Regional Health Systems, Regional Employment Relations?  
The case of Italy

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Abstract

In many Western countries, varying, optimal levels of involvement of the State and the Regions in the provision of healthcare are debated. In Italy, though still defined as ‘national’, when referring to the health system it is now common to talk of ‘regional models of healthcare provision’. Regions have become increasingly responsible for the organisation and the financing of healthcare. The health sector employment relations system in place does not formally include a regional level of intervention. By looking at 16 (out of 20) regions in Italy and at the possible functional role performed by regional government in employment relations matters, it is contended that territorialisation of healthcare provision may challenge the effective implementation of the New Public Management-inspired reforms that were designed at a national scale.
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1. Introduction and research questions

Throughout the 1980s and 1990s, in various Western countries, a common feature of the transformation of traditional public administrations, including health sectors, has been that of a New Public Management (NPM)-inspired trend of reforms. NPM reverses the two cardinal doctrines of public traditional administration by ‘lessening or removing differences between the public and the private sector’ and ‘shifting the emphasis from process accountability towards a greater element of accountability in terms of results’ (Hood 1995, 94). For public health systems this meant, amongst other things, restructurings, mergers, closures or privatization of hospitals, saving-based re-designing of treatments and care, especially for non-acute patients, experimentations of mix of public and private providers. Though variable in their extent and timing across different countries and public sub-sectors, comparative research highlighted common ‘trajectories of change’ (Mehaut et al 2010; Weber and Navala, 2011). Managerialisation relates to the introduction of private sector management techniques such as, to use the doctrinal components identified by Hood (1995, 96), increased discretionary powers and control for senior managers and mechanisms of performance measurement, both of the human resources, at all levels, and of the outcomes; marketisation has been introduced in the hospital sector with the distinction between ‘providers’ and ‘purchasers’ of health provision services, so to create a competitive environment; corporatisation involves the disaggregation of organisational units and decentralization of provision, identifiable in the legal private company-like status accorded to hospitals and local health units in several countries; privatization, finally, led to a growing participation of private providers to the health sector ‘market’. This has taken various forms: Private Finance Initiatives (PFI), widely used in England (Galetto and Marginson, 2011) where private contractors build hospitals and other NHS facilities, then run by the public health sector; outsourcing of operations ranging from tests laboratories to catering, from specialized clinics registered for ‘patient choice’ to professional cleaning and laundry, common across countries.

Such changes were aimed primarily, at least in the discourse, at a more efficient control of governments’ public expenditure and a greater responsabilization of the organisations (hospitals and local health units). In parallel, health systems have been also territorially decentralized. Budget pressures led countries as diverse in size and approach to their national health systems as Italy, Canada, Germany, Spain, Belgium, partly France, only to name a few, to devolve financial, as well as organisational responsibility of the healthcare provisions to regions, federal states, Lander,
‘autonomous communities’, according to the administrative option available at an intermediate level between national and organisational.

All these measures had a significant impact on industrial relations, though not necessarily in line with what was predicted. Given the highly labour intensive nature of the public services, including the health sector, and the higher than average union density and participation, it has been contended that NPM-inspired reforms could not be fully realized without a concurrent restructuring of the employment relations (Bordogna 2008). Reforms of established employment relations arrangements indeed took place, but despite the expectations of the proponents of NPM reforms, several studies highlighted, for instance, an only partial achievement of the objective to decentralize collective bargaining at the organisation level; limited success of the attempts to measure, and adequately reward, performance; a continuing distinctiveness of the workforce governance arrangements covering hospitals that is strictly linked to the role of political choices and of governments interventions (Hood, 1995; Bordogna, 2008; Bach and Kessler, 2011; Mehaut et al 2010; Greer et al. 2013). Straightforward implementation of a private model had to take into account also the capacity of organised social actors, such as unions and employers to frustrate or promote change (Schulten et al 2008; Galetto et al 2014). Given the irreducible responsibility of the budget on governments, the unilateral interventions on employment relations matters, especially in times of austerity, also remains a distinctive feature that does not have an equivalent in the private sector (Bordogna and Pedersini 2013).

The effects of the measures specifically related to territorial decentralization, on the other hand, have generally been analysed from points of view not strictly related to employment relations. We find accounts of territorial variations in the introduction of certain accountancy practices, such as the centralization at regional level of payments to private providers; the initiatives of some regions in encouraging the implementation of innovation, like the ‘electronic medical records’; the diffusion of Private Finance Initiative or public-private partnerships in some areas of a country compared to others (e.g. in England as opposed to Wales). Changes in the mechanisms of workforce governance did not formally include an intermediate, regional level of intervention in the public employment. A recent body of literature has investigated the effects of territorialisation in terms of responses from the local workforce. Greer and colleagues have researched the reasons behind the resulting variations of local level industrial relations of market mechanisms introduced in the hospital sector and rolled out on a national scale in Germany. They identified Landerrlated variation in co-determination rights, unemployment rates and local politics as the elements that determine the ‘locale’ capacity to respond to market pressures in a public services (Greer et al 2013: 231). Changes in the provision of primary healthcare in Alberta, Canada, in the 1990s have also proved useful a case study for the analysis of a ‘variety of forms of resistance’, from the local community and from the workforce (Reay and Hinings 2005). Though dispersed across different disciplines, the literature on the local workforce responses to territorialisation of health services suggests a peculiarity and a variety of, not only reactions, but also effects of regionalisation that go beyond single national cases. On one hand, the principles of nationally designed models of healthcare provision may ‘get lost in
regional translation’, therefore challenging an effective implementation of reforms. On the other, as a result of differentials in the economic performance of the regions, terms and conditions of the workforce, especially where meant to be nationally homogenous, may change according to the resources available locally, or to the relative ‘powers’ of the social actors involved.

The paper analyses today’s public health sector in Italy and the effects of the combination of NPM-inspired health sector reforms and territorial decentralization on the mechanisms of workforce governance. Though not formally recognized by the industrial relations arrangements in place today, we ask whether a regional level is emerging as a new arena of social dialogue and level of regulation of workforce conditions in the public health sector. That is, given the devolved responsibility of much of the healthcare provision to the Italian regions, is a new level of workforce governance likely to be established at a ‘new scale of the market’? Second, what is the resulting relationship with the other, national and organisational, levels of CB? Given the significant diversity in the performance of the regions and resources available to deliver healthcare, we could question whether the two-tier, national-organisational, industrial relations arrangement is still adequate to regulate the demand of governance in the health sector. The question is relevant in the light of the increasing divide between well- and less-well performing regions in terms of control on healthcare expenditure, peculiar to Italy, but not uncommon in other countries too.

To answer these questions, we will focus on the health sector employees, in particular public hospital nurses, technical and ancillary staff. The following two sections present the Italian case and the research design and methods. The theoretical framework will be introduced in the fourth section and used to map and interpret the evidence of regional variation. Findings will then be discussed and some conclusions drawn.

2. Reforms and territorial decentralization of healthcare in Italy and effects on employment relations

Two decades on since the first reforms that led to an organised decentralization of employment relations in the healthcare sector; 15 years after the roll out of the ‘federalist project’ that has, in the case of health provision, partly increased the divide between regions; five years of austerity measures since the onset of the economic crisis and the consequent declining investments in healthcare, make Italy an interesting laboratory of responses to key, common challenges to the health sector and their workforce in many Western countries.

Institutionalized in 1978 with the law no. 833 (‘Reform of the Health System’) the Servizio Sanitario Nazionale (SSN) was the first in Europe to be based on the principle of ‘full democratic universalism’. Previously based on an occupational regime model, it was to be financed, from then on, with general taxation, though this was to be effectively rolled out only at the end of the 1990s (Ferrera 1995; Neri 2006).

Important reforms were carried out at the beginning of the 1990s. In 1992 and 1993
two reforms were implemented in the public sector and at the end of the decade, in 1999, the so-called ‘reform-ter’ took place. These reforms promoted a company-oriented vision, making corporatisation a key, prominent trajectory of change in the SSN. Local Health Units (USL, Unita’ Sanitarie Locali) were transformed into ‘Local Health Organisations’ (ASL, Aziende Sanitarie Locali) and together with the independent hospitals (AOs, Aziende Ospedaliere) they represent the ‘company-level’ of the health sector, reporting directly to the regional administration they belong to. With the 1999 reform, general directors of ASLs and AOs were given full management autonomy. However, the trend towards what was looked at as managerialisation has been a compromised one, as the appointment of the general director is still based on the politically oriented choice of the regional government. With marketization both private and public providers were encouraged to bid for the provision of services to the public healthcare sector. This was however implemented to rather different extents across the twenty Italian regions. Lombardy remains the only region that did attempt a marketization of the health provision (Neri 2006). Privatization also took various forms, from experimentation of PFI in some regions, like Lombardy and Veneto, to externalization of some services such as test laboratories, but without marking a revolution in the combination of public and private hospitals. A cross-region common feature was that of outsourcing non-core services, such as cleaning, laundry and catering.

Regions have been involved in the participation in the health expenditure since the reform in 1992, and responsibility of the regions on public services, including healthcare provision, was then further strengthened with the federalist reform of 2001. The financing of healthcare coming from the regions reflects the significant diversity not only in the resources available, but also in the solutions considered. Regional taxation allocated to the local health sector averages 39 percent, but varies from 10 percent in Calabria to over 60 percent in Lombardy (Formez 2007). At the same time, it has been noted how certain measures prevailed in the northern regions, notably, increases in regional taxation, and others in the South, where structural changes prevailed, such as re-organisation of hospitals, drugs management, fees on prescriptions (Maino 2004), marking significant diversity from region to region. The ‘Conference State-Regions’ is in charge of coordinating the two levels, ensuring that national minimum standards are met and that the expenditure on health is kept under control. The Conference also acts as interlocutor with the government when the national budget is jointly decided by the Ministry of Health and the Ministry of Finance. The Conference participates in discussions about reforms, revisions of the national minimum care standards (LEA, Livelli Essenziali di Assistenza), changes in the relative weight between State and Regions in the operation and organisation of healthcare. It has been observed how this has

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1 AOs are hospitals that become independent from the ASL and report directly to the regional administration. Independence can be achieved once some criteria are satisfied, proving that they are financially robust and well governed structures able to provide and deliver health services. There are about 82 AOs in Italy with an average of 2.2 sites each. The rest of the hospitals are part of, and report to, their ASL. Following restructurings, ASLs are now about 146, as opposed to 228 in 1995.

2 The Italian regions are 20, but in the health sector the two autonomous provinces of Trento and Bolzano (in the same region) are administratively separate units.
ensured, on one hand, a form of re-distribution and equality, so that the poorest regions are not disadvantaged; on the other, however, the well-performing regions have historically been in a better position to lobby within the Conference and steer decision making outcomes.

In 2005, due to the persistent serious budget problems and excessive spending of some regions, the Conference decided to impose solvency schemes or ‘recovery plans’ (piani di rientro). As of today, there are eight out of twenty regions under recovery plans\(^3\). This leads to some automatic increases in regional taxes to finance healthcare, but also to the automatic hiring freeze for usually two years, when budget revisions take place and decisions on staffing are, in case, accordingly reformulated. In the annual State Accountancy review, it was reported how the percentage of the regional health expenditure allocated to personnel has been decreasing in all regions between 2002 and 2012 (with the exceptions of Bolzano and, to a minor extent, Friuli Venezia Giulia) but with particularly sharp decreases in Molise and Calabria (from 39% to 31.9% and from 41% to 36% respectively).

With the territorial decentralization following the federalist reform, the Italian regions came to play an increasingly focal role. Free to organise their health service, within the limit and largely variable amount of resources available, different ‘regional health systems’ emerged. Neri (2006, 2009) identifies three. One is the competition model, where mechanisms to encourage competition and private-public partnerships and financing have been introduced. Lombardy is the only Italian region that experimented a clear distinction between purchasers and providers under the principle of guaranteeing ‘freedom of choice’ to patients and the chance for ‘any willing provider’ to bid for service provision. Sicily is also planning to adopt a similar system of ‘managed competition’.

A second cluster of regions was grouped under the so-called cooperation or integration model. Some regions adopted mechanisms of ‘negotiated planning’, like Emilia-Romagna and Tuscany; other adopted managerial planning and control instruments, like Veneto and Friuli-Venezia Giulia. Within this model the various public and private subjects are perceived as part of a network, complementary to each other rather than in competition, in order to achieve an optimal organisation of the healthcare services. Some of the instruments used for this purpose are the

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\(^3\) Piano di rientro (PdR) was here translated with ‘recovery plan’ for simplicity. Cuccurullo et al (2010) in their chapter of the OASI report (Anessi Pessina et al 2010) point out that PdRs should be seen as more complex instruments. On the basis of the evidence collected, it was shown that PdR have been interpreted in different ways by different regions, distinguishing between simple ‘recovery plan’ and ‘turnaround plans’. This distinction is operated on the basis of the prevailing direction of the measures envisaged by the PdR, whether more, respectively, of financial control or more widely meant as instruments to intervene on the structural causes of the deficit. The national agency for regional health systems, AGENAS (Agenzia nazionale per i servizi sanitari regionali) is in charge of monitoring the progress. The regions under recovery plans at June 2014 are Piedmont, Lazio, Abruzzo, Molise, Campania, Puglia, Calabria and Sicily. Of these, some like Calabria, Campania and Lazio, are under controlled administration (commissariato), therefore further limiting the room for maneuver in organisation and employment relations adjustments of the local health sector.
unification at the regional level of the booking services, the purchase of training or other services in ‘bulks’ by all region’s health organisations, instead of by individual hospitals.

Finally, a residual model, also defined as bureaucratic model, interested in particular some Southern regions, where practices, though, are various. In Campania and Sicily there have been attempts to introduce competition. In the central region of Lazio after the period 2000-2005 oriented to competition, a more integrative approach is now being adopted, like it happened also in the Puglia region (Neri 2009, 368-372). All attempts, however, have in common a primary budget-control objective imposed by the recovery plans to which most of the regions belonging to this model are subject.

A strong regional divide has historically characterized Italy on a number of different dimensions, amongst which the provision of public healthcare. There have been, in this sense, undeniable improvements from the first reforms in the 1970s. Situations in which patients from the South had to cue over night outside the big hospitals in Rome, possibly with a recommendation letter from a politician or a priest, to be admitted the following morning (Koff 1982) are not common anymore. There are still, however, considerable regional differences. Various comparative, regional level research confirms this. A comparative research of the Quality of Government Institute, University of Gothenburg, ranked 18 European countries and their regions on the basis, amongst other indicators, of the quality of local government, which includes local health systems. Italy as country ranks at the tenth position, but Calabria, for example, is at the 172nd place amongst the regions, whereas the province of Bolzano is at the 9th (Charron et al 2012). The research highlights how regional divides are particularly marked also in other European countries, such as Spain. The perceptions of Italian citizens and the access to quality healthcare was surveyed by the centre for social investment studies, Censis (Centro Studi Investimenti Sociali) in 2012 and confirmed that more than 73% of the population who live in regions under recovery plans declared themselves contrary to a complete autonomy of the regional government in healthcare, as against 52.7% of the population in regions not under recovery plans.

There is concern of both the Finance and Health ministries about the within-country ‘health tourism’ generated by such divide, which exacerbates the differences, instead of prompting solutions to improve territorial inefficiencies (State Accountancy review, August 2013).

The research into possible differences in the mechanisms of workforce governance in the regional health sector is seen in relation to the established two-tier employment relations framework and to its advantages or limits in the context of such a marked, persistent differentiation.

As with regards to the first set of New Public Management-inspired reforms, a consistent, rather radical change took place as the ‘sovereign model’ system of statutory and administrative regulation of all civil servants was abandoned in favour of collective bargaining in 1993. Articulated on two levels, a national/sector and a
decentralized/organisational one, the arrangements of collective bargaining in the whole public sector are the distinctive features of the two-tier multi-employer system still in place. Consistently with the NPM reforms, the ‘contractualisation’ of public employment was introduced to reflect the arrangements of the private sector industrial relations. In terms of contents, public health sector collective bargaining retains a distinctive feature. The national level collective agreements are highly detailed, whereas the hospital/organisation level collective bargaining has developed on a range of non-pay issues, but not over pay related to performance, which is a key feature of larger organisations in the private sector. Performance related pay, which came to ‘symbolize’, in a way, the achievement of a private mind-set has had varied implementation across different organisations. According to union representatives interviewed at the national level, some hospitals did attempt a definition of criteria to assess and reward performance of nurses and allied professional, but this often ended up including attendance and availability to work (with issues emerging in terms of discrimination towards those who had limited availability because, for example, of care responsibilities) rather than set objectives and related bonuses. The resources allocated by the national level to the collective bargaining at hospital/organisation level have been usually ‘redistributed’ amongst different groups of health staff, in turns, to top up poor increases obtained at the national level negotiations.

In January 2009, a new industrial relations framework agreement established that, while maintaining the two-tier multi-employer bargaining arrangement, further responsibility was to be devolved to the decentralized level. In 2009 also two bills of reorganisation of the public sector were issued under the centre-right government to tackle inefficiency and according greater discretion at managers in local public administration to unilaterally solve employment disputes in case a collectively agreed decision was not made within a given time. The 2010 budget law froze the national collective bargaining in the public sector until 2013, imposing a tighter control of the regional health expenditure and new rules in the definition of wage increases (not anymore related to the real inflation but to the index of consumer prices). The austerity measures in place since 2009 and the consequent state unilateral decisions to cut or freeze public sector wages further confirm the persistent differences between public and private realms of employment relations (Glassner 2010; Bordogna and Pedersini 2013).

Given this frame of reference, matched with the regional diversity found in Italy, the research question this article sets out to investigate is whether there is a role for the regions in the governance of workforce that corresponds to their increased role in the financing of healthcare.

3. Research design and methodology

The focus of the research is on nurses and allied health professions. Within the Italian health sector this represents one of the largest professional groups: 270,000 staff, 75% of which are women, out of a total of 673,000 public health sector

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4 Law no. 15, 4 March 2009 and Law Decree no. 150, 27 October 2009
employees. With a similar total population to that of Italy, the UK employs double the number of nurses and overall 1.5 million NHS staff. A wider international comparison shows that Italy exceeds in number of doctors, 3.9 against an Oecd average of 3.2 per 1,000 inhabitants, but has far less nurses per 1,000 inhabitants, 6.4 as opposed to a Oecd average of 8.8, and of 8.6 in the UK (Oecd Health Statistics 2013).

The hiring freeze and expenditure control regime of the past decade led to a relatively modest overall reduction in permanent staff, -1.3% since 2007. This was partly achieved by recourse to temporary contracts, though these also decreased (-24% in the period 2007/2012) and agency work (+4% in the same years) and by a containment of wages. The national collective agreement that covered 2006-2007 established an increase of 4.85%; the following, last renewal of national collective agreement in July 2009 agreed on so 3.2% average increase for health staff. Estimates highlight a shortage of 40,000 nurses, with particularly negative effects in the hospitals of the North of the country.

To investigate the possible effects of territorialisation of healthcare provision on the mechanisms of workforce governance, data were collected to map the use of regional additional resources allocated to the health sector according to its potential impact on employment relations matters. In particular, the challenging situation of nurses and health staff was found to be a good starting point to analyse the possible sources of intervention and the effectiveness of the different levels of employment regulations here considered. Medics and managers of the health sector are covered by different, separated collective agreements and were not included in the study. Data were derived from the analysis of documentation such as sector and organisation level collective agreements for the health staff (comparto), regional accounts (including minutes of meetings between the regional governments and the respective local health councils - assessorati regionali alla sanità) and national reports of the State accountancy office. Qualitative, semi-structured interviews were carried out with employers’ associations and health staff trade union officials and experts at national and regional levels. The health sector officials of the public sector federations of Cgil and Cisl, as well as officials from Aran (the State-representing body for health public sector collective bargaining), were interviewed in Rome in 2010 and 2011\(^5\). Interviews at the national level were aimed at gaining information also on specific regional experiences. In the same years, the Lombardy union representatives of the same union federations and the representative of the regional health department were also interviewed. Scholars and experts in public sector employment relations were also contacted and interviewed. All the interviews were transcribed and manually coded.

This was aided and complemented by a three-year (2011-2013) systematic and extensive review of press and articles in specialized websites and centres of study of health management. Examples of these sources are Quotidiano Sanità, an institutional news website – linked to the Ministry of Health and Federsanità\(^6\). It

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\(^5\) Cgil and Cisl are not the only representative union organisations for health staff but were selected on the basis of their respective density in the union domain of 17.8% and 12.5% and their constant presence at the negotiations tables at national and decentralized level in the health sector.

\(^6\) Since October 2006, Federsanità is an interest organisation that includes 17 Regional federations and 166 ASL and the Conference of the Mayors (Conferenza dei Sindaci).
publishes daily updates in the area of private and public health. The website has a section specifically dedicated to the regions and their individual initiatives, conferences, proposals, meetings. The Sole24Ore Sanita’ is another example. It is the health-sector specialized section of the main Italian economic and financial newspaper Sole24Ore. The websites and databases of professional bodies and interests’ organisations were also monitored and drawn from. Other useful sources of data were research centres such as the Bocconi’s Observatory on health organisations (OASI, Osservatorio Aziende Sanitarie Italiane – one of its senior members was also interviewed) and the Management and health Laboratory in Pisa (Laboratorio Management e Sanita’ of the Istituto Superiore in Pisa). These are specialized in projects and research on a number of different healthcare related topics, from clinic processes to risk management, from trends in care in certain specific areas, such as maternity or diabetis, to integration with territorial systems of social and health care, to payment methods to private providers, or hospital patients’ flows and logistics. They greatly aided the search of a rounded view of the regional health systems and, more or less directly, alerted on possible implications of regional interventions on employment relations matters.

The aim has been that of tracking the developments, if any, of the region’s role in possible changing mechanisms of workforce governance, with particular reference to interventions in the stabilization of temporary health workers, recruitment practices, changes in their terms and conditions of work.

The approach has been mainly qualitative and 16 out of 20 regions were looked at in detail: eight of these are under recovery plan (Lazio, Calabria, Abruzzo, Campania, Sicily, Molise, Puglia and Piedmont); the other eight regions are considered ‘well-performing’ regions and have their health expenditure budget under control (Tuscany, Lombardy, Emilia Romagna, Veneto, Friuli Venezia Giulia, Liguria, Umbria and Marche)7 – figure 1 in Appendix.

4. The Regions: an intermediate level of regulation?

Over the years, the national level has successfully managed, on one hand, to control the overall health expenditure, which has remained relatively stable in the past 20 years as a percentage of the GDP, moving from 8% in 1990 to 9% in 20128. From the point of view of the industrial relations, according to the unions, the national level has made it possible to coordinate and bargain minimum standard for the health staff across the whole national territory, minimizing regional divides and therefore responding effectively to the function of an equal distribution of the resources.

Partly limited results were shown to be achieved at the decentralized level, even though this mainly relates to the implementation of performance appraisal systems, which were amongst the great expectations that accompanied the contractualisation of public sector employment in 1993. However, analysis of organisation level

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7 Every year three regions are chosen as ‘benchmark’ for the ‘standard costs’ of a number of operations. In 2013 these were Emilia Romagna, Umbria and Veneto.

8 In 2012, the UK health expenditure was 9.8% of GDP; 11.6 in France and Germany (Eurostat 2012).
agreements, documentation and interviews to the social partners, unanimously confirmed that often the collective bargaining at the organisation level has proved capable of addressing demands of flexibility in the use of work, of proposing original solutions to improve patients care, and of managing the effects of outsourcing processes (Bordogna and Ponzellini 2004, Zoppoli 2008, interview with Cisl and Cgil national public health sector officials).

Considering the functional role of each level of collective bargaining here outlined, a question emerged about the effects of regionalisation on such arrangements. In particular, we refer to the extent to which regional resources can enhance or, on the contrary, frustrate this ‘division of work’ between national and decentralized level. Evidence of an only voluntaristic approach to the involvement of region in public health sector employment matters can be found in the renewal of the national collective agreement for the health staff signed in July 2009, where art. 3 foresee that ‘in case of restructuring of regional or above-organisation scale’ the criteria for the mobility of workers can be discussed at regional level. What functional role can this possible intermediate level of workforce regulation take?

Within the European industrial relations debate, a regional level of regulation has long been discussed, either for its variable formal/informal nature, or in the attempt to gauge its possible role in the process of European integration. In the analysis of industrial relations systems and state traditions, Colin Crouch highlighted how European countries in their continuous and various attempts to coordinate national and local level bargaining, never resorted to establish a regional level as a new strategic, formal site for industrial relations activity (Crouch 1993). A role, however uncertain and undefined, was debated also within the context of European integration, in the early 1990s in particular. European regions were seen as potentially effective levels of intervention to solve problems of labour markets inefficiencies. Critics were raised in terms of feasibility, given that institutional foundations of, for example, wage determination are mainly national and the strong diversity within Europe could lead to more instability, rather than stability. According to Teague (1995), for instance, the fragmentation that would generate from such a regionalization of structure of governance of labour markets undermined its desirability. The assumption that seems to underlie this area of the debate is that a regional level could ‘hollow out’ the existing national level, in the attempt to affirm itself as a more appropriate substitute.

Though invoked by many (Carriero and Nastasi 2009, and the contributions in the same book specific to the health sector by Carriero, Alessi and Dal Gesso & Ferrari), it is not an easy task to define how regions could be usefully, formally included within the extant employment relations arrangements. In response to the need of some adjustments identified by Carriero (2009), the author proposes to increase the power of the regions to intervene in the negotiations as a substitute, possibly more effective, of the company level, where career progressions were abused and an efficient allocation of the resources never really took place (Carriero 2009, Alessi 2009, Bordogna 2009 and Bordogna and Ponzellini 2004). Such a shift to a regional level could here lead to a ‘squeeze’ of the organisation level of collective bargaining.
Later comparative research has indicated a *de facto* role of an ‘intermediate level’ of social regulation (Regalia 1998), at times more widespread than expected if one looks at the traditional national industrial relations focus of national or company levels (Regalia 2006). Looking at Baden-Wuttemberg, Lombardy, Catalonia and Rhone-Alpes, Regalia and colleagues found common patterns of relationships between regional governments and institutions and interests’ organisations. The research is insightful of the variety of forms that such initiatives and interactions can take in these ‘dynamic regions’. Of specific relevance for the purpose of the present work, is the identification of both a voluntaristic approach of regions (it is, after all, an ‘easy’ level given that *exit* is always available), as well as the marked segmentation of their involvement in industrial relations. Overall, the experiences observed vary according to the *local institutional systems, if by this is understood not simply the disposition of resources to the regional authorities (degree of autonomy and scope for action) but also their administrative styles (their willingness to provide space for interaction with interest organisations, in particular the unions)* (Regalia 1998, 163).

The advantages observed by this level of possible, though never formal(ised), coordination is that of flexibility and adaptability, with the weaknesses of poor coordination and discontinuity.

The positions briefly sketched so far apply mainly to the private sector. The case of public sector bears an additional element of a formal role for regions in some countries to manage the financial resources for, in the case here considered, healthcare provision and organisation. In his evaluation of the public sector reforms and the approval of the ‘regionalist’ Constitution, Zoppoli (2008) highlights that there has been a polarization of the functions of the two employment relations levels, with a centralised control of expenditure for staff and update of terms and conditions of work (in terms of contributions, regulation around work) and a decentralised level for the flexible utilisation of work that have concrete, strong effect on the actual organisation of administration. Particularly in the case of healthcare provision, he argues that some expenditure variables and guidelines could be usefully decided at the territorial, regional level, given that regions are now important centres of the governance of public expenditure.

**Drawing from the combination of past experiences and the specific organisational framework of healthcare, we could expect an occasional/on-demand shift from two- to three-tier arrangements, with regions intervening in employment regulations when resources and other conditions, such as power of social partners, are in place.**

5. **Healthcare and employment relations in the Regions**

According to many, an increased differentiation has become the feature of the Italian national health system. In the preface to *The possible change. Healthcare in Sicily between North and South* (edited by Pavolini, 2011), Carlo Trigilia writes that *Talking about the Italian National Health Systems means talking about Regions*. On the other hand, when asked to focus on a possible, new regional level of mechanism
of workforce governance, the Cgil national public health official interviewed, firmly replied that ‘The Italian National Health System is national and is one’.

The two statements are not in contradiction. There are indeed different regional models of healthcare provision, but in terms of employment relations, existing arrangements make no reference to a formal, procedural involvement of the regional level, except only to a possible, voluntary engagement in case of restructuring at a regional scale.

It is within this ‘possible’ space open between national and organisational level that a closer insight into the chosen 16 regional experiences reveals important differences in the mechanisms of workforce governance.

A first major distinction is visible between experiences in the so-called ‘well performing’ regions, i.e. those who are not under recovery plans, and in those under recovery plans.

Examples of the former come from Lombardy, Veneto and Friuli Venezia Giulia. The interviews carried out with the social partners in Lombardy (Cisl and Cgil regional officers, and the general director of the regional health directorate) show that the region has intervened and allocated own additional resources to solve matters related to workforce governance. Apart from more common regional level projects such as improvement of the waiting lists, bureaucratic simplification, organisation of the booking system, Lombardy allocated money to create accommodations for nurses (particularly in Milan, where the cost of living is higher) in order to attract applicants from outside Lombardy, contributed to an increase of the average salary of nurses to deal with the problem of staff shortages. Other cases confirmed the will of region to intervene, when necessary, to the solution of conflict. An example was a dispute over the merger of a number of hospitals, among which the big public Ospedale Maggiore in Milan, in the early 2000s and the agreement for the staff of the unified organisation. The negotiations between the social partners of the involved came to a stall over the amount of the pay increase. The managers were concerned with the tight budget and the Region intervened assuring the financial coverage, to facilitate the merger.

Veneto and Friuli Venezia Giulia, in the North East of the country, have been mentioned in the specialized media for the above-average additional regional resources on healthcare. The former has allocated 200 million Euros in two years explicitly to reinforce the territorial services, i.e. having more General Practitioners to work longer to cover more shifts. Friuli Venezia Giulia has also committed 9 million Euro as incentive to work unsocial hours (night shifts, holidays and weekends) for nurses and allied professions. In particular, 7 million are to be managed via collective bargaining at the organisation level to cover critical areas such as staffing of A&E departments, reduction of waiting lists, prevention of work accidents, project for innovative organisational models, clinical governance, etc. Though the resources are allocated by the regions, it is then the responsibility of collective bargaining at the hospital level to distribute them in line with the needs of specific services. The Santa Maria degli Angeli hospital of Pordenone, in the Friuli
Venezia Giulia region, has established that the CAT (computer-assisted tomography) can be performed by health staff, without medics having to be present. This ‘job enlargement’ for health staff has the objective to reduce waiting lists, optimize the use of the technology and machines available, but relies on the flexible utilization of the workforce that has become possible thanks to the additional resources made available by the region to the specific organisation.

In May 2013, the regional social partners in Umbria, central Italy, signed a ‘regional agreement on industrial relations’, where the Regional government committed to be part of the ‘bargaining, concertation, consultation, information and joint analysis’ of any effects on employment of possible organisational changes of the regional health system. Also located in central Italy, the healthcare directorate of the Marche region signed an agreement in December 2013 with the regional public health sector unions (Cgil, Cisl and Uil) on the stabilization of 1,200 temporary workers. Marche hospitals and local organisations are grouped under a single Local Health Organisation so that the collective bargaining at the decentralised level coincides with the regional level. Despite overall cooperative relations between social partners, trade unions have expressed concerns and criticisms that such grouping has led to a disempowerment of the organisation level collective bargaining.

Tuscany and Emilia Romagna are also regarded as well performing regions, they act as ‘benchmark’ for less well performing regions and are often quoted for their cost control and efficiency in public health expenditure reports. They have also established joint initiatives to further ‘learn from each other’ and share best healthcare practices. According to our analysis, there is little evidence of direct, nor indirect, forms of intervention in the mechanisms of workforce regulation by these regional governments. There is indeed evidence of numerous activities aimed at the improvement of territorial healthcare assistance (in Tuscany this has been achieved with the grouping of some ASLs under ‘wide-area’ units, which have mainly organisational/management implications) and of the excellence of some local organisations and hospitals (e.g. in November 2013 the ASL of Ferrara and the AO of San Carlo di Potenza received the ‘Public Administration Award’). The president of Agenas commented on the great capacity of individual ASLs in Emilia Romagna ‘to plan and make decisions on their priorities in terms of care, and decide what to cut’\(^9\). Organisation level collective bargaining takes place without apparent interference/steering from the regional level.

When considering Lombardy, the example and only case of the ‘competition’ model, as classified by Neri (2006), we find a willingness for an autonomous approach to employment relations matters. All social partners interviewed in Lombardy, except, to an extent, the Cgil regional official, agreed on the desirability of a greater independence from the central level in terms of scope for action in employment regulation. This was argued in particular with reference to the greater flexibility in the involvement of private providers and introduction of performance related pay as an incentive tool for health staff. From the regional government directorate, the

\(^9\) Interview to Giovanni Bissoni, president of Agenas, the national agency of regional health systems.
message was that greater autonomy in collective bargaining at a regional level would ensure greater flexibility in the organisation of healthcare provision. An example mentioned during the interview was the attempt to outsource the ‘dental service’ of the San Paolo hospital, in Milan, which was eventually blocked by the unions. This could have been more easily achieved, it was said, if public employment relations arrangements had been ‘lighter’, not ‘dictated’ from the central level. All partners recognized the advantage of a relatively stable regional government (center-right) and the consequent building up of cooperative, keen-to-compromise employment relations with the unions. The central level was referred to as ‘interfering’ by the regional Cisl officials, arguing on the greater consistency needed between industrial relations and regional healthcare model: ‘We would like to have a lighter national collective agreement that defines wages linked to the professional profiles, and then have the control at the decentralised level of all the variable pay, with the possibility of changing some terms and conditions like allowances for the shifts, allowances for working on holidays. Something is slowly changing, thanks to the industrial relations framework agreement [of 2009]. Hopefully it will speed up. This will allow the additional regional resources to be linked to the specific organisational model of regional health service’.

The Lombardy Cgil regional health official interviewed confirmed that ‘there is greater scope here, compared to other regions, to reach a contractual federalism’. More than in terms of ‘desirability’, he expressed in terms of possible, functional advantages. Because of the regional diversity, some flexibility could be useful in how regional funds are spent, also with regards to managing employment relations. In particular, he highlighted how the greater presence of private providers in Lombardy, along with religious hospitals and cooperatives, is having the effect of diversifying the conditions of work of, for examples, nurses working in the same hospital but for different organisations and under different national agreements. A regional level of intervention could address this fragmentation.

The evolution in this case would be towards a ‘hollowing out’ of the national level and a greater prominence of the regional level that is more respondent to the regional health system here implemented.

Amongst the regions grouped under the ‘cooperative’ model, we find a great variation of level of involvement of the regional governments in employment relations matters.

Friuli Venezia Giulia and Veneto appear to act more as regional facilitators of employment relations at the organisation level. In Veneto and Friuli Venezia Giulia, the additional regional resources are allocated to improve public health services, but the hospital organisation level retains discretion in how to use them. It would appear as an ‘on demand’ three-tier system: to ensure the achievement of macro-objectives established at regional level, the regional governments allocate resources to facilitate the relative employment adjustments, such as for example wage resources for overtime and re-organisation of shifts.

The cases of Tuscany and Emilia Romagna, on the other hand, show that the region can be equally willing to improve the healthcare service, but not necessarily steering the resources made available towards specific workforce-related use. There is, rather, a fully recognized and enacted independence of the organisation level.
Significantly different is the case of the regions under recovery plans, though within this group an important difference needs to be drawn.

For cases such as Campania, Calabria, Lazio and Sicily the block of turnover and a minimized scope of collective bargaining at decentralized level have been constant features for nearly a decade. The complexity of each case would require a specific focus on the individual regions but for the purpose of this work a relevant, common characteristic is the vicious circle where the hiring freeze leads to the massive recourse to overtime and temporary workers, normally to be managed at organisation level. Here, however, according to the national level union officials interviewed, collective bargaining struggles to take place beyond ‘routine issues’ due to the dramatic lack of resources and discretion. The ASL of Naples, one of the largest in Europe in terms of remit, has had to undergo a dramatic reduction in staffing between 1993 and 2011, causing extraordinary use of overtime from nurses and doctors, and recourse to an increasing number of temporary contracts. At the ASL of Avellino, again in the Campania region, some 273,000 Euros were due to medics for the overtime worked between 2011 and 2012 to cover the minimum service. Doctors’ representatives were refused payments by their organisation and the compensation only arrived following a decision of the Employment Tribunal.

In Calabria, the hospital ‘dell’Anunnziata’, in Cosenza, was occupied in January 2014 by employees, protesting not for a salary increase but for the hard conditions of work: the lack of staff led to increase in workload and to a consequent, increasing difficulty in delivering the minimum levels of service. The search for a dialogue with the management ended as the hospital director declared to be ‘trapped’ by the lack of resources imposed by the region.

A similar limitation in the use of resources at the local level imposed by the recovery plans was experienced in Lazio. In more than one occasion, the social partners at the regional level sought to establish a regional level concertation to address issues such as ‘staffing needs’ and ‘accreditation and control over employment relations of the private providers’, but unsuccessfully.

Though further, in depth research would be required to establish difference amongst the regions under recovery plans in responding to the effects of long lasting hiring freeze, it seems a common feature that the main effect of the responsabilization of the regions to recover health expenditure financial debt has led to a ‘squeeze’ of the organisation level collective bargaining and has preempted it of the chance to propose solutions. The dis-empowerment of ASLs and AOs has been pointed at as a possible cause of the failure of recovery plans implemented in Campania, where targets have been imposed to all health organisations, regardless of the individual characteristics and needs (Cuccurullo et al, 2010: 234). On the other hand, the national union representatives and the experts on the employment relations of the health sector interviewed have highlighted the past negative experiences of the collective bargaining at organisation level in the regions today under recovery plans. Mis-management at organisation level, both of operations and of employment relations, was considered a key factor responsible for the escalating financial debt of the regions. Cases of corruption in the purchase of services and equipment for local hospitals and health units have been common in the past and are still, not infrequently, coming to the fore in discussions on the causes of the regional divide.
Though these scandals are common across Italy, they happen to be more frequent in the South\textsuperscript{10}. The use of public employment as a channel of political consensus has, on its hand, interfered with not only the distribution of resources via collective bargaining at organisation level, but also with the possibility to build a tradition of a more constructive approach to employment regulation at the decentralised level.

There are other regions that, although under recovery plans, are showing to have an approach that includes social dialogue to find solutions and ways to ‘recover’. Piedmont and Sicily are two examples. In Piedmont, an agreement between the regional government and the social partners has been recently signed to formalize the will of the region to engage with possible effects of the restructuring (i.e. minimize job losses) that may become necessary to accomplish a control of the expenditure. In Sicily, according to the national level union representatives interviewed, regional social partners are being involved in the decisions concerning the recovery plan. In one of the latest reviews, Sicily’s 2013 recovery plan was judged as a substantially ‘positive’ for having achieved the ‘promised’ reduction in personnel. Overall the reduction was -3% of staff between 2006 and 2008, both of permanent (-5%) and of temporary (-1%) staff. There was, on the other hand, an increase in the health and technical staff.

6. Discussion

The concomitant roll out of the two sets of reforms, NPM reforms on one hand, and territorialisation of the healthcare on the other, led to the formation in Italy of different regional systems. The existing two-tier multi-employer arrangement of its industrial relations has led to what Zoppoli (2008) called a polarization of the function of the two levels, with a centralized, national level control on expenditure for staff and general terms and conditions of work, and a decentralized level that has ensured flexible utilization of work and influenced the implementation of new projects, improvements and organisation of health provision. The regional differences stretched the capacity of the decentralized level to deal with this ‘responsibility’ in opposite directions.

In the ‘well-performing’ regions, whether with the mediation of the regional government or not, the decentralized level was further ‘empowered’ of its responsibility to deliver healthcare and manage the human resources associated with it. The financial difficulties of the ‘less-well performing’ regions, on the contrary, acted as a bottleneck of the resources, ending up frustrating the ‘corporatisation’ project initially envisaged on a national scale. By contrast, in these cases, the national level has proved to be able to guarantee a minimum protection level that would have been otherwise undermined by the severe (especially in some cases) cuts of resources to the local healthcare sector.

Though perhaps not fully accomplished, according to some, the contractualisation of employment relations in the public sector was consistent with the set of reforms that have been identified with the introduction of New Public Management in Italy.

\textsuperscript{10} Lombardy is overall regarded as a success case, but has too been often in the focus of public and media attention for big scale scandals in the healthcare sector.
By contrast, to the greater financial responsabilization of regions that followed the Italian federalist reform of 2001 in the provision of healthcare did not correspond a concurrent territorial level of regulation of employment relations. The evidence here presented confirmed, on one hand, the endurance of the two-tier multi-employer bargaining system for the public sector. The union officials interviewed confirmed that the role of national CB level has been of fundamental importance to maintain minimum levels of wage and protection of basic terms and conditions of employment for the staff in regions under recovery plans throughout the processes of redundancies, mergers, reconversions and rationalization of services. All agreed also on the fact, however, that recent austerity measures and the consequent collective bargaining freeze in place since 2009 have frustrated the role of social dialogue and collective bargaining at both levels. Despite the adversities, literature and cases show also that great diversity is found at the organisation level, where ASLs and AOs have been at the forefront of the implementation of the regional plans of healthcare.

A closer look into regional experiences reveals that the great territorial diversity of the health systems has challenged functional role of the two levels of employment relations and the capacity of such arrangements to deliver and promote equality. Depending on the type of regional health system, the resources available and the ‘administrative style’, local governments have shown more or less keen to intervene in employment relation matters.

In Lombardy, where more than in other cases, competition amongst providers of different nature was achieved, and where there has been a long tradition of social dialogue in the healthcare sector, there is an inclination of the region to become a primary level of regulation for employment relations, manifested not only in the interviews to the social partners, but also in the concrete presence of the region in organisation level disputes and in steering the direction of the resources allocated. ‘Hollowing out’ the national level of regulation, however, would lead to possible fragmentation and difficulties in the coordination of, in this case, a national health system to which Lombardy still belongs.

In most of the well-performing regions, what is visible is rather a regional ‘on-demand’ intervention when resources are available and the need arises. Examples are Friuli Venezia Giulia and Veneto, where resources have been allocated to ensure personnel coverage and motivation to implement regional health plans. We could therefore talk of an occasional shift from a two- to a ‘three-tier system’ of collective bargaining, though largely based on a voluntary and contingent approach, as in the tradition of this intermediate level of regulation well captured by past research (Regalia 1998).

In other cases, similar in terms of performance, the regional governments has not been interested in influencing the collective bargaining at the organisation level in the use of the additional regional resources. Emilia Romagna and Tuscany are two examples. Here, ASLs and AOs are given full autonomy in the implementation of the regional macro-objectives for the provision of healthcare, enhancing the functional role of the decentralized level of collective bargaining.

Marche and Umbria, Piedmont and Sicily, are examples of forms of social dialogue between social partners and regional government related to health employment relations (for the stabilization of temporary workers; the establishment of forms of
regular consultation; the engagement with possible effects of reorganisation of the healthcare provisions) but the implementation of such intents can be subject to national limitation, due to the possible costs involved or because of restrictions coming from the recovery plans. Though for some a regional regulation would be desirable (e.g. Carriéri and Nastasi 2009), where this was experimented (though not on a voluntary basis), the effect has been to frustrate the collective bargaining at organisational level and ‘squeeze’ its autonomy. This was evident in the regions with particularly severe recovery plans such as Calabria and Campania, where employment needs were overlooked by economic objectives.

**Conclusion**

In various Western countries we assisted to an unquestionably necessary, but also nearly exclusive concern on the costs of healthcare. The reforms designed to improve efficiency of the service are usually designed on a national scale, but with the implementation increasingly devolved to territorial, intermediate levels. The effects on workforce governance mechanisms, however, seem to have been overlooked by policy makers. The case of Germany presented by Greer and colleagues (2013), or those of Spain or Belgium, and, to an extent, the UK, however, point at the risk that some key principles of the reforms may ‘get lost in regional translation’.

The different regional health systems resulting from the federalist reform of 2001 in Italy have challenged the effective implementation of reforms that were designed on a national scale. A regional divide has been confirmed, if not further emphasized, by these sets of reforms. Economically better performing regions are finding themselves in a privileged position from which they can be aided by a fully empowered and well functioning decentralized level of collective bargaining in the implementation of their regional health plans. On the other hand, the ten years of austerity imposed on some regions with the recovery plans, led to a squeeze of the function of the decentralized level of collective bargaining, in the most difficult cases leading to the exclusion of social partners from the recovery process.

The existing multi-employer bargaining has proved functional to balancing regional differences and maintaining a national minimum level of protection across the various regions. The pressure on public sector costs at national level, however, and the government unilateral decision to freeze collective bargaining seems to point to a return to a pre-contractualisation era. A tendency common to various countries that found themselves dealing with the crisis, which however misses out potential contribution that collective bargaining proved capable to bring about.
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Appendix

Figure 1. Italian regions (in bold those included in the study)