

Title: Hardening sub-national budget constraints via administrative subordination: the Italian experience of regional Recovery Plans

Authors and affiliations:

Massimo Bordignon, Università Cattolica del Sacro Cuore – Milano;

Silvia Coretti*, Università Cattolica del Sacro Cuore – Roma;

Massimiliano Piacenza, Università del Piemonte Orientale;

Gilberto Turati, Università Cattolica del Sacro Cuore – Roma.

Topic of the paper: Evaluation of health policies

Presentation format: Oral with discussant

Presenter:

Silvia Coretti

Università Cattolica del Sacro Cuore

Facoltà di Economia

L.go F.Vito 1

00168 Roma

Tel +390630158719

e-mail: silia.coretti@unicatt.it

Abstract

Background

The problem of how to harden the budget of sub-national government to avoid deficits in a decentralized setting is not new. Different mechanisms have been proposed in the literature, from the attempts to reduce bailout expectations in order to increase accountability of local entities to different forms of administrative subordination. Interestingly, after attempts to introduce some sort of fiscal federalism, since 2007 Italian regions running large deficits were progressively enrolled in Recovery Plans. These plans were part of a more general

agreement contracted between the Central and the regional Government, and were aimed at restoring a balanced budget while keeping constant the quality of services (basically health care services) provided at the regional level. Besides a standard version of the Plan, a harder form of recovery plan also encompassed a Supervisor appointed by the Central government in charge of leading the implementation of the plan at regional level. After a few years from the implementation of recovery plans, some data on the results obtained by regions are currently available and researchers started discussing and evaluating the impact of such plans.

Objective

To provide a general assessment of Recovery Plans in Italy investigating if recovery plans have reached their objectives in terms of cost containment and safeguard of an acceptable provision of health care services and whether different recovery plans had different performances.

Methodology

Data on recovery plans comes from the Italian Ministry of Health. Data on health outcomes, supply and patients' satisfaction comes from "Health for All" OECD database. Data on health care services use and efficiency comes from the periodic monitoring of the provision of the basic package (Griglia LEA) published annually by the Italian Ministry of Health. Data on Health Care Expenditure comes from the reports published annually by the Ministry of Economics and Finance. The observation period is 2000-2014.

We use standard difference-in-differences models to study the effect of *i)* soft (without supervisor) and *ii)* hard (with supervisor) recovery plans on: health care expenditure, health care supply, health services consumption, health care system efficiency, health outcomes, patients' satisfaction.

All our models include region and year fixed effect, cluster SE at the regional level, and control for socioeconomic variables such as population, working age individuals, share of population aging more than 85, average number of members per household, occupation rate, youth unemployment, number of poor households, share of population with university degree, per capita GDP. Models considering expenditure as dependent variable also control for consumption and supply. Models considering satisfaction as a dependent variable also control for the regional supply structure. For each model, we run also an event study in order to test the robustness of the estimated treatment effect.

Main results

Per capita health expenditure is lower in regions undergoing recovery plans. However, it seems that regions with worse financial performance (and more likely to undergo recovery plans) started to cut their health care expenditure well before the issuing of the programs. In these regions, the growth of health care spending has been significantly slowing down over time. Per capita expenditure on health workforce and on social services,

were significantly reduced only in regions with harder recovery plans. Their mean annual growth rate, instead, is significantly lower (about -70% per year for workforce spending) in treated regions.

Overall, NHS beds have decreased in number in regions under recovery plan compared to other regions but according to event analysis only NHS beds for long term care and rehabilitation have been decreasing at a higher rate after 2008 in regions undergoing hard recovery plan.

Hospitalization rate is significantly lower in treated regions with no differences with respect to the type of plan. The rate of surgical DRGs on the overall hospital admission is significantly lower in regions facing hard recovery plans but, these differences appear as prior to the beginning of the plan and could be motivated by the strong interregional passive mobility that characterizes these regions with the exception of Piedmont.

Recovery plans proved to not effect health negatively. Regions in hard recovery plans are characterized by a 0.2% higher infant mortality compared to those with no or soft recovery plan but this effect is not necessarily due to recovery plans. Regions in recovery plan are characterized by a lower mortality rate for psychic conditions and a higher mortality rate for hepatic diseases. However, the interregional differences in the diffusion of these conditions might well justify the differences in mortality rates. Patients satisfaction on assistance received in hospital did not worsen in regions undergoing recovery plans.