LSE Research Online

THE LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

Marianna Mauro, Anna Maresso, Annamaria Guglielmo

Health decentralization at a dead-end: towards new recovery plans for Italian hospitals

Article (Published version) (Refereed)

Original citation: Mauro, Marianna, Maresso, Anna and Guglielmo, Annamaria (2017) *Health decentralization at a dead-end: towards new recovery plans for Italian hospitals.* Health Policy, 121 (6). pp. 582-587. ISSN 0168-8510
DOI: 10.1016/j.healthpol.2017.04.003

Reuse of this item is permitted through licensing under the Creative Commons:

© 2017 The Authors
CC BY-NC-ND

This version available at: http://eprints.lse.ac.uk/74066/
Available in LSE Research Online: June 2017

LSE has developed LSE Research Online so that users may access research output of the School. Copyright © and Moral Rights for the papers on this site are retained by the individual authors and/or other copyright owners. You may freely distribute the URL (http://eprints.lse.ac.uk) of the LSE Research Online website.

http://eprints.lse.ac.uk

Health Policy 121 (2017) 582–587

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Health Reform Monitor

Health decentralization at a dead-end: towards new recovery plans for Italian hospitals☆,☆☆

Marianna Mauro[a,*], Anna Maresso[b], Annamaria Guglielmo[a]

[a] *Department of Clinical and Experimental Medicine, Magna Græcia University, Catanzaro, Italy*
[b] *European Observatory on Health Systems and Policies London Hub, The London School of Economics and Political Science, Italy*

ARTICLE INFO

Article history:
Received 8 April 2016
Received in revised form 10 February 2017
Accepted 4 April 2017

Keywords:
Recovery plans
Italy
Hospitals
Health system decentralization
Financial deficits

ABSTRACT

The recent introduction by the central government of recovery plans (RPs) for Italian hospitals provides useful insights into the recentralization tendencies that are being experienced within the country's decentralized, regional health system. The measure also contributes evidence to the debate on whether there is a long-term structural shift in national health strategy towards more centralized stewardship. The hospital RPs aim to improve the clinical, financial and managerial performance of public-hospitals, teaching-hospitals and research-hospitals through monitoring trends in individual hospitals' expenditure and tackling improvements in clinical care. As such they represent the central governments recognition of the weaknesses of the decentralization process in the health sector. The opponents of the reform argue that financial stability will be restored mainly through across-the-board reductions in hospital expenditure, personnel layoffs and closing of wards, with considerable negative effects on the most vulnerable groups of patients. While hospital RPs are comprehensive and complex, unresolved issues remain as to whether hospitals have the necessary managerial skills for the development of effective and achievable plans. Without also devising an overall plan to tackle the long-standing managerial weaknesses of public hospitals, the objectives of the hospital RPs will be undermined and the decentralization process in the health system will gradually reach a dead-end.

© 2017 The Author(s). Published by Elsevier Ireland Ltd. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

1. Introduction

Over the past 40 years, in both developed and developing countries, health system organization has undergone a decentralization process from the national to regional and local levels, introducing a multi-level governance structure [1–5]. The main aims of the devolution reforms have been two-fold: to increase efficiency and to improve the financial responsiveness of decentralized authorities [2,6,7]. However, during the early years of the 21st century, a re-centralization process in European health systems has been observed, even if this trend has been limited only to certain functions specifically related to political and fiscal competences, while legislative powers over health sys-

☆ This article has been made Open Access through funding by the European Observatory on Health Systems and Policies as part of its Health Systems and Policy Monitor (www.hspm.org), an innovative platform that provides a detailed description of health systems and provides up to date information on reforms and changes that are particularly policy relevant.
☆☆ If this is present then the following footnote needs to be added to the title: Open Access for this article is made possible by a collaboration between Health Policy and The European Observatory on Health Systems and Policies.

* Corresponding author at: Department of Clinical and Experimental Medicine, P.O. Box 88100, Viale Europa snc – Loc. Germaneto – Catanzaro, Italy.
E-mail address: mauro@unicz.it (M. Mauro).

http://dx.doi.org/10.1016/j.healthpol.2017.04.003
0168-8510/© 2017 The Author(s). Published by Elsevier Ireland Ltd. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

tem organization have remained at the regional level. The adoption of these measures has mainly been due to policymakers' concerns about the financial sustainability of healthcare systems, equity problems relating to population health outcomes and accessibility to services, and wide interregional differences resulting from devolution policies [5,8–12]. This re-centralization process has favoured the diffusion of theories on the reversal of decentralization trends, with some authors claiming that the "new long wave of re-centralization" is a long-term structural shift in national health strategy [5]. Conversely, other authors have identified in these policies only an attempt by policymakers to rapidly cut costs (consistent with EU austerity conditionalities), thus merely representing the adoption of a stronger stewardship approach in the management of highly decentralized health sectors [11,13].

The recent experiences of the Italian National Health Service (INHS) may provide useful evidence for the debate on the decentralization of healthcare. We describe the context of a new reform measure by the central government that introduces hospital recovery plans and discuss the expected benefits and potential issues that arise in their implementation. We also consider the arguments that have been advanced by proponents and opponents of the reform. The results may be useful to policymakers in considering the transferability of the approach to other countries.

2. Background

In Italy, the process of devolving healthcare from the central government to the regions began in 2001 with the transfer of major fiscal, financial and managerial responsibilities to the regional level, which was already responsible for the delivery of healthcare [14]. This process produced mixed results. Some regions implemented all the actions that they were capable of executing to meet the broad objectives of the reform, thus strengthening their systems. In contrast, regions that had weak managerial capacity and lower health service performance failed to reach the set goals [13,15–17]. A major consequence of the decentralization process to date is a significant imbalance in health expenditure levels among regions, resulting in considerable health budget deficits in 10 out of the 21 regional health systems. Since 2006, a re-centralization process has been underway, with a special focus on the weakest regions. Specifically, the central government has obliged those regions to adopt regional recovery plans (RRPs) with the aim of reducing healthcare expenditures in their own public spending. In the worst cases, the national government has appointed a Commissioner to pursue the central government's targets [9,13,15–17]. The overall effect of this regime has been a decrease in the annual level of overspending. Indeed, in 2014, the public sector's total deficit was €864 billion, an 85% decline since 2006 (€6.010 billion) [18,19]. This decline suggests that RRPs are effective tools for improving economic and financial performance in the short term [9,13,16,18–20] with some limitations. Indeed, several authors have observed i) RRPs' limited efficacy in solving the structural causes of the deficits and ii) the lower quality of health prevention projects developed in Italian regions with financial deficits and recovery plans [9,16,21].

In light of the RRPs' positive results, in terms of both health system efficiency improvement and deficit reduction, and the Italian government's need to rebalance its finances, the Ministry of Health introduced hospital recovery plans in 2015 (Law No. 208/2015 art. 1 paragraphs 524–526) [22]. This article reports on these new financial instruments for Italian hospitals, which is the country's first experience of compulsory recovery plans for hospitals.

3. The new decree

3.1. The purpose and the content of the reform

Law No. 208/2015 introduced recovery plans for hospitals [22], with the draft decree being sent to the State-Regions Conference, Italy's inter-governmental body regulating the relations between the central government and the regions, in February 2016. This draft contained guidelines for improving the clinical, economic, financial and managerial performance of public hospitals (known as *Aziende Ospedaliere*, AO), teaching hospitals (*Aziende Ospedaliere Universitarie*, AOU) and research hospitals (*Istituti di ricovero e cura a carattere scientificio*, IRCCS) [23]. The endorsed decree, which was originally scheduled to be enacted in March 2016, was enforced in July 2016 [24].

Specifically, the new decree outlines the operational tools (recovery plans) for a) monitoring trends in individual hospitals' healthcare expenditure and b) implementing vigorous and effective interventions to improve the care provided and to ensure that all hospitals provide at a minimum, the services outlined in the "Essential Levels of Care" (LEAs), the basic benefits package that must be provided uniformly across the country. The main aim of this approach is to provide an effective tool for hospitals that is consistent with the growing demand for health services induced by demographic trends and epidemiological tendencies. The decree regulates two different types of recovery plans, both of which have a three-year horizon: Type A and Type B [23]. Type A plans deal with efficiency and are designed to ensure that hospitals develop strategies to balance their budgets. They apply to hospitals where the difference between costs that are recognized in the income statement and income that comes from healthcare "is greater than or equal to 5% or, in absolute terms, at least €10 (or 8) million". Type B plans relate to clinical care and aim to identify measures that may improve care. They apply to hospitals that do not comply with the parameters concerning volume, quality and outcomes of care established by the central government. To draft the plans, hospitals must undertake several activities, as summarized in Table 1.

Each region must identify the health organizations within its jurisdiction that meet the above criteria and therefore are required to draft either one or both of the recovery plans. Each of the identified organizations has ninety days to present its three-year plan in accordance with the decree. The region must ensure that the actions outlined in the plan are implemented [23].

Table 1
The Content of Recovery Plans.

A – Efficiency Recovery Plan	B – Clinical Care Recovery Plan
Sections	
Section 1 Analyse the economic and financial situation over the past three years in order to identify the causes that led to the deficit.	Section 1 Verify and evaluate the quality of data upon which the compulsory drafting plan is based.
Section 2 Define the goals, interventions and actions of the plan by outlining drivers to improve efficiency. The decree does not define the objectives or indicators. It provides only a few areas of focus (as examples) for change: • Adjusting the size of operating units; • Optimizing the type and amount of care provided by assessing the appropriateness of services; • Controlling the quantity and/or price of production factors, (eg. rationalizing staffing levels).	Section 2 Analyse the situation through clinical and organizational audits regarding: • An analysis of services; • The definition of the audit methodology; • Verification of the differences between clinical practice and international medical standards; • Variance analysis, focusing on the cause; • The definition of indicators for monitoring and regulating clinical practices in order to ensure adherence to international standards.
Section 3 Draft an income statement that shows current trends, actions and the effect of such actions on current trends. This is a new instrument introduced by the decree, which has the potential to be a useful programming and management instrument.	Section 3 Define actions to resolve critical issues identified during the previous phase; synthesize these in a matrix that links remedial measures, intermediate objectives of process and outcome, with a time schedule (achievement milestones).
Section 4 Define quantitative and qualitative indicators for monitoring the actions and verifying the results.	Section 4 Define instruments to monitor the implementation of the plan. In this case instruments refer to periodic reports.

Source: Extracted from Law No. 208/2015 art. 1 paragraphs 524–526.

3.2. The stakeholder positions

The new decree will directly or indirectly involve a plurality of stakeholders, such as regional governments, hospital managers, personnel and citizens/patients [25]. In Fig. 1, we summarize stakeholders' influence in the policy process and their support or opposition to the introduction of hospital recovery plans.

Most regional governors, with some exceptions, and hospital managers supported the implementation of hospital recovery plans as opportunities to reduce regional financial deficits and to improve health system organization and the care provided by health organizations [26,27]. The main opposition came from trade union representatives and several workforce and patient associations, which feared that the adoption of these measures could lead to linear spending cuts, personnel layoffs and the closing/reorganization of wards, with considerable negative effects on the most vulnerable groups of patients [27]. Consequently, they demanded that they be involved in all phases of the reform process but no opportunity to participate in the planning or implementation of the hospital recovery plans was extended to such groups. Notably, regional governments and hospital managers had a moderate influence on the policy process, but they are currently involved in the implementation process [28]. Indeed, before the decree entered into force, central government representatives, a delegation from the Italian Federation of Health Organizations and Hospitals (FIASO) and regional governors discussed the planning of interventions that would form the basis of future hospital recovery plans. In contrast, front-line medical personnel had a weak influence on the policy process and are barely involved in the implementation of recovery plans. Finally, although public opinion is important, patients/citizens had a weak influence on the process.

4. The expected outcomes and potential limitations of the reform

The decree will target improvement in both hospitals' operational efficiency, their performance in terms of the health services they provide, and the quality of care. Estimates indicate that this decree will affect approximately 49% of Italian public hospitals; altogether, these organizations have a deficit of approximately €1.8 billion (Table 2). Among all the measures that will be introduced, reducing hospital deficits will result in estimated savings of more than €1.4 billion over three years, which represents 80% of the total deficit [29].

To reduce hospitals' deficits, the central government has planned several measures for implementation [23]. The following are expected to produce the greatest impact:

- the reorganization of hospital wards through the closure of organizational units that do not have at least 15 hospital beds, in order to incentivize economies of scale and technical efficiency; and
- the rationalization of human resources and medical technologies in the health system.

The latter goals involve extending the opening hours of operating rooms, surgeries and facilities providing diagnostic services; planning personnel needs for each health organization; and identifying excess staffing, which determine turn-over and mobility of personnel. Overall, the measures imply cuts in the cost of personnel but the way in which each hospital will opt to reach its targets is not yet known.

Notably, despite the need to rationalize health expenditure and to both reduce deficits and improve the quality of care provided by hospitals, many unresolved issues remain with regard to the deficit-reducing reorganization

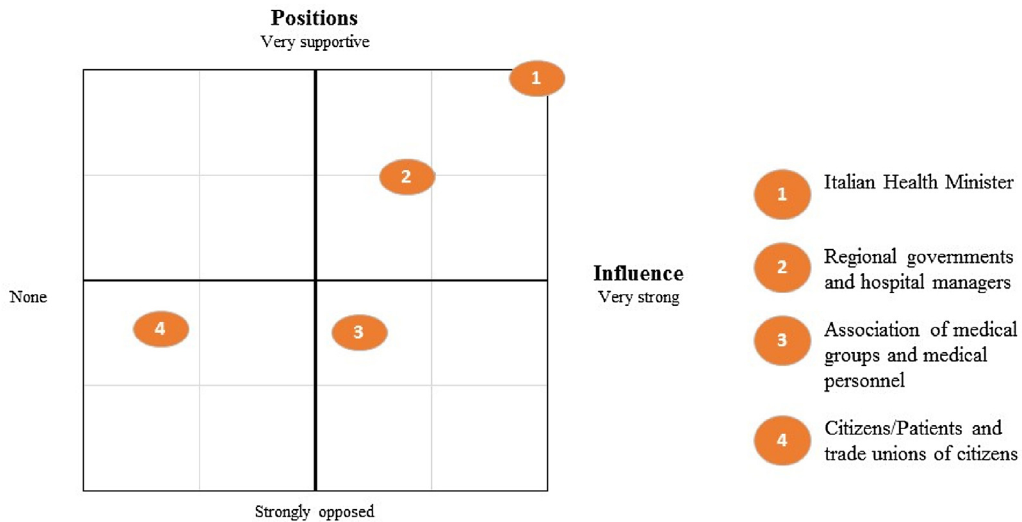

Fig. 1. Stakeholders' positions and their influence on the reform process.

Table 2
Hospital organizations required to implement Recovery Plans

Hospitals (including AO, AOU, IRCSS) – 2014						
Regions	Total number of public hospitals in the Region	Number of hospitals with Type A recovery plans	Number of hospitals with Type B recovery plans	Number of hospitals with both Type A and Type B recovery plans	Total number of hospitals with deficits needing a recovery plan	Potential deficit (million €)
Piedmont	6	1	0	0	1	183 036
Lombardy	35	4	1	0	5	141 222
Veneto	3	1	0	0	1	16 337
Friuli-Venezia Giulia	5	3	1	0	4	92 545
Liguria	2	1	0	1	2	137 895
Tuscany	4	2	1	0	3	71 953
Marche	3	0	2	0	2	NA
Lazio	9	3	1	2	6	282 660
Campania	10	3	3	4	10	309 081
Apulia	4	2	1	0	3	48 730
Basilicata	2	0	1	0	1	NA
Calabria	5	0	0	4	4	105 552
Sicily	9	5	0	3	8	340 250
Sardinia	3	2	0	1	3	112 247
Total	**108**	**27**	**11**	**15**	**53**	**1 841 499**

NA: Not Available.
Source: Extracted from "QuotidianoSanità"; based on data from AGENAS.

measures developed by the central government. First, the decree does not address pre-existing managerial weaknesses. In this context, hospitals' General Managers are responsible for reducing deficits but, as reported by several sources, in the recent past many of them have been weak in managerial capacities and have been responsible for generating deficits [8,9,11,17]. Moreover, preliminary analyses of the financial statements of the hospitals across the country (results summarized in Table 2) have been based on heterogeneous financial reports, in which data reliability and comparability are not a foregone conclusion. Second, the monitoring of regions' and hospitals' healthcare performance has highlighted a wide gap not only between regions but also between hospitals operating in the same region, both of which are closely linked to weak administrative and management capacities [9,11,13,15–17]. Third, a three-year programme does not demonstrate a long-term view, evidencing the lack of strategic oversight and planning across the health system [9,17,21]. Given these considerations, it is clear that the healthcare system would benefit from a re-organization that pays greater attention to long-term strategic reforms. To summarize, the recovery plans for hospitals follow on from RRPs, thus representing effective tools to reduce deficits, even if doubts still remain as to whether they will impact effectively on health system performance in the long run.

5. Discussion

The recent experience of the INHS clearly shows how the initial decentralization process employed by the Ministry of Health as a tool to help regions manage their own health services has led back to a new re-centralization process in Italy, similar to experiences in other decentralized countries [1–6]. RRPs can be seen as a major policy measure that exemplifies the tendency towards renewed centralization in Italy [30]. To date, the RRPs have represented the main tool used by the central government to limit the damage caused by devolution policies in terms of wide interregional differences and major public debts [9,13,15–17], with significant success in reducing the deficits of regional governments [9,15–20]. This result implies that the consolidation and strengthened monitoring of costs and of the quality of services provided across the country should continue in line with the policy actions that have been taken in recent years.

The further introduction of hospital recovery plans reinforces the Ministry of Health's stewardship role for regional authorities [22–24]. In general, the structure of the hospital recovery plans is comprehensive and complex, and focuses on a number of operational problems and weaknesses. However, as has been highlighted, many issues in the reorganization process contained within the hospital recovery plans, including ward restructuring, personnel deployment and financial management, remain unresolved. The main doubts relate to whether hospitals have the managerial skills that are necessary to develop effective and achievable plans. This leads to a twofold risk. First, a lack of skills can hinder the proper implementation of the health policy, increasing the risk that the three-year plans will be achieved mainly through linear spending cuts. Second, as previously noted, this situation affects many of the regions that are already implementing broader RRPs and, thus, unavoidably exacerbates the gap between regions in terms of financial performance. Finally, on a more positive note, the decree's creation of a homogeneous accountability system among all hospitals, based on shared measurement criteria of costs and revenues, should strengthen the ability to develop effective and achievable recovery plans.

Overall, we argue that the introduction of recovery plans, first for the regions and more recently specifically for hospitals, represents the central government's recognition of a weakness in the decentralization process: the decree directly affects those responsible for health budget deficits and for delivering health services. Several authors observe that although the central government is increasing its role in steering the INHS, the decentralized regional organization of the health sector *per se* does not appear to be at risk [5,11,13,17]. What is clear, however, is that the governance of the entire multi-level Italian health system is crucial for the effective management of policy changes. In our view, if central government continues to define top-down extraordinary measures, such as RRPs and hospital recovery plans, without also devising an overall plan to tackle the long-standing structural and managerial weaknesses of hospital organizations, and without supporting regional authorities through adequate funding, then decentralization in the health system will gradually reach a dead-end. In order to strengthen regions' capacities to achieve performance and efficiency targets, the Ministry of Health should focus greater effort on the accountability systems that are adopted by public hospitals, ensuring the comparability and reliability of the data in financial reports, and providing the means, ex-ante, for actors within the regional health systems to develop adequate skills, tools, and competencies. This will require more investment in the health system rather than the adoption of linear cuts.

6. Conclusion

The Italian experience with RRPs and specifically with hospital recovery plans reinforces the international evidence that financial prerogatives constitute a major driver of re-centralization tendencies in regionalized health systems. But it also provides some insights to policy-makers (both national and international) on the potential pitfalls of top-down stewardship approaches to improving budgetary and operational performance in decentralized health systems. The objectives of the hospital recovery plans are ambitious in that their ultimate aim is compel regions to reduce or eliminate their health budget deficits through structural changes that will ultimately improve efficiency. At the same time they aim to tackle improvements in clinical care. In theory, these are sound objectives that put in motion much needed and deeper structural reforms in the hospital sector which may have stalled in the past at regional level and can now gain traction through an 'external' directive from the central government. However, without also working with the regions to invest in improving the weaknesses in managerial capacity within hospitals, regions will likely resort to short-term cost-containment measures to meet budgetary targets rather than adequately focus on more fundamental improvements in efficiency and hospital performance. Such investment requires funding, longer-term planning and knowledge transfer initiatives within a broader framework of regional co-operation than is currently promoted within top-down planning instruments such as hospital recovery plans.

References

[1] Anton JI, Munoz de Bustillo R, Fernandez Macias E, Rivera J. Effects of health care decentralization in Spain from a citizens' perspective. The European journal of health economics: HEPAC: health economics in prevention and care 2014;15:411–31.

[2] Greer SL, da Fonseca EM. Decentralization and Health System Governance. In: Kuhlmann E, Blank RH, Bourgeault IL, Wendt C, editors. The Palgrave International Handbook of Healthcare Policy and Governance. London: Palgrave Macmillan UK; 2015. p. 409–24.

[3] Greer SL, Jarman H, Baeten R. The new political economy of health care in the european union: the impact of fiscal governance. International journal of health services: planning administration, evaluation 2016;46:262–82.

[4] Magnussen J, Hagen TP, Kaarboe OM. Centralized or decentralized? A case study of Norwegian hospital reform. Social science & medicine 2007;64:2129–37.

[5] Decentralization Saltman RB. re-centralization and future European health policy. Eur J Public Health 2008;18:104–6.

[6] Saltman RBB, Vrangbaek V. Decentralization in health care: strategies and outcomes. European Observatory on Health Care Systems series 2007.

[7] Bordignon M, Turati G. Bailing out expectations and public health expenditure. J Health Econ 2009;28:305–21.
[8] Ferrario C, Zanardi A. Fiscal decentralization in the Italian NHS: what happens to interregional redistribution. Health Policy 2011;100:71–80.
[9] Ferre F, Cuccurullo C, Lega F. The challenge and the future of health care turnaround plans: evidence from the Italian experience. Health Policy 2012;106:3–9.
[10] Martinez-Vazquez J, McNab RM. Fiscal decentralization and economic growth. World Development 2003;31:1597–616.
[11] Tediosi F, Gabriele S, Longo F. Governing decentralization in health care under tough budget constraint: what can we learn from the Italian experience. Health Policy 2009;90:303–12.
[12] McMichael AJ, Beaglehole R. The changing global context of public health. Lancet 2000;356:495–9.
[13] Lega F, Sargiacomo M, Ianni L. The rise of governmentality in the Italian National Health System: physiology or pathology of a decentralized and (ongoing) federalist system. Health Serv Manage Res 2010;23:172–80.
[14] Consiglio dei Ministri. Decreto Legislativo 18febbraio 2000 No.56. Disposizioni in materia di federalismo fiscale, a norma dell'articolo 10 della legge 13 maggio 1999, No. 1333. Gazzetta Ufficiale 2000.
[15] de Belvis AG, Ferre F, Specchia ML, Valerio L, Fattore G, Ricciardi W. The financial crisis in Italy: implications for the healthcare sector. Health Policy 2012;106:10–6.
[16] Ferre F, de Belvis AG, Valerio L, Longhi S, Lazzari A, Fattore G, et al. health system review. Health systems in transition 2014;16:1–168.
[17] Longo F. Lessons from the Italian NHS retrenchment policy. Health Policy 2016;120:306–15.
[18] AGENAS. Andamento della spesa sanitaria nazionale e regionale 2008–2014. Report 2015. Monitoraggio Spesa Sanitaria; www.agenas.it : AGENAS, 2015.
[19] Ministero dell'Economia e delle Finanze-Dipartimento della Ragioneria dello Stato. Il monitoraggio della spesa sanitaria. Rapporto n. 2. Il monitoraggio della spesa sanitaria; www.rgsmefgov.it : MEF, 2015.
[20] AGENAS-Ministero della Salute, Risultati del Piano Nazionale Esiti, Report 2015. www.salutegov.it, 2015.
[21] Rosso A, Marzuillo C, Massimi A, De Vito C, de Belvis AG, La Torre G, et al. Policy and planning of prevention in Italy: results from an appraisal of prevention plans developed by Regions for the period 2010–2012. Health Policy 2015;119:760–9.
[22] Consiglio dei Ministri Legge di stabilità 2016. Disposizioni per la formazione del bilancio annuale e pluriennale dello Stato (L. 28 dicembre 2015, n. 208). Gazzetta Ufficiale 2015.
[23] Ministero della Salute-Ministero dell'Economia e delle Finanze. Bozza di decreto contenente le linee guida per i piani di rientro degli ospedali. http://www.sanita24. ilsole24ore.com/2016.
[24] Ministero della Salute. Decreto 21giugno 2016. Piani di cui all'articolo 1, comma 528, della legge 28 dicembre 2015, n. 208, per le aziende ospedaliere (AO), le aziende ospedaliere universitarie (AOU), gli istituti di ricovero e cura a carattere scientifico pubblici (IRCCS) o gli altri enti pubblici. Gazzetta Ufficiale n164 del 15-7-2016.
[25] Phillips S, Pholsena S, Gao J, Oliveira Cruz V. Stakeholder learning for health sector reform in Lao PDR. Health Policy Plan 2016.
[26] Sanità24. Piani di rientro in corsia/Ripa di Meana (Fiaso): «L'ultimo miglio del risanamento. Poi serviranno nuovi investimenti per promuovere il Ssn». http://www.sanita24. ilsole24ore.com/, 2016.
[27] Sanità24. Piani di rientro in corsia/Troise (Anaao): «Ricetta fallimentare, serve un patto con gli operatori». http://www.sanita24. ilsole24ore.com/, 2016.
[28] FIASO. FIASO incontro il Commissario della spending review sui Piani di Rientro delle Aziende Ospedaliere, http://www.fiaso.it/, 2016.
[29] QuotidianoSanità. Sintesi regionale di applicazione della bozza di decreto contenente le linee guida per piani di rientro ospedali, 2016. www.quotidianosanita.it, 2016.
[30] Signorelli CF, Odone GM, Zangrandi A. The reform of the Italian Constitution and its possible impact on public health and the National Health Service. Health Policy 2016 http://dx.org/10.1016/j.healthpol.2016.10.008.