is due not to the economic recession, but to the fact that in the regionalization and implementation of the stability Pact there is an imbalance between the State/EU relationship (on the one hand) and the regional-local government/EU relationship (on the other hand). The consequence is that, at the moment, the autonomy of regional-local government does not seem to correspond to the liability of regions and subregional levels of government towards the European union¹⁹. This effect is added to those elements which seem to be primary weaknesses of the implementation of art. 119 of the Constitution, i.e.: a) the fact that it does not deal with the State fiscal system²⁰; b) the fact that it does not deal with the implementation of art. 118 of

¹⁸ L. VANDELLI, *Conclusive Report at the Convention of the San Martino Group, Un nuovo assetto Costituzionale per le autonomie?*, Bologna, Aula Stabat Mater - Archiginnasio, November 8 2013.

¹⁹ See M. SALERNO, *Autonomia finanziaria regionale e vincoli europei di bilancio*, Napoli, Editoriale Scientifica, 2013.

²⁰ V. CERULLI IRELLI, *Report at the Convention of the San Martino Group, Un nuovo assetto Costituzionale per le autonomie?*, quot.

the Constitution²¹; c) the fact that it does not promote in the right way the autonomy of regional and local government in the meaning of the widest development of diversities²².

After these clarifications, it is now possible to affirm that the implementation of fiscal federalism: a) tends to stimulate, through the financial autonomy mentioned in the reform, the diversification of the regional healthcare systems, mainly with regard to their fiscal systems; b) thus also tends to stimulate the financial liability of the regions, at least towards the State.

However it is possible to add the following further effects to these goals: a) the incentive to improve, up to a common standard which is considered essential to ensure the basic level of benefits related to healthcare, the quality of the healthcare services provided by the most inefficient regional systems; b) the incentive to optimize spending and not to reduce it in absolute terms (even though spending could increase, because in the most efficient regional systems public spending is often higher than in the others, but resources are used in a better way); c) the disincentive to further improve the quality of the less efficient regional systems, whether and when they have reached the level of optimization funded by fiscal incentives; d) the disincentive to further improve the quality of the already efficient regional systems, because this further implementation can be funded only by regional budgets, whose present autonomy also depends on principles and dispositions regarding budget balance.

So it seems that inefficiency below a certain level is rewarded, and that at the same time the implementation of efficiency over a certain level is discouraged: these effects are

²¹ G.C. DE MARTIN, *Report at the Convention of the San Martino Group, Un nuovo assetto Costituzionale per le autonomie?*, quot.

²² R. BIN, *Report at the Convention of the San Martino Group, Un nuovo assetto Costituzionale per le autonomie?*, quot.

both motivated by the aim of leading all the regional healthcare systems to the same initial condition (in the meaning of their capacity to ensure certain quantity and quality of basic level of benefits related to healthcare), starting from which they will have the responsibility and the opportunity to implement their efficiency more. However, as we have already noticed, these responsibilities and opportunities will depend only on the skills and the financial resources of each regional system. These effects can be produced because, as we have said, the reform aims at: a) making the regions self-sufficient in the financing of their healthcare systems, through the effective implementation of their financial autonomy; b) ensuring however a complete fiscal equalization, covered by a State fund, to guarantee the basic level of benefits related to healthcare in the regions which are not able to provide it with the quantity and quality standard required; c) replacing the criterion of ‘past spending’ with the parameter of the ‘standard need’ in the distribution of financial resources.

So the relationship between the implementation of fiscal federalism and competition in healthcare seems to be mainly negative, and only partially positive. First of all, however, it is necessary to clarify again that in this case the possible competitors involved are the regional healthcare systems, more than the stakeholders of each system. Furthermore the exam of the above mentioned framework suggests that its first effects could be a reduction in the moving of patients between different regional healthcare systems and the implementation of a soft form of competition among regional welfare systems, in the meaning of competition between financial systems in healthcare. The first effect is necessary, because it is linked to the essential mechanism of the complete fiscal equalization to ensure the basic level of benefits related to healthcare. On the contrary the second effect is only possible (and not necessary), because it is related to the ability of each region which has achieved the ‘minimum level of efficiency’ to further improve this efficiency using its own financial resources. However, it is now necessary to try to also answer to the question left pending, which is the one regarding the relationship between competition and the other tools used for spending control in healthcare according to a macroeconomic perspective. Here the concept of competition is used with its most common meaning, which refers to the competition between the stakeholders operating in a system (and not between systems).

We have already noticed that this article refers only to public spending (including that coming from private accredited healthcare trusts, but limited to those healthcare services which are covered by public financing). Private spending (to which this essay does not refer) identifies that kind of market which is commonly defined as ‘private’: the stakeholders of this market are the professionals providing healthcare services autonomously and the healthcare trusts (only authorized²³, and not accredited), which can provide healthcare services covered directly by the financial resources of the users that have requested them. The level of competition of this kind of market can be better ensured: a) if the requirements to provide the authorizations are transparent, predetermined and clear, so that the administrative power implied for their release can be considered ‘bound’; b) if the healthcare trusts (only authorized and not accredited), are protected, through an appropriate regulation, from competition exercised by the strongest stakeholders in the market concerned (i.e. the necessary providers of the healthcare system covered by public financing²⁴ or, in any case, the accredited ones); these stakeholders have in fact a higher

²³ Delegated decree 502/92 provides, however, two levels of regional authorization: the first one is necessary to build hospitals (in addition to the building permit granted by the competent Municipality); the second is necessary to provide the healthcare services concerned.

²⁴ This is for example the case of the district health authorities, which are necessary regional institutions and often have a double competence, consisting both in the organization of the local healthcare system and in provision of healthcare services. The above mentioned double role (of buyers and providers of healthcare services) can, however, induce them to ask for healthcare services first of all from themselves (i.e. from their hospitals) and then from the other stakeholders. See G. CORSO, *Pubblico e privato nel sistema sanitario*, quot., 17. The system in force in the Lombardy region is different: here the District health authorities have only the role of buyers (and not of providers) of healthcare services from the accredited trusts. So they have only a competence consisting in the organization of the local healthcare system. For a comparison between different regional healthcare systems, see Q. CAMERLENGO, *Le politiche sanitarie in Emilia-Romagna, Lazio, Lombardia, Toscana*, in L. VIOLINI (edited by), *Sussidiarietà e decentramento*, Milano, 2003, 223; E. GRIGLIO, *L'esperienza della Lombardia: il ruolo della regione*, in C. DE VINCENTI - R. FINOCCHI GHERSI - A. TARDIOLA (edited by), *La sanità in Italia. Organizzazione, governo, regolazione, mercato*, Bologna, il Mulino, 2010; B. PEZZINI, *Ventuno modelli sanitari? Quanta disuguaglianza possiamo accettare (e quanta*

capacity to attract patients, even when the healthcare services are paid directly by the patients themselves (the so called out of pocket services) or are provided after the exceeding of the spending limits (the so called extra budget services, which have to be paid for directly by the patients themselves). This is the case of the so called ‘cross subsidies’, which occur when a stakeholder benefits from its position as producer of goods or provider of services of different kinds or subject to different regulations, if it tends to support a part of its production or its activity with the better performances or the more useful regulations applicable to another part of its production or of its activity. However, in the National healthcare system (unitary perspective) and in the regional healthcare ones (differentiated perspective), also the conditions described in the above mentioned points a) and b) often seem to be prejudiced: a) the first one because, in order to provide authorizations, planning needs are often considered, thus giving the idea that the administrative power implied for their release can be considered at least in part discretionary; b) the second one because there are no useful tools to avoid ‘cross subsidies’, with the exception of spending limits for healthcare services, which, however, can reduce the above mentioned effect in a very limited manner.

Moreover it is necessary to clarify that the exceeding of the spending limits generally causes only some cuts in the tariffs that the region have to pay the providers, and/or the possibility, for the providers, of refusing the provision of the so called extra budget services²⁵, or the withdrawal or the suspension of the accreditation for the healthcare

disuguaglianza riusciamo a vedere). Il cosiddetto modello lombardo, in R. BALDUZZI, I servizi sanitari regionali tra autonomia e coerenza di sistema, Milano, Giuffrè, 2005; S. NERI, La regolazione dei sistemi sanitari in Italia e Gran Bretagna, quot.

²⁵ Regarding the cuts in the tariffs that the regions have to pay the providers see, ex multis: C. Conti, sezione centrale di controllo sulla gestione delle amministrazioni dello Stato, Relazione sulla gestione delle risorse statali destinate alla riduzione strutturale del disavanzo del servizio sanitario nazionale, adopted with resolution n. 22/09/G; see moreover the laws of the Puglia region 26/06 and 4/03.

services provided extra budget²⁶. After these clarifications, it is now possible to go back to the relationship between spending control regarding demand and supply (on the one hand) and competition in the market of healthcare services covered by public financing (on the other hand).

Also in this case the second element (competition in the market of healthcare services covered by public financing) is significantly prejudiced, if we think of: the tools to control and limit the fruition by the patients of the healthcare services covered by public financing (such as gatekeeping); the tools to control and limit the entering of the providers in the market concerned (such as accreditation); the discretionary nature of the administrative power implied for the release of the accreditation and for its withdrawal or suspension; the introduction of spending limits for healthcare services covered by public financing; the unilateral determination (by the public regulator) of the content of the contractual agreements (regarding the quantity and the quality of the healthcare services which the accredited stakeholders can provide); the imbalanced relationship between the private providers and the ‘strong’ stakeholders (i.e. those providers which are necessary in the healthcare system covered by public financing, such as the district health authorities directly providing healthcare services and the public healthcare trusts which have been separated from them as autonomous subjects²⁷).

²⁶ Regarding the other measures to ‘punish’ the provision of the so called extra budget healthcare services, see C. Conti, sez. regionale di controllo per il Lazio, resolution adopted on July 28 2009, n. 29.

²⁷ The public healthcare trusts which have been separated from the District health authorities as autonomous subjects are, however, not present in all the regional healthcare systems and have a public legal personality. They provide healthcare services, which can also be linked to medical scientific research and didactics. In the second case these kinds of healthcare trust are also university institutions, because the medicine universities also participate in them. Regarding the difficulties related to the adoption and execution of the second model, and, in a more general perspective, regarding the evolution of the integration between university and healthcare services, see, *ex multis*, G. FARES, *Il faticoso cammino dell’integrazione fra università e servizio*

In the perspective of the relationship between providers, the healthcare systems like those in force in Lombardy (where the District health authorities have only the role of buyers - and not of providers - of healthcare services from the accredited trusts) thus seem nearest to a condition of real competition²⁸. On the contrary, the systems in which the District health authorities have a double role (of buyers and providers of healthcare services) stress the different influence exercised in the market concerned by the ‘strong’ and the ‘weak’ providers²⁹.

Also the restraints emerging in the planning phase determine a relevant control and limit of the entering of providers in the market concerned, not only due to the necessity to obtain accreditation, but also – and mainly – because it is difficult to obtain accreditation in a framework in which the market is full of stakeholders and public spending has to be limited (also reducing the providers of the healthcare services, in order to low their management costs and/or to prevent the existing healthcare providers from remaining underexploited). In fact usually the accreditations granted are not subject to an expiry, but just to possible suspension and/or withdrawal. And, even when some cases of expiry are foreseen, usually the reiteration of accreditation is admitted, because reiteration is normally preferred to a new provision³⁰. Moreover, in the perspective of spending control starting

sanitario, in G. CORSO - P. MAGISTRELLI (edited by), *Il diritto alla salute tra istituzioni e società civile*, quot., 105 ss., and there other references. Regarding the role of the District health authorities in the different regional healthcare systems, see *supra*.

²⁸ Regarding this model, see the Lombardy law 33/09. See more over *supra*.

²⁹ Regarding this model, see the Lombardy law 33/09. See more over *supra*.

³⁰ Regarding this aspect and generally the relationship between public and private stakeholders in healthcare, see M. CONTICELLI, *Privato e pubblico nel servizio sanitario*, quot.; M. CONSITO, *Accreditamento e terzo settore*, quot.; M. CONTICELLI - F. GIGLIONI, *L'accreditamento degli erogatori*, in C. DE VICENTINI - R. FINOCCHI GHERSI - A. TARDIOLA (edited by), *La sanità in Italia. Organizzazione, governo, regolazione*,

from regional healthcare planning, often the release of accreditation to private providers is limited, assuming that the provision of healthcare services by public stakeholders requires using less financial resources³¹.

Some tools limiting competition between stakeholders in the market of healthcare services covered by public financing are the following: the possibility of applying the Plans to eliminate the healthcare deficit to the providers: this possibility significantly limits the autonomy of each regional healthcare system, also because, if the Plans are not observed, the central Government can intervene in substitution of the regions concerned, the spending review to control the intermediate costs of healthcare trusts. The measures listed in the last two points regard however all the institutions / organizations / providers of each regional healthcare system, albeit in an indirect way. However they mainly and directly concern public institutions / organizations / providers of regional healthcare systems. The above mentioned Plans to eliminate the healthcare deficit and the consequent power of the central Government to intervene in substitution of the regions concerned reflect the emergency need to eliminate the excessive healthcare deficit or to ensure the basic level of benefits related to healthcare or other essential needs. The spending review to control the intermediate costs of healthcare trusts, which is surely one of the most important measures to eliminate the healthcare deficit, is, however, mainly a consequence of the aim of setting up new ordinary tools for the governance of certain situations, more than the extraordinary nature of other situations (such as the healthcare deficit exceeding a certain limit). So the

mercato, quot.; M. CONSITO, *L'accreditamento come limite dell'appalto pubblico di servizi*, in A. PIOGGIA - M. DUGATO - G. RACCA - S. CIVITARESE MATTEUCCI (edited by), *Oltre l'aziendalizzazione del servizio sanitario*, quot.; E. JORIO, *L'accreditamento istituzionale e il ruolo del privato nell'organizzazione della salute*, in *Sanità pubb. e priv.*, n. 2, 2004; A. BATTISTELLA, *L'accreditamento istituzionale: una scelta difficile*, in *Prosp. soc. e san.*, 2001, 1; G. CORSO, *Pubblico e privato nel sistema sanitario*, quot., 17.

³¹ Regarding the restraints in the releasing of accreditation to private stakeholders, see C. Cost., October 8 2010, n. 289, in *www.giurcost.org*.

economic recession only represents the opportunity for the adoption of the above mentioned measures. In fact they are destined to be applied even after the recession has been overcome.

3. DOES THE COMPETITION BETWEEN STAKEHOLDERS IN HEALTHCARE AND BETWEEN HEALTHCARE SYSTEMS INFLUENCE SPENDING CONTROL? THE ROLE OF THE USER'S FREEDOM TO CHOOSE, AND THE SEPARATION BETWEEN STAKEHOLDERS IN HEALTHCARE

What we have just pointed out should thus suggest that the National healthcare system is not open to real competition. However, this conclusion does not seem to be right in an absolute meaning. There are in fact at least three groups of elements able to counterbalance some other factors in contrast with the concept of competition (namely the discretionary nature of accreditation and the absence of competitive procedures in substitution of accreditation). They are: a) the separation of the financing, organization and provision of healthcare services (if done properly), which is linked to the plurality of the providers (we have already spoken about both these aspects in the previous paragraph); b) the implementation of fiscal federalism (with the limits and for the reasons that we have already explained in the previous paragraph); c) the user's freedom to choose between different providers, on the one hand, and in some cases between different systems, on the other hand.

It is now necessary to say a little more about the last point, also with the aim of opening this study to the supranational perspective, which represents one of the dimensions of the user's freedom to choose. The user's freedom to choose consists of different levels, both in a horizontal (from direct assistance to indirect one, as we will try to clarify later) and in a vertical meaning (starting from the local healthcare systems and then going to the national ones, both in the EU and outside the EU). In the horizontal perspective it is necessary to distinguish between the choice of the public system (in the meaning clarified above) and the choice of the private one (to which only authorized providers / institutions /

organizations belong). The private system, in turn, can remain private, or can at times become a part of the public system. This happens when the patients ask for healthcare services provided by the private system, but at the same time ask the competent District health authority or region (on the basis of the conditions provided by the regional legislation or the State one in its absence) for the reimbursement of what they have directly paid to use the service. This distinction is based on the diversity between the system of healthcare services covered by public financing and the system of healthcare services covered directly by the users or their insurance, in the framework of the same healthcare system considered, on the contrary, in a vertical dimension, in the meaning that we are going to clarify. In the 'vertical' perspective it is necessary to distinguish the choice between providers of the same system and the choice between providers of different systems, and thus also between different systems. From this point of view the healthcare systems of different States (in the EU or outside) are undoubtedly different. However, although with some limits, also the regional healthcare systems of the State can be considered different from each other and, albeit, with further limitations, the local healthcare systems (corresponding to the area of every District health authority) existing in each regional healthcare system can be considered different too. The patients move physically between these poles, exercising of their freedom to choose. The intraregional mobility (between District health authorities within the same region) can be due to the choice between providers of the same regional healthcare system, or to the choice between the private and public system (to which also the accredited providers belong). In the first case the mobility is covered by the District health authority in which the patient concerned resides (passive mobility), and the related costs are determined on the basis of the current tariffs. In the second case, if the choice falls on the private system without involving any request for indirect assistance, the mobility is covered directly by the patient concerned. On the contrary, if the choice falls on the private system but according to the model of the indirect assistance, the mobility is covered again by the District health authority in which the patient concerned resides. Conversely interregional mobility can be due to the choice between providers belonging to different regional healthcare systems, or to the choice between the public and the private system.

In the first case the mobility is covered by the region in which the patient concerned resides (passive mobility), on the basis of the current tariffs in this region (and on the condition that the healthcare services required belong to those covered by the regional healthcare system concerned). In the second case, if the choice falls on the private system without involving any request for indirect assistance, the mobility is covered directly by the patient concerned. On the contrary, if the choice falls on the public system or on the private one but according to the model of indirect assistance, the mobility is covered again by the region in which the patient concerned resides. Finally, international mobility (in the EU or outside) can be caused by the choice between providers belonging to different national healthcare systems, or to the choice between the public and private systems.

In the first case the mobility is covered by the State in which the patient concerned resides, and is funded more exactly from regional budgets, if the following conditions are observed: a) in cases of international mobility outside the EU the healthcare service concerned has to belong to those healthcare services listed by the State where the patient resides, from which the patient can choose those he wishes to use in another National healthcare system; moreover the healthcare system to which the patient belongs has to authorize this kind of mobility, and the repayment has to observe the specific limits set by the healthcare system to which the user belongs ; b) in cases of international mobility in the EU the healthcare service concerned has to belong to those healthcare services covered by public financing in the State where the patient resides; moreover the healthcare system to which the patient belongs has to authorize this kind of mobility, whether he needs specialized or hospital care, and the repayment has to observe the limits of the cost of the service in the healthcare system to which the user belongs. Now we can go on to the choice between the private and public healthcare systems: a) if the choice falls on the first one without involving any request for indirect assistance, the mobility is covered directly by the patient concerned; b) on the contrary, if the choice falls on the public system or on the private one but according to the model of indirect assistance, the mobility is covered again by the region in which the patient concerned resides.

All the above mentioned aspects could determine a certain competition between different healthcare systems (at local , regional and national level), especially in the EU, and this competition could in turn regard the quantity, quality and financing procedure of the healthcare services guaranteed by each system. This aspect, which will be clarified later, is in turn related to the fact that normally also the healthcare services can be considered ordinary ‘services’ in the meaning proposed by art. 57 Tfeu , or, even better, services of general economic interest in the meaning proposed by art. 106 Tfeu .

It determines, in the EU perspective: a) the tendency to apply the rules regarding the internal market to healthcare services, as established by articles 57 and 106 p. 1 Tfeu (ensuring the free movement of goods, persons, services and capitals, protecting and improving competition, prohibiting State aid), in so far as the application of such rules does not obstruct the performance, in law or in fact, of the particular tasks assigned to them (such as established by art. 106 p. 2 Tfeu); b) the tendency to favour, in accordance with certain rules and principles, the mobility of patients between the EU Countries.

However the mobility of patients regards not only the EU dimension, but also, as we have said, the international non-EU one and the infranational one (i.e., in the second case, the mobility of patients between regional or local healthcare systems, in addition to the possibility of choosing between direct and indirect assistance). It is now necessary to say a little more about the above mentioned migrations of patients and, to understand the possible relationship between each kind of migration, trying at least to answer the following questions. a) It is first of all necessary to understand whether they determine some kind of competition. b) Moreover it is necessary to understand what kind of competition it is, whether it has an economic or ‘social’ meaning. c) And finally it is necessary to understand whether the mobility of patients between healthcare systems is related to possible conditions of State failures (i.e. the inability of the State to provide its citizens with services and benefits which it has the duty to guarantee). State failures are the contrary of the better known market failures, which happen when the market is not self-sufficient to produce and finance some services of general interest, which, as a consequence, are removed from it .

This comparison reminds us of the difference between economic services and services of general economic interest: this difference is based on the fact that the latter are provided by public authorities even when the market is not sufficiently encouraged to guarantee them itself (and thus market failures occur) . In fact the services/activities of the second kind pursue goals of general/public interest. Thus a derogation from the discipline regarding competition is admitted, as established by art. 106 Tfeu, if it is strictly necessary to protect the particular tasks assigned to the activities/services concerned (as long as the providers are able to meet the demand of the users). This can happen, for example, by compensating the stakeholders' obligations which are determined by the public/general interest in the activities/services they provide: in this case the compensation may also entail the adoption of fiscal measures, which are not considered State aid, and hence are admitted, if they are necessary to compensate the stakeholders' obligations which are determined by the public/general interest in the activities/services they provide, but only as long as these measures conform fully to the principle of proportionality .

However it is necessary to distinguish the healthcare services requiring public financing from those which, on the contrary, are covered only by private market rules (such as all the healthcare services known as out of pocket services, supra). In the Italian system the healthcare services of the first kind are those covered by public financing. The existence of this form of financing (public financing), which is different from the financing provided only by private market rules, naturally determines a certain distortion of competition, which is, however, admitted, as established by art. 106 p. 2 Tfeu. This distortion is directly related to the amount of public financing, which in turn depends directly on the extent of the possible obligations determined by the public/general interest in the activities/services concerned and which is different from the financing provided only by private market rules. However, as we have said, this form of distortion can be admitted only in the form established by art. 106 p. 2 Tfeu.

The difference between the healthcare services covered by private financing (in 'absolute' market conditions) and those covered by public financing characterizes the Italian healthcare system and, more generally, universalistic healthcare systems. However,

it is possible that in these systems the provider of the service tries to move the costs of his activity mainly to the part of the activity covered by public financing, with the aim of removing them from the services covered by private financing. It is a phenomenon which reminds us of the above mentioned 'cross subsidies'. The 'cross subsidy' (which in this case would be internal to the same entity and applied in the relationship between activities exercised by this entity according to different regulations) could for example be used by the accredited healthcare trusts, mainly in managing the relationship between the healthcare services provided observing the spending limits and those provided exceeding them. Furthermore the 'cross subsidy' can prejudice the role of the healthcare trusts which are only authorized (and not accredited) in the market concerned, mainly because they provide healthcare services paid directly by the patients and rarely resort to indirect assistance. In this case we refer to a single kind of market if such a market is considered on the basis of the services/goods exchanged in it (healthcare services), and different kinds of market if such markets are considered on the basis of the discipline applicable to the services provided.

These possible consequences have been considered and censured by the European Commission, which has clarified that the compensation of obligations related to a general/public service, if granted for the provision of services of general economic interest, but essentially used to act in other markets, is a kind of State aid which is not admitted . In this case the European Commission refers just to services of general economic interest, and it seems to assume that, also for this kind of activity, the 'cross subsidies' should be traced back to the ordinary discipline contained in art. 106 p. 1 Tfeu (application of the rules about competition), and not to the special discipline contained in art. 106 p. 2 (possible derogation of the rules about competition for reasons of general interest fully observing, however, the principle of proportionality). Also in this perspective the national or regional healthcare systems like those in force in Lombardy (where the District health authorities have only the role of buyers - and not of providers - of healthcare services from the accredited trusts) seem nearest to a condition of real competition.

However, going back to services of general economic interest, we can say that it is a duty of each State to clarify in which particular cases the rules about competition can be derogated and, first of all, to establish what the services of general economic interest are, giving reasons for this choice. Also the meaning and the practical consequences of this assertion need, however, to be clarified, because at the moment the providing of social services is not an exclusive competence of the States. It is, however, true that they represent a field which has been and in part is still closely related to the idea of National sovereignty: but, as we have already said (*supra*), it is also true that, for some years, this model has begun to change, mainly because the supranational governments have increased their interest in the social policies of the States.

Thus, also in the activity aimed at finding the reasons useful for the derogation of the rules about competition and, first of all, in the activity aimed at identifying which social services are services of general economic interest too, probably it will no longer be possible to consider the States absolutely autonomous in taking their decisions. Now it is possible to go back to the State failures, trying mainly to answer the following questions: a) is it possible that, especially at the time of the economic recession, public authorities do not have the capacity to provide and finance certain services/activities (of general interest) on their own? b) and is it possible, as a consequence, that these services/activities are thus left, even partially, to the market? c) And, moreover, could the above mentioned possibility, especially when very important activities/services related to the concept of Welfare State are involved, encourage public providers to find some solution to improve the relationship between the price/cost and quality of the services of general interest? d) And, finally, is it useful nowadays to ask and try to answer the above mentioned questions? Or, on the contrary, is the advancing of the market encouraged, and not only by the economic recession?

A recent decision of the European Court of Justice allows us to go back to the last two questions: in fact, according to the Court, those measures which make the free movement of services between the member States more difficult than the provision of the same services in each member State can be considered in contrast with the principle of free movement of

services in the EU (as established in art. 56 Tfeu). As a consequence, the fact that the National healthcare system in which the patient concerned resides does not guarantee him a set of healthcare services covered by public financing of quantity and kind at least corresponding to those existing in other member States, may represent a hindrance to the free movement of (healthcare) services, as it seems to discourage the mobility of patients between the EU member States because of deficiencies in the quantity and kind of the healthcare services covered by public financing in the State where the patient resides: in fact, if the healthcare service that the patient wishes to use in another member State is not listed among those covered by public financing in the State where the patient resides, it is not possible for him to obtain authorization from his State to use the same service in another member State.

At this point, however, an anomaly emerges. It is essentially the following: in order to guarantee the level of competition required, it is necessary that the healthcare systems improve their performance, to reach a common uniform standard. The starting point seems, as a consequence, to be the improving of supply, as a tool to ensure a certain level of competition; even though it is usually considered that this relationship should be inverted, namely the starting point should be competition as a tool for improving the quality and quantity of supply. The above mentioned condition can in turn be considered a consequence of the fact that in this case the competition between healthcare systems, and not between different stakeholders in the same healthcare system, is involved. In fact the meaning and the features of this kind of competition are quite peculiar. It is true that the main aim of each kind of competition is the achievement of some benefit, which the stakeholders involved try to subtract from their competitors. Thus, if the above mentioned benefit is considered in an economic point of view, competition plays a limited role, because the migration is reimbursed by the State in which the patients reside, applying the tariffs established in this State and only to finance healthcare services covered by public financing in the same State. The limited role played in this case by competition is linked to the relationship between passive and active mobility of the patients: in fact, when passive mobility occurs, the National healthcare system to which the patient belongs has to cover not only the service received by the user in other National healthcare systems, but also the

management costs of the healthcare trusts which remain underexploited as a consequence of this kind of mobility.

On the contrary, if the above mentioned benefit is considered in a social meaning, i.e. as the capacity of the State to meet in an acceptable manner the needs of its citizens, competition would refer to the financing system adopted to cover these needs, and thus also to the way in which, first of all considering the resources available, the public authorities can identify the quantity and quality of supply. It would be, thus, a kind of competition having a social meaning, and existing between welfare State systems (on the one hand) and systems adopted to finance the services granted by the welfare State systems concerned (on the other hand): this kind of competition is determined, in other words, by the inability of the States to meet the needs of their citizens (State failures). The social nature of the competition concerned can, however, also cause the worsening or the stagnation of the performances of the competitors, instead of their improvement. In fact, when the sanctions characterizing the private markets (first of all the loss of profits) are absent, each competitor could give up trying to improve his performance by imitating the other competitors, since he knows very well that the user will simply ask another supplier for the services he is unable to provide. The worsening, stagnation or improvement in the performances of the stakeholders involved can regard the relationship between healthcare system in an international dimension. However, they can also regard the relationship between the regional healthcare systems in the same National healthcare system. The regions (and the States) should, in any case, try to improve the quality of the services provided for their citizens irrespective of the possibility of attracting new patients from other regions (or other States).

The implementation of fiscal federalism regarding healthcare in Italy is, at least in part, related to the above mentioned perspective, because it promotes the improvement of the quality of regional healthcare systems up to a common standard and irrespective of the rules governing competition, while these rules, on the contrary, apply in the event of further improvement of the regional healthcare systems concerned (in fact this further

improvement can be funded only by regional budgets and not by the State equalization fund).

4. CONCLUSIVE REMARKS

We have seen that in the Italian healthcare system, according to a macroeconomic perspective, the relationship between spending control (regarding demand and supply) and competition is mainly negative.

And we have also seen that this relationship can only be partially improved if some corrective measures are adopted: like the nature of administrative power (which should be ‘bound’ and not discretionary) used for the release of accreditations or authorizations, or for their withdrawal or suspension; and the separation between funders, buyers and/or providers of healthcare services. Furthermore we have seen that, in this framework, a double role is played by the implementation of fiscal federalism, both in the light of its relationship with the recentralization of financial policies as a consequence of the economic recession, and the constitutional reform regarding the budget balance. This is caused mainly: a) by the contents of art. 119 Const. (and of l. 42/09 and d.d. 68/11); b) by the meaning of competition, which in the above mentioned case must be regarded in a social dimension, as competition between healthcare systems (at least regional), and thus between welfare State systems and financial systems in healthcare. This dimension is related to another aspect, which is the influence of the competition between stakeholders in healthcare and between healthcare systems on spending control.

We have also seen that, in the macroeconomic perspective, the main tools aimed at promoting competition between stakeholders in healthcare and between healthcare systems are the following: a) not only the separation of the financing, organization and provision of healthcare services (if done properly), which is linked to the plurality of the providers, b) and not only the implementation of fiscal federalism (with the limits and for the reasons we

have already explained in the previous paragraphs), c) but also, and above all, the user's freedom to choose (between providers and in some cases between healthcare systems).

The user's freedom to choose, considered in the above mentioned meaning, was the tool used to open this study also to the international perspective, and especially to the mobility of patients non only between regional healthcare systems belonging to the same National healthcare system, but also between National healthcare systems. As we have seen, the discipline and effects of this mobility, and the kind of competition which it determines (in the meaning of competition between healthcare systems and thus between welfare and financial systems in healthcare) suggest the following question: is the above mentioned framework a consequence, also (and above all) in the light of the economic recession, of possible conditions of State failures (in the meaning of inability of the State to provide its citizens with services and benefits which it has the duty to guarantee)? A positive answer would mean that a new tendency is now emerging: this tendency is the exact opposite of the one which, as the market was unable to provide certain services, determined the removing of such services from the market.

We have also seen that, in this framework, the European Court of Justice deemed that the measures making the free movement of services between the member States more difficult than the provision of the same services in each member State can be considered in contrast with the principle of free movement of services in the EU. As a consequence, the fact that the national regulation does not guarantee the patient a set of healthcare services covered by public financing of quantity and kind at least corresponding to those existing in other member States may represent a hindrance to the free movement of (healthcare) services, as it seems aimed at discouraging the mobility of patients between the EU member States because of deficiencies in the quantity and kind of healthcare services covered by public financing in the State where the patient resides. In fact, if the healthcare service that the patient wishes to use in another member State is not listed among those covered by public financing in the State where the patient resides, it is not possible for him to obtain authorization from his State to use the same service in another member State.

We have already said that at this point, however, an anomaly emerges, because, in order to guarantee the level of competition required, it is necessary for healthcare systems to improve their performance, to reach a common uniform standard. The starting point seems, as a consequence, to be the improving of supply, as a tool to ensure a certain level of competition; even though it is usually considered that this relationship should be inverted, namely the starting point should be competition as a tool for improving the quality and quantity of supply. However, we have also supposed that this anomaly is due to the way in which competition between healthcare systems should be mainly and substantially interpreted. This is in fact a kind of competition that, as we have said, regards the way in which the needs of the citizens are covered, and thus also the way in which, through the resources available, the public authorities can identify the quantity and kind of supply. It would be, thus, a kind of competition having a social meaning, and determined by some forms of State failures, which in turn can cause, as we have supposed and for the reasons we have already pointed out, different effects: like the improvement, stagnation or worsening of the performances of competitors.

These are the reasons and effects which, as we have said, can regard not only the international dimension, but also the regional one in the framework of the national dimension. This perspective is related, at least partially, to the implementation of fiscal federalism in healthcare in Italy, which promotes the improvement of the quality of the regional healthcare systems to reach a common essential standard, irrespective of the rules governing competition: these rules, on the contrary, apply in the event of further improvement in the regional healthcare systems concerned (in fact this further improvement can be funded only by regional budgets and not by the State equalization fund). In this framework the market, in the meaning and with the limits clarified above, can be ‘subsidiary’ to possible State failures. The subsidiarity involved in this case would be, however, an “inclusive subsidiarity”, because it would mainly be aimed at improving the performances of the public system. Thus it is possible to believe that the market can also be considered a tool to protect some rights. This new role of the market is mainly a consequence of the following elements: a) the fact that social services (including healthcare services) have sometimes been considered services of general economic interest; b) the

user's freedom to choose; c) the mobility of patients between healthcare systems. As a consequence, for example, the right to use certain healthcare services abroad is recognized by the healthcare systems to which the patient belongs, and is also based on art. 35 of the Charter of Fundamental Rights of the EU. The protection of a social right seems thus to start from the protection of economic freedom.

These conclusions, however, express an idea which is, at least in part, just 'visionary', because the mobility of patients at an international level, unlike mobility at a national level, is at the moment still of little importance. The trends observed, however, seem to have all the elements useful for determining, together with the necessary developments, the future consequences that we have imagined.