25 January 2021

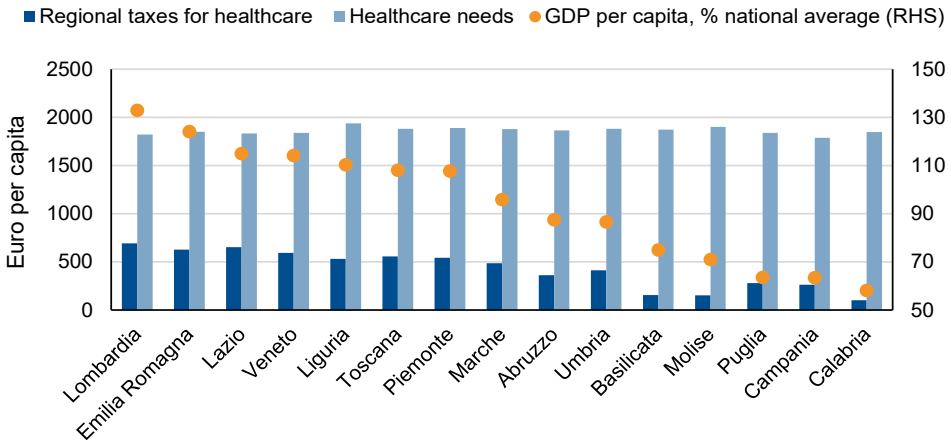
Healthcare spending dynamics to challenge Italian regions' fiscal framework

Italian regions have made progress towards balancing their healthcare accounts in recent years. The extra financial burden of coping with the Covid-19 pandemic has fallen largely on the central government, which has provided extraordinary support mitigating the impact of the pandemic on regions' finances. However, the need for heavy investment in public health, exposed by the pandemic and partly to meet the needs of Italy's ageing population, will permanently raise healthcare spending. The regions may face more limited budgetary flexibility and greater reliance on central government for redistributing healthcare funds.

Italian regions are largely responsible for healthcare provision with healthcare accounting for 80% of their operating expenditure. This limits the regions' budgetary flexibility, as large proportions of revenue and expenditure are earmarked for healthcare transfers.

In the context of wider economic discrepancies across Italian regions, the need to ensure minimum standards of healthcare and provide equal per capita healthcare financing, requires a significant redistribution of financial resources. Economically stronger regions finance a large part of their needs with their own taxes, but weaker regions rely more on central-government transfers and equalisation flows[1] (**Figure 1**).

Figure 1: Per capita healthcare funding needs and tax financing, by region, 2019



Sources: Ministry for Healthcare "Riparti 2019", refers to the "fondo indistinto", Eurostat, Scope Ratings GmbH

Our main takeaways are:

- The regions' responsibilities for healthcare limit their budgetary flexibility, but increase the likelihood of support from the central government, as demonstrated by the Covid-19 crisis, which protects regions' finances in the short term.
- Regional healthcare sector deficits narrowed in recent years, partly through restructuring plans under central government oversight. However, varying degrees of service quality and administrative capacity, including the successful absorption of EU healthcare funds, will continue to weigh on individual regions' creditworthiness.
- Meeting investment needs and the healthcare requirements of Italy's growing proportion of elderly people will increase pressure on regional budgets and the broader financing framework, requiring larger fiscal redistribution and greater central-government funding, further interlinking regions and the central government.

[1] A major source of funding for regional healthcare expenditure is VAT shared with the central government. We consider it as a "quasi-transfer", rather than a tax, since it includes equalization flows.

Analyst

Giulia Branz
+49 696677389 43
g.branz@scoperatings.com

Team leader

Dr Giacomo Barisone
+49 69 6677389 22
g.barisone@scoperatings.com

Media

Matthew Curtin
+49 30 27891 147
m.curtin@scopegroup.com

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Scope Ratings GmbH

Neue Mainzer Straße 66-68
D-60311 Frankfurt am Main

Phone +49 69 66 77 389 0

Headquarters

Lennéstraße 5
10785 Berlin

Phone +49 30 27891 0
Fax +49 30 27891 100

info@scoperatings.com
www.scoperatings.com

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Healthcare responsibilities result in limited budgetary flexibility for regions, but increase likelihood of central government support

The bulk of healthcare spending passes from regions' budgets in the Italian healthcare system

Italy's healthcare system is a shared responsibility between central and regional governments[2]. The central government determines minimum levels of service provision (LEA), allocates financing sources and monitors performance. Regions have the responsibility to organize services and act as "holdings" in regional healthcare systems, by controlling and financing local healthcare authorities (LHAs) and hospitals.

Rigid budgetary composition, reflecting earmarked transfers to fund healthcare services

The budgetary composition of Italian regions reflects their mandates in healthcare services. In aggregate, the share of healthcare spending in total current expenditure is close to 80% (**Figure 2**), including both ordinary status regions (RSO) and special status regions (RSS) [3]. However, the share tends to be higher for the former and lower for the latter, as RSS are responsible for a wider set of functions vis-à-vis RSO.

The importance of the healthcare function results in a large share of transfers in current expenditure (**Figure 3**), which comprises resources that regions allocate to their LHAs and hospitals, based on services provision. On the revenue side, transfers from the central government dominate regional budgets. Besides 'pure' transfers, we consider also VAT shared with the central government and earmarked for healthcare as a quasi-transfer, rather than a tax. We do this because VAT shares are allocated to regions after equalisation processes, which significantly modify the amounts related to each region's territory, by taking into account fiscal capacities, historical costs and socio-demographic aspects. Main regional taxes include the tax on productive activities (IRAP), the supplement on the personal income tax (IRPEF), and the "car tax". Regions earmark shares of the IRAP and IRPEF to healthcare financing. The budget composition differs in the case of RSS also on the revenue side. Special status regions' financing is regulated by bilateral agreements with the central government, which define shares of central government taxes devolved to the RSS, which, in turn, do not receive any transfers.

Figure 2: Regions' expenditure, by function, 2019
Aggregate for regions and autonomous provinces, %

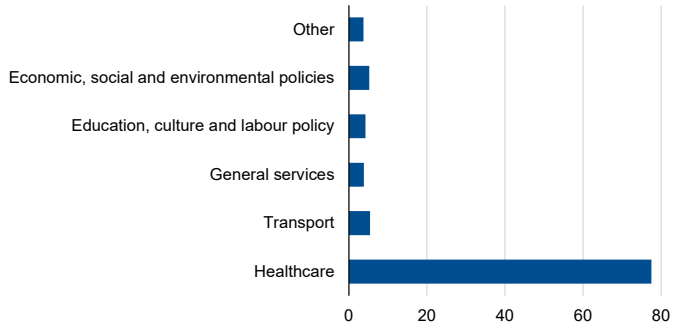
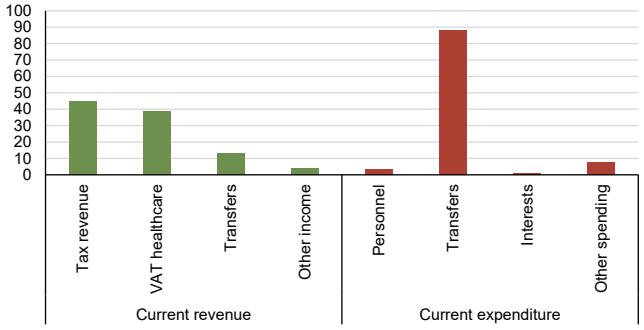


Figure 3: Regions' budgetary composition, 2019
Share of total current revenue and expenditure, %



Source: BDAP Ragioneria Generale dello Stato, Scope Ratings GmbH

In times of crisis, like Covid-19, the budgets are protected by central government support

The large shares of rigid expenditure and revenue stemming from regions' healthcare mandates limit their budgetary room for maneuver. In addition, the relatively strict borrowing and debt limits, which the regions have to comply with, are calculated on the basis of their "non earmarked" revenue, thereby excluding the large part of the budget that is allocated to healthcare financing. Limited budget flexibility is a challenge in times of financial distress, as regions are constrained in the extent they may react to shocks by adjusting or reallocating revenue and expenditure items. At the same time, given the

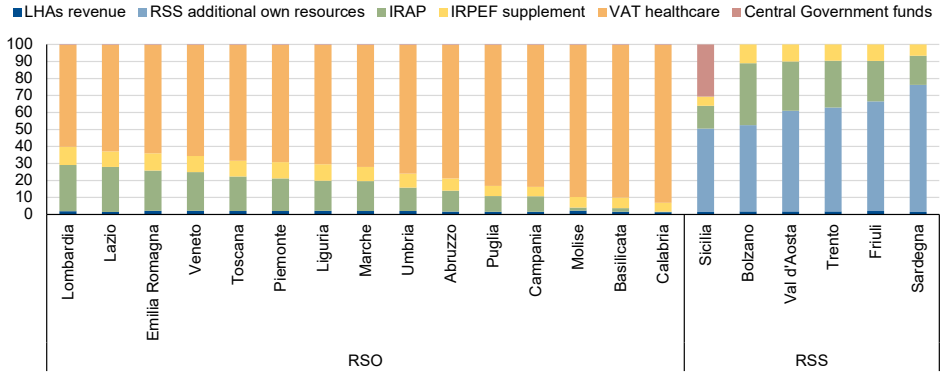
[2] Italian Constitution, art.117
[3] There are fifteen ordinary status regions (Abruzzo, Basilicata, Calabria, Campania, Emilia-Romagna, Lazio, Liguria, Lombardia, Marche, Molise, Piemonte, Puglia, Toscana, Umbria, Veneto) and six special status regions and autonomous provinces (Friuli-Venezia Giulia, Sardegna, Sicilia, Valle d'Aosta, P.A. Bolzano, P. A. Trento)

fundamental nature of the healthcare function and the shared responsibility with the central government, this increases the likelihood of central government support to regions. This has been highlighted by the Covid-19 healthcare emergency, with the Italian government stepping in with additional funding. The various decrees in response to the crisis should result in increasing the funds allocated to healthcare to EUR 119.6bn, up from EUR 114.4bn in 2019 and from EUR 116.4bn expected before the crisis. For 2021, the overall healthcare financing need has been set at 121.4bn[4].

Funding sources differ across regions, reflecting redistribution

The governance of the healthcare system is based on the "Intese Stato-Regioni", namely agreements between the central and regional governments to determine the healthcare financing needs and the share to which each region is entitled, based on the economic outlook, public finance rules and the need to guarantee LEA. By analysing the different sources of funding across regions, we can observe strong equalisation across entities, with implications for regions' budgets and fiscal reform processes.

Figure 4: Healthcare financing resources
% of total, by region, 2019



Sources: Ministry for Healthcare "Riparti 2019", refers to the "fondo indistinto", Scope Ratings GmbH

Different sources of funding reflect strong redistribution across regions

The bulk of healthcare funding ("fondo indistinto")[5] is financed, in the case of RSO, from: i) LHAs revenue, from services for which citizens have to pay, ii) regional taxes earmarked to healthcare (IRAP and IRPEF supplement), and iii) the central government budget, through the shared VAT for healthcare and the national healthcare fund.

The share of VAT that each region receives depends on what part of their funding needs cannot be covered by their taxes. Economically weaker regions finance higher shares of their needs with the VAT transfer vis-à-vis stronger regions, which can cover a larger part of healthcare expenditure with own taxes. This is evident in **Figure 4**, showing the shares of financing sources for healthcare across regions. The wealthy region of Lombardy funds around 40% of its standard healthcare needs with own taxes and 60% with the VAT transfer, while Calabria, on the opposite side of the spectrum, finances only about 5% of its healthcare needs with regional taxes, relying for more than 90% on the shared VAT. **Figure 5** represents the shares of VAT for healthcare that each region receives in relation to its GDP. Economically stronger regions receive much lower VAT amounts in relation to their economy than weaker regions, highlighting significant equalization effects.

The sources of financing for healthcare needs are different for special status regions, which can count on the additional taxes they retain in their territory and do not directly take part in equalisation processes. Only the Region of Sicily receives also funds from the central government.

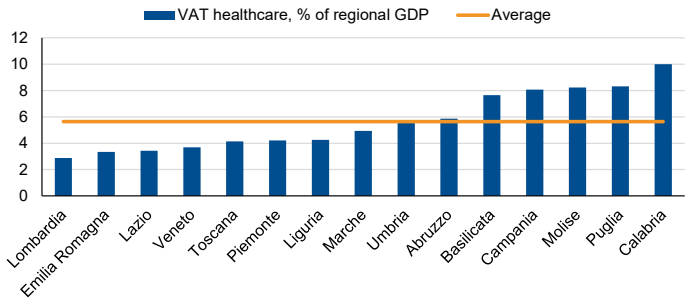
[4] Italian Parliament,"Il Livello di finanziamento del Servizio sanitario nazionale", Januar 2021.
[5] For 2019, overall healthcare funding needs have been determined at EUR 114.5bn, of which EUR 111bn in the so-called "fondo indistinto", or "unbounded fund", while the rest relates to funds earmarked to specific programmes.

Similar per-capita funding needs, reflecting demographics

Strong resources redistribution is necessary to satisfy per capita healthcare funding needs, which are relatively similar across regions, despite the large economic disparities, with the variation mostly depending on demographic factors **(Figure 6).**

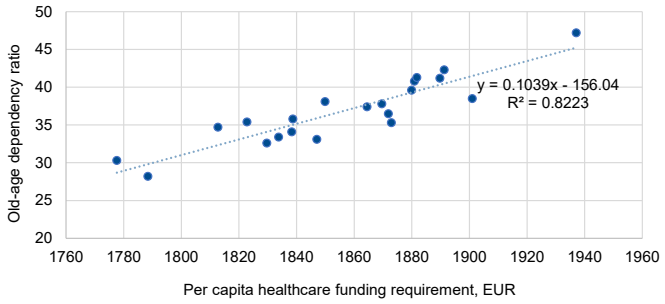
Figure 5: VAT healthcare, % of regional GDP

For regional GDP, latest data available are from 2018



Source: BDAP Ragioneria Generale dello Stato, ISTAT, Scope Ratings GmbH

Figure 6: Per capita healthcare needs and old-age dependency ratio[6], 2019



Source: Ministry for Healthcare "Riparti 2019", Eurostat, Scope Ratings GmbH

Large redistribution across regions constrains progress towards fiscal federalism

Significant redistributive fiscal flows across wealthier and poorer regions impede the ongoing project of enhancing regional fiscal autonomy. The reform process related to the fiscal federalism reform of 2009, aimed at enhancing fiscal responsibilities and overcome transfer-based regional finance, has been postponed multiple times in the last decade. In addition, negotiations around the devolution plans ("autonomia differenziata", see our previous research) from three regions - not surprisingly, all net contributors to the equalisation system, namely Lombardy, Veneto and Emilia Romagna - to increase their responsibilities and control on taxes generated in their territories, have also slowed down. If the process in the direction of more fiscal autonomy for Italian regions takes place, at the same time, strong redistribution mechanisms to ensure the provision of fundamental services in the whole national territory have to be constructed.

The governance of the healthcare system has ensured cost control, but investment needs and demographic dynamics pose challenges

Expenditure under control and improved financial results…

The current framework for public healthcare provision has been relatively successful in containing costs and improving regional healthcare systems' aggregate accounts, especially after the global financial and sovereign debt crises. **Figure 7** shows Italy's public healthcare expenditure as a share of GDP, while **Figure 8** shows aggregated financial results of LHAs and hospitals in each region, as a share of allocated financing. Significant rebalancing has been achieved after 2006, with the implementation of reforms aimed at making regions more responsible of their healthcare systems' accounts and preventing expectations of ex-post deficit financing from the central government[7]. This has been achieved via the introduction of "rebalancing plans" ("piani di rientro") in regions with large deficits, with associated strong monitoring powers of the central government and provision of financial support contingent on service reorganisation, cost containment plans, and tax increases.

…but at the cost of underinvestment, as highlighted by Covid-19

Strict cost controls, however, are also likely to have caused, at least in part, underinvestment in healthcare facilities and personnel, made evident by the pandemic. For instance, Italy has a lower number of beds per 1,000 inhabitants than the EU average (3.14 versus 5.0), as well as lower hospital employment, with an headcount of 1,000 workers per 100thousend inhabitants, vis-a-vis 1,400 in the EU[8]. The pandemic is therefore set to speed up investments in the sector in the next years, with costs likely to

[6] The old-age dependency ratio is calculated as the share of population aged over 65 divided by the share aged 15-64.
[7] Ministry of Finance, "Monitoraggio della spesa sanitaria" 2020
[8] Eurostat

be mostly undertaken at the central government level, including via the EU funded Recovery Plan, which is expected to allocate close to EUR 20bn to healthcare.

Figure 7: Healthcare spending
% of GDP

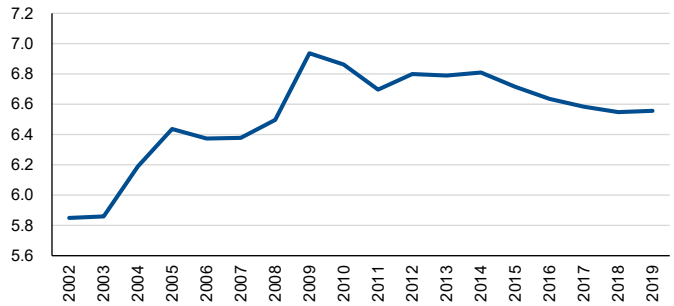
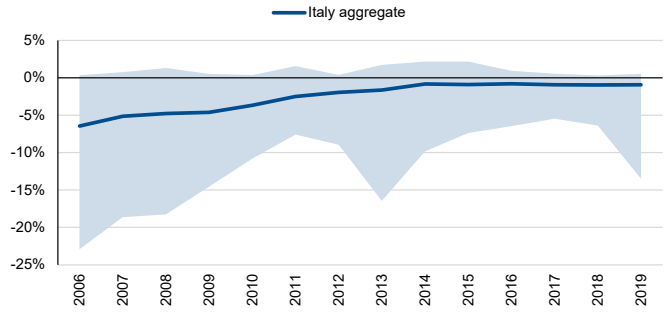


Figure 8: Regional healthcare systems' net income
% of financing



Source: Ministry of Finance, "Monitoraggio della spesa sanitaria" 2020, Financial accounts of Local Healthcare Entities by region, Scope Ratings GmbH

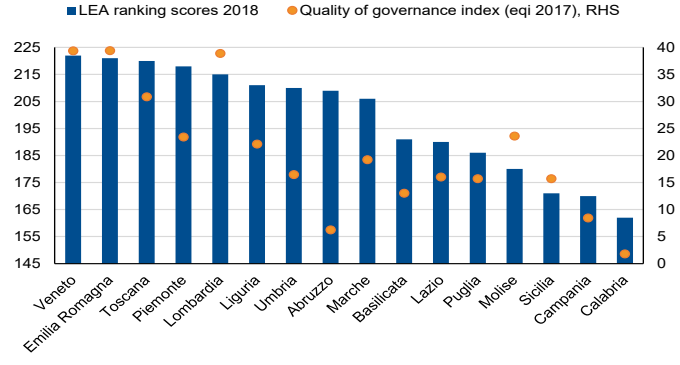
Quality of services varies across regions, in line with different governance capacities

The impact of additional funds on healthcare services adequacy will likely depend on administrative and spending capacities of regional governments. In fact, while per capita funding is similar across regions, service performance varies widely in the different territories. **Figure 9** shows the ranking prepared by the Ministry of Healthcare related to the adequacy in provision of essential levels of cure (LEA). On a 225-point scale, the best performer in 2018 was the region of Veneto, with 222 points, while on the other side Calabria scored 162 points. The variation in healthcare quality scores is broadly in line with discrepancies in the quality of governance index prepared by the European Commission, which captures citizens satisfaction with the quality and impartiality of public services, as well as their perception of corruption.

The demographic challenge is ahead

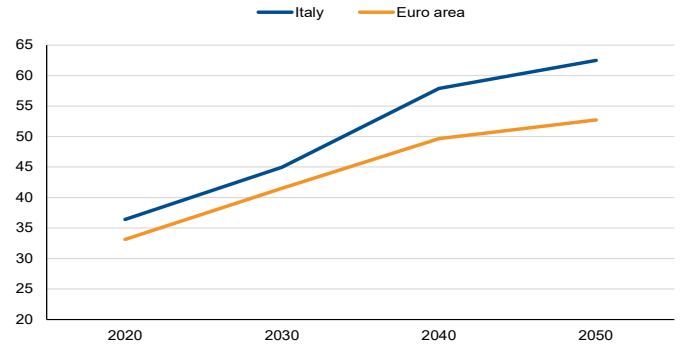
Going forward, regional finances are set to come under further strain also from ageing dynamics. According to the 2018 Ageing Report of the European Commission, in 2020, Italy faced the most adverse demographic imbalance in the euro area in the parameter of the old-age dependency ratio. Moreover, Italy's ageing dynamics are expected to worsen more rapidly than for the euro area average (**Figure 10**) in the next decades. By 2050, Italy's old-age dependency ratio is projected at 62.5%, meaning the share of the population aged 65+ related to those aged 15-64 will be two-thirds, with significant negative implications for regional healthcare expenditures. Regions may find themselves facing significant pressures on their budgets, with limited flexibility to react, and the need to rely more on central government financing. As healthcare costs structurally increase, the share that regions can cover with their own taxes is set to shrink, absent a significant restructuring of the overall framework.

Figure 9: Ranking LEA
LEA achievement score (0-225), eqi score (0-100)



Source: Ministry of Healthcare, European Commission, Scope Ratings GmbH

Figure 10: Ageing dynamics projections
Old-age dependency ratio, %



Source: European Commission, Ageing Report 2018, Scope Ratings GmbH

Scope Ratings GmbH

Headquarters Berlin
Lennéstraße 5
D-10785 Berlin

Phone +49 30 27891 0

Frankfurt am Main
Neue Mainzer Straße 66-68
D-60311 Frankfurt am Main

Phone +49 69 66 77 389 0

Paris
23 Boulevard des Capucines
F-75002 Paris

Phone +33 1 8288 5557

Oslo
Karenslyst allé 53
N-0279 Oslo

Phone +47 21 62 31 42

Madrid
Edificio Torre Europa
Paseo de la Castellana 95
E-28046 Madrid

Phone +34 914 186 973

Milan
Via Nino Bixio, 31
20129 Milano MI

Phone +39 02 30315 814

Scope Ratings UK Limited

111 Buckingham Palace Road
London SW1W 0SR

Phone +44020-7340-6347

info@scoperatings.com
www.scoperatings.com

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