Organised decentralization, uneven outcomes:

employment relations in the Italian public health sector

Abstract

This article looks at the difficulties of adapting a very centralised employment relations system in a country characterised by a deep regional economic divide. In particular, by looking at the Italian public health sector, it is contended that organised decentralisation *of employment relations implemented against wide regional differences led to uneven outcomes in second-level (organisation) collective bargaining.*

The debates on changes in the organization of healthcare in the past forty years and their effects on employment relations in all countries have focussed almost exclusively on the national level. This article aims to add a 'regional dimension' to the analysis that can be crucial in the assessment of processes and outcomes. The Italian public healthcare sector is chosen as case study as it is one of the European countries with the deepest economic divides, but also characterised by a highly centralised system of employment relations.

Throughout the 1980s and 1990s a common feature of the transformation of traditional public administrations in most countries across the world has been that of a New Public Management-inspired trend of reforms. For public health systems this has meant, amongst other things, restructurings, mergers, closures or privatization of hospitals, cost saving re-designing of treatments and care, especially for non-acute patients, experimentations of mix of public and private providers (Bach et al., 1999; Bach and Kessler, 2011). Such changes were aimed primarily, at least in the discourse, at more effective control of governments'

public expenditure and greater responsibilities for these organisations - hospitals and local health providers.

Changes in the established systems of employment relations also took place in an attempt to implement allegedly more efficient, private sector-like practices. Degrees of decentralisation of collective bargaining (CB) to organization level, increases in managerial discretion, introduction of job enlargement and other internal labour and occupational experimentations took place in several countries. Despite the expectations, however, studies highlighted both limited success, for instance, of early attempts of performance related pay mechanisms for health staff at the organization level, as well as a continuing distinctiveness of public sector employment relations that are strictly linked to the role of political choices and of central government interventions (Hood, 1995; Grimshaw et al., 2007; Bordogna, 2008; Mehaut et al., 2010; Bach and Kessler, 2011). The industrial relations literature showed, in particular, that straightforward implementation of a private sector-like model of employment relations had to take into account the capacity of organised social actors, such as unions and employers, to frustrate or promote change (Galetto et al., 2014; Greer et al., 2013; Schulten et al., 2008).

Health systems have also become systematically and increasingly *territorially* decentralized. Budget pressures led countries as diverse in size and approach to their national health systems as Italy, Germany, Spain, Belgium, Sweden, Denmark and partly France to engage in devolution of financial, as well as organisational responsibility of the healthcare provisions to subnational administrative units (regions, *Länder*, *comunidades autónomas*, federal states, etc). Similarly, territorial decentralization took place in North and South America, India and central Asia (Pavolini and Vicarelli, 2012).

Given their increased involvement in healthcare planning and organization, this article explores what role and effects, if any, regional governments have in the relevant industrial relations? While it has been established that 'regions matter' in the reform of public sector (Neri, 2006; Sarto et al., 2015, Greer et al., 2013), we

know less about whether and how they matter in the regulation of the labour relations involved in those changes. Is the role of the regional governments as commissioning and planning authorities to be matched by a role as employers too? And if so, what is the resulting relationship with the extant levels of regulation of employment relations? This is theoretically relevant for the study of industrial relations. National systems are the default unit of reference when comparing developments in labour relations across countries. Here, within-country variations are taken into consideration in the interpretation of changes and trends in industrial relations. Regional differences are shown to affect the access and quality to public services, but are rarely analysed according to their implications on the terms and conditions of work of healthcare staff and, in particular, on the institutions and the governing mechanisms that determine those working conditions.

The following section introduces the case study; section two, then, drawing from the available, though sporadic theoretical contributions on the role of the regions in employment relations, outlines four possible scenarios of an intermediate, regional level of regulation to guide the interpretation of our findings; the third section describes the methodology and the findings are then presented in section four, followed by discussion and conclusions.

1. The case of Italy: tension between national employment relations and regional health systems

Across different countries, hospitals are possibly amongst the most decentralised public services and will be the focus of this paper. Italy is then chosen as a textbook example of historically wide economic regional divide contrasting with a very centralized system of collective bargaining.

Italy's overall national health expenditure has remained generally under the OECD countries average, moving from 8% in 1990 to just under 9% of GDP in 2015 (OECD, 2015) but with a forecast of a decrease to 6.5% by 2019, according to the Italian

National State Account (Corte dei Conti, 2015). At the regional level, however, there are significant differences in terms of how much each region allocates to healthcare to match nationally distributed funds, in the mix between private and public providers and in terms of control over such expenditure (table 1). Comparative research by the Quality of Government Institute in Gothenburg ranked 172 regions in 18 European countries on the basis of, amongst other indicators, the quality of local government, including local health systems. Italy as a country ranked 10th, but amongst its regions, southern Calabria was in last position (172nd) while the Bolzano autonomous province ranked at a noticeable 9th place (Charron et al., 2012). It is therefore not surprising that Italian regional differences have been at the centre of widely known socio-economic analyses - such as for example the historical reconstruction of civic traditions by Putnam (1993).

[Table 1 about here]

The public Italian health sector was institutionalised in 1978 and was one of the first in Europe to be based on the principle of 'full democratic universalism' (Ferrera, 1995). Three major reforms of the public sector in the 1990s and the federalist reform in 2001[1] represent the main turning points. Regional governments were increasingly made responsible for the costs and the organisation of healthcare. Differences in the resources available and in the mix of private and public providers, contributed to the creation of different 'regional health systems'. Amongst the many proposed classifications, table 1 reports those by Formez (2007), based on the distribution of functions between hospitals

[1] In 1992 and 1993 two reforms were implemented in the public sector and in 1999 the so-called 'reform-ter' took place. These reforms promoted a company-oriented vision, making *corporatization* a key, prominent trajectory of change in the public health sector. With the 1999, general directors of ASL (*Azienda Sanitaria Locale*, local health organisations) and AOs (*Azienda Ospedaliera*, hospitals) were given full management autonomy. A full *managerialisation*, however, was never accomplished, with general directors nominated by regional governments.

(AOs) and local health units (ASLs), and by Neri (2006), based the forms of economic interactions between providers (*competition* between private, public, cooperatives, religious providers, as opposed to *cooperation* and *integration*; and a 'residual' or *bureaucratic* model, where organisation is constrained by financial problems).

In 2005, due to the persistent serious budget problems and excessive spending of some regions, the national government imposed solvency schemes, or 'recovery plans' (*piani di rientro*). As of 2016, eight out of twenty-one[2] regional health systems are in recovery plans (five of these are under administration, Figure 1). Recovery plans automatically lead to increases in regional taxes and to compulsory hiring freezes until financial balance is reached. Coordination across such diverse healthcare systems of provision is ensured by the so-called State-Regions Conference, which defines and monitors national minimum standards of patients' care. What is increasingly fragmented and less coordinated are the working conditions of health staff under which such standards are met.

The proposition therefore put forward is that compared to a highly centralised system of employment relations, regional governments, who finance public healthcare together with the central state, could become an actor of employment relations. Despite lacking formal and legal recognition of their role as 'employer', regional governments might find themselves in the position to shape the institutions and governance mechanisms of healthcare workforce.

In the early 1990s Italy changed from a 'sovereign employer', where public sector terms and conditions of employment were centrally defined via law, to a multi-employer bargaining system common to both private and public sectors. The state-employer is represented in employment negotiations by the ARAN agency at the national level (*Agenzia Rappresentanza Negoziale nelle Pubbliche Amministrazioni*), and by the organisations' management at the decentralized level. Both private and public sectors' systems of employment relations are

[2] Italian regions are twenty, but the Trentino Alto Adige region is made of two 'autonomous provinces', Bozen and Trento, which account for two separate healthcare systems.

organized around a main central, national sector level of collective bargaining and a decentralized/organization level. The respective competences of collective bargaining of both sector and organization levels are clearly defined according to an 'organised decentralisation' process (Crouch and Traxler, 1995). The articulation between national and organization level of CB is achieved through 'demarcation' of the respective competences. Basic terms and conditions of work for employees in a given sector are negotiated at the national level by representative employers' and workers' interests' organisations. Other issues such as organisation of working time, allocation of productivity bonuses, part time schemes, annual training programmes, to name a few, are then collectively bargained at the organization level. The Italian system is designed to minimise territorial disparities in wages, especially after the so called 'wage cages' - mechanism of pay determination to align wage levels to the different cost of living in different regions - were abolished in 1969 (Ferrera and Gualmini, 2004). Since then, regional variations of wages have been opposed by the national unions and any emergence of mechanisms to determine wages and terms and conditions of work at the regional level would mark a qualitative shift in the employment relations system.

'Organised decentralisation', of which Italy is an example, as opposed to the 'disorganised decentralization', as found in the UK, has been regarded as more effective in ensuring a redistribution of resources underpinned by national solidarity on one hand and, at the same time, empowering CB at the organization level to adjust to employers' local demands for competitiveness and flexibility (Traxler, 1995; Marginson, 2011). Significant regional differences, combined with increasing responsibility for healthcare financing devolved to the regional governments and a declining investment in healthcare expenditure at the national level are here looked at as possible sources of disruption to the established 'division of labour' between the national-organisation levels of CB.

While pay bargaining continues to be determined at national level and then integrated by CB at the organizational level, there is abundant evidence of regional governments intervening in the regulation of healthcare in a way that

carries implications on the wider working conditions of health staff. Formally responsible only for the organization of healthcare delivery, regional governments have simultaneously found themselves in the position to intervene on broader workforce issues despite no legal role nor responsibility to do so. The economic crisis and the consequent pay freeze at national level imposed by austerity measures since 2009 has further exacerbated the regions' role, as well as consequent, increased territorial disparities. It is therefore contended that while decentralization of CB in the public health sector was indeed *organized*, the resulting experiences of decentralized level CB vary greatly depending on the region, leading to uneven outcomes.

2. Regions: an intermediate level of regulation of employment relations?

The 'fad of regionalism' has been looked at through various lenses, especially in political science, from a desire of higher level governments to escape responsibility for outcomes they regard as beyond their control by devolving decision-making authority to lower-level jurisdictions to a strategic choice, aimed at greater efficiency in the administration or, in the case of European countries, at entitlement to access the Regional Development Funds of the European Union (Sabel 1996; Keating and Loughlin 1997).

In industrial relations, a regional level of regulation has known periodic revivals, similarly either in praise of its flexible, formal/informal nature and more effective intervention in local labour issues, 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, Crouch noted 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) and systems of employment relations have predominantly maintained a national legal framework of

reference. The process of European integration itself led to a legitimisation of mainly national level actors. Nevertheless, a role for the regions, however uncertain and undefined, was debated within the context of European integration in the early 1990s, in particular as evidence was pointing at the effectiveness of a regional level of intervention in solving inefficiencies of local labour markets (Teague 1995; Regalia 1998).

Drawing from this body of literature, four possible scenarios resulting from a greater involvement of the regions in the employment relations of the healthcare sector are identified. A first possibility is that a regional level of intervention in employment regulation could 'hollow out' the existing national level, in the attempt to affirm itself as a more appropriate substitute. Despite a possibly better position in identifying solutions to local labour market problems, the fragmentation that would be generated from a regionalization of the structure of governance of labour markets has been put forward as a reason against its desirability within Europe (Teague, 1995). Within a single country this could lead to a variety of regional models of employment relations and undermine the solidarity on which national systems of CB have traditionally been based.

A second scenario, often invoked by some public sector industrial relations scholars, especially in Italy, would see the regions becoming a substitute of the organization level of CB. An increased coordinating power of the regions would be seen as an effective substitute of the organization/hospital level, where the use of career progressions was abused and an efficient, performance-related allocation of the resources never really took place (Pavolini and Vicarelli, 2012; Carrieri, 2009; Alessi, 2009; Bordogna, 2009; Bordogna and Ponzellini, 2004). Such intervention by the regional government could lead to a 'squeeze' of the organisation level of CB.

A third scenario would entail an only occasional, on-demand shift from two- to three-tier arrangements, with regional governments intervening in employment regulations. Comparative European research during the 1990s and the early 2000s indicated a *de facto*, rather than formal role of an 'intermediate level' of social regulation (Regalia, 1998; 2006). Looking at the economically successful regions of

Baden-Wuttemberg, Lombardy, Catalonia and Rhone-Alpes, Regalia and colleagues found common patterns of relationships between regional governments and institutions and interests' organisations. Overall, the experiences observed seemed to vary according to the local institutional systems, i.e. not simply degree of autonomy and scope for action but also the regional governments' administrative styles ('their *willingness* to provide space for interaction with interest organisations, in particular the unions') (Regalia, 1998: 163). The advantage observed by this additional level of possible, though never formal(ised), coordination is that of flexibility and adaptability, counterweighted by the weakness of poor coordination and discontinuity.

A fourth scenario is that regional governments do not play any role in the regulation of employment relations of healthcare *despite* their increased involvement in financing and organising it. In his evaluation of the public sector reforms and the approval of the 'regionalist' Constitution[3], 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 (pay and contributions, regulation around work organisation) and a decentralised level for the flexible utilisation of work that have concrete, strong effect on the actual organisation of administration. Regional governments, according to this view, do not enter the scene as actors of the public sector industrial relations.

To summarise, if the increased financial role of the regional governments in healthcare provision is to correspond to a greater role in employment relations, this could end up replacing one of the two established levels of collective regulation of work relations, national (scenario one) or decentralized (scenario two); the regional level could become an additional level of regulation of employment relations (scenario three), in particular when perceived as necessary or strategic by the regional government; or, finally, the regions might not 'interfere' in the regulation of the workforce in the absence of any formal provision to do so (scenario four).

3
Reference to the so-called 'federalist' reform of 2001. Title V of the Italian Constitution was reformed to give greater legislative and administrative powers to the local authorities, in particular to the regions.

3. Research design and methods

To investigate the possible role of regional governments as potential new actors of employment relations, systematic data were collected to map the use of regional additional resources allocated to the health expenditure according to its potential impact on employment relations matters. The focus is on nurses and allied health professions in particular, which are usually the largest professional groups. In Italy they account for 41% of the health staff. 273,000 staff, 77% of which are women, out of a total of 665,000 public health sector employees in 2011. Medics and managers are covered by different national collective agreements and are not included in the study. The challenging situation of nurses and health staff (e.g. shortage, especially in some northern regions; job enlargement; overtime; requests for part time work, etc.) provided a good starting point to analyse how these issues were more effectively dealt with at the different levels of employment regulation available.

The research is based on in depth interviews with key actors of the public healthcare sector industrial relations at national and regional level carried out between 2011 and 2016 and on a close examination of available documentation. As reported in detail in table 2, data were derived from the analysis of a substantial amount of documents ranging from sector and organisation level work collective agreements for the health staff (*comparto*), to regional accounts (including minutes of meetings between the regional governments and the respective local health councils - *assessorati regionali alla sanità*), regional healthcare plans (which are often drafted in consultation, not negotiation, with social partners) and national reports of the State Accountancy Office. This was aided and complemented by a five-year (2011-2016) systematic and extensive review of academic research, press and articles in specialized websites and centres of study of health management. Scholars and experts in public sector employment relations were contacted and interviewed. Finally, based on purposive sampling aimed at strengthening the conceptual validity of the study

(Miles et al. 2014), the Lombardy region was selected for a deeper insight and interviews were conducted with regional social partners in 2011. Lombardy's higher public health expenditure, compared to all other regions, and the extent of changes in healthcare organization implemented since the federalist reform make it an interesting case of how far healthcare can change from the national, pre-federalist 'norm' and whether this has led the regional government to act as employer and/or somehow intervene in workforce-related issues.

Further interviews with three of the national most representative union organisations and academic experts were conducted at the end of 2015 to share and discuss the interpretation of the five-year research (2010-2015). The nineteen interviews have all been transcribed and manually coded.

The approach taken was to track individual regions' specific interventions in health staff matters. All twenty-one regional models were looked at in detail in the preliminary desk research.

[Table 2 - here]

Organised decentralization, uneven outcomes?

As anticipated, regional governments often found themselves involved in workforce planning and governance issues. The examples below highlight how their interventions, while not dealing directly with pay matters, have been indirectly shaping the outcomes of collective bargaining at the decentralised level.

Table 3 summarises the findings according to the four scenarios of possible relation between the regional intervention in staff matters and the existing levels of CB.

A first, prominent divide in the way that regional interventions related to established levels of collective bargaining is based on the economic conditions of the regional

health systems.

[Table 3 – here]

The well-performing regions

Amongst the better performing regions, Lombardy, Friuli Venezia Giulia and Veneto have been found to allocate regularly substantial additional resources to address explicitly workforce planning issues. The resulting interrelation with the national and decentralised levels of CB, however, falls under different scenarios.

Scenario 1 – 'Hollowing out' of the national level

Lombardy is the only region to have implemented the option to open the market of healthcare to 'any willing provider'. This led to the presence of a mix of public and private organisations in the regional health system, defined as a 'competition model' (table 1, classification by Neri, 2006). As a result, this regional health system is the one that perhaps changed most radically from the pre-federalist reform. The documentary analysis and the interviews show that the Lombardy regional government invested in accommodation for nurses (particularly in Milan, where the cost of living is higher than the regional and national average) so as to attract employees from outside the region. Following *ad hoc* consultations with regional level social partners, the regional government also allocated money to increase the average salary of nurses and allied professionals to deal with the problem of staff shortage. Interestingly, with regards to the amount of the basic wage increase, what the regional directorate described as 'peanuts', was referred to as 'a lot' by the trade union regional representatives interviewed. The documentary analysis confirmed the will of Lombardy regional government to intervene directly, if needed, to the solution of workplace conflicts. The local press reported an example of a dispute over the merger of a number of hospitals in the early 2000s, among which the big *Ospedale Maggiore* in Milan. The negotiations between the social partners stalled over the compensation for the staff being moved during the merge. Management

were concerned with the tight budget until the Lombardy regional government intervened assuring financial coverage to facilitate the operation.

All social partners interviewed in Lombardy, except, to an extent, the regional official of Cgil (the left-oriented union), agreed on the desirability of greater independence from central government 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. The message of the regional government directorate was that greater autonomy in personnel relations 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 opposing fragmentation of the staff and service. This could have been more easily achieved, the representative of the regional directorate said, if public employment relations arrangements had been 'lighter', not 'dictated' from the central level. All partners interviewed recognized the advantage of a relatively stable, centre-right regional government and the consequent building up of 'keen-to-compromise' employment relations. The national level of CB was referred to as 'interfering' also by the regional officials of Cisl (the centre-left, Catholic-oriented union), arguing on the greater consistency needed between industrial relations and regional healthcare model. From the point of view of the Cgil regional representative a 'contractual federalism' could have been functional rather than desirable, in that it could potentially recompose fragmented terms and conditions of staff employed by different providers in the sector such as religious hospitals and cooperatives. Some of these organisations were said to be looking to 'escape' the constraints of the national public healthcare sector collective agreement and wanting to apply the national collective agreements of the service sector or that of the cooperatives.

The natural evolution in this case would be towards a 'hollowing out' of the national level of CB and a greater prominence of a regional level of intervention to respond more effectively to the specific regional health system implemented.

Scenario 2 – Squeeze the organisational level of CB

Amongst the financially healthy regions, only in one case a squeeze of the organisational level of CB has been noted. The healthcare directorate of the Marche region signed an *ad hoc* agreement in December 2013 with the regional public health sector unions (Cgil, Cisl and Uil) on the stabilization of 1,200 temporary workers. The hospitals and local organisations in the Marche region are grouped under a single Local Health Organisation so that the CB at the decentralised level coincides with the regional level. Though this unification has been pursued in name of greater organizational efficiency, and despite overall cooperative relations between the social partners, trade unions have expressed concerns and criticisms that such grouping has led to a 'disempowerment' of the CB at the decentralized, organisational level.

Scenario 3 – From two- to three-tier (on demand) CB

The regional additional resources of the north-eastern regions of Veneto and Friuli Venezia Giulia have often been referred to in the specialized media as being above national average. Veneto recently allocated 200 million Euros in two years explicitly to reinforce the territorial services, by hiring more General Practitioners, have them work longer hours and cover more shifts. Friuli Venezia Giulia committed 9 million Euros as incentives for nurses and allied professions to work unsocial hours (night shifts, holidays and weekends). In particular, it was established by the regional government, 7 million were to be managed via CB 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 and clinical governance. Though resources are allocated by the regional government, it is then down to CB at the hospital level to allocate them in line with the needs of specific services. In one of the cases, the *Santa Maria degli Angeli* hospital of Pordenone, in the Friuli Venezia Giulia region, has established that the computer-assisted tomography could start to be performed by health staff only, without medics having to be present. This 'job enlargement' for health staff had the objective to reduce waiting lists and optimize the use of the technology and equipment. Such

flexible utilization of the workforce became 'affordable' thanks to the additional resources made available by the Friuli Venezia Giulia, but found opposition in other regions where no economic incentive was offered in exchange of the proposed job enlargement.

Friuli Venezia Giulia and Veneto allocate additional regional resources to improve public health services and gives indications on where they should be invested, but the decentralised level of CB retains discretion in defining the details of such investments in the relevant hospital. 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 the mentioned resources to cover overtime, re-organisation of shifts, job enlargement.

In an official meeting with social partners, the Umbria regional government also declared itself available to act as facilitator in staffing matters that could arise with the implementation of the regional healthcare system. In May 2013, the regional social partners in Umbria 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.

The examples above show how regional governments are participating in the shaping of working conditions in a flexible, *ad hoc* and rather variable fashion.

Scenario 4 – no intervention

Tuscany and Emilia Romagna are often referred to as exemplars of efficient cost control and public health expenditure. They have established joint initiatives to continue learning from each other and share best healthcare practices. There is little evidence of either direct or 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, amongst other things, with the grouping of some

ASLs under ‘wide-area units’, in order to optimise and share the cost of common services) and of the excellence of some local organisations and hospitals (for instance, in November 2013 the ASL of Ferrara received a ‘Public Administration Award’). A spoke person of the National Agency for Health services (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’.

The cases of Tuscany and Emilia Romagna show that the regional governments are indeed engaged in the continuous improvement of the regional healthcare service, but trust the CB at the decentralised, hospital level to address the needed workforce-related adjustments. There is a full recognition of the role and independence of the organisational level of CB. The material and the interviews collated for this study tell a story of continuity in the established division of roles between unions, employers and local communities that leave the regions of Tuscany and Emilia Romagna less concerned about the minutiae of the expenditure and its redistribution to the workforce.

The regions in recovery plans

Significantly different are the regions under recovery plans, though within this cluster too there are important distinctions.

For Campania, Calabria, Lazio and Sicily the block of turnover and a minimized scope of CB at decentralized level have been constant features for more than a decade. The complexity of these cases would require a specific focus on each individual region but for the purpose of this work a relevant, common characteristic is a catch-22 situation in which the lack of financial resources led to hiring freezes, which led to a massive recourse to overtime and temporary workers and an increase in expenditure. Such issues would normally fall under the competence of organisation level CB, but the financial restraints of the regions in recovery plans have hampered negotiations between the relevant social partners.

At the ASL of Avellino, in the Campania region, some 273,000 Euros were due to medics for the overtime worked between 2011 and 2012 to deliver minimum healthcare services. Doctors were refused payments by the organisation and compensation only arrived following a decision of the Employment Tribunal that forced the regional government to pay the hours worked. Another example is the ASL of Naples, one of the largest in Europe in terms of remit, which had to undergo a substantial staff reduction between 1993 and 2011, causing an extraordinary use of overtime from nurses and doctors and an increasing recourse to temporary contracts. Temporary workers gradually became eligible to be made permanent. This then led to various disruptions, from staff migrating to other regions attracted by a permanent contract, to disputes with the regional directorate and stoppages at workplace level.

Alarmingly low staffing levels, jeopardising the delivery of minimum care standards, were also the cause of a temporary, symbolic occupation by the employees of the hospital *Dell'Annunziata*, in Cosenza (Calabria) in January 2014. Attempts of the local unions to open negotiations with the management were forcibly ended, as the hospital director declared him/herself to be 'trapped' by the lack of resources imposed by the regional government.

A similar, severe limitation in the use of resources at the local level imposed by the recovery plans is experienced in Lazio where social partners at the regional level recurrently, but unsuccessfully, tried to establish social dialogue at regional level to address similar workforce issues. The delays in solving the regional financial debts is, once again, preventing a solution to the poor economic conditions of healthcare staff.

There are other regions under recovery plans that have been more effective in establishing some forms of social dialogue as a *modus operandi* or in finding ways to 'recover'. In Sicily, according to the national level union representatives interviewed, regional social partners are being *consulted* in the decisions concerning the recovery plan. However, this often entails a simple communication from the regional government of the redundancies involved in the plan. 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 control the expenditure.

The main effect of shifting responsibilities to the regions to recover health expenditure debts has been of a 'squeeze' of the organisation level CB (scenario two) and has prevented it from proposing solutions tailored to the local needs. The dis-empowerment of ASLs and AOs had already 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 employment relations in the health sector interviewed unanimously highlighted past negative experiences of CB at organisation level in the regions currently under recovery plans. This may have de-legitimised social partners as participants in today's decision making arena. Mis-management at the organisational 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 have been common in the past and are still, not infrequently, coming to the fore in discussions on the causes of the regional economic divide (Pavolini, 2011). Though such scandals are common across Italy[4], they happen to be more frequent in the South. The use of public employment as a channel of political consensus has interfered not only with the distribution of resources via CB at organisational level, but also with the possibility to build a tradition of more cooperative employment relations at the decentralised level. The difficulties for the second-level of CB seem particularly acute in the regions that are under administration. The same limited capacity of decentralised CB is found in the Italian private sector too (Negrelli and Pulignano, 2008).

4 Lombardy
is overall regarded as a success case, but has also been often in the focus of public and media attention for big scale scandals in the healthcare sector.

Discussion

The research showed that the increased role of Italian regional governments in contributing to the planning of healthcare provision led to changes in the shaping of employment relations in the public healthcare sector. The organised decentralisation of the employment relations in this sector has been intercepted by the process of decentralisation of responsibilities for healthcare expenditure to the regional governments. As a result, while pay and minimum terms and conditions of work are still determined by the national sector collective agreement, the outcomes of the decentralized level of CB are strongly influenced by the relevant regional healthcare system. Regional governments have at times willingly intervened in financing and regulating staffing levels, or imposing redundancies to keep the books in order, adjusting wage levels or freezing pay, unilaterally or via *ad hoc* consultations with social partners. The findings underscore that the role regional governments *can* play appears to be dependent first of all on the economic performance of the region itself and, secondly, on the way its healthcare system has been organized.

Lombardy proved an interesting example. Where health expenditure is high and the chosen mode of healthcare delivery deviates significantly from the public healthcare system around which the employment relations system was originally designed, the intervention of the region in employment matters is likely to be particularly prominent. We saw that in the attempt to accommodate the presence of a greater variety of providers within its new 'competition-based model', the regional government intervened in disputes that stood in the way of financially advantageous deals for the main investor (the region itself) and increased basic pay to address inefficiencies of the labour market such as nurses shortage. Discretion in the regulation of employment matters and a 'hollowing out' of the central level (scenario one), was felt as desirable by the regional government representative interviewed. The risk of fragmentation highlighted by Teague (1995) is here confirmed. Should a regional government replace the national level of CB, there

would be a risk of greater regional fragmentation and a further, amplified divide in healthcare performance within the country. On the other hand, the increased marketization of healthcare experimented in Lombardy has itself produced a fragmented workforce, with nurses and health care staff working sometimes in the same unit but under different arrangements corresponding to different employers (private, public, religious, cooperative, service sector). Interestingly, some unions declared themselves in favour of a regional level of coordination, rather than a single national collective agreement, on the basis that it could guarantee better internal harmonization. The principle of *national* solidarity, on the basis of which 'wage cages' were abolished forty years ago, seems today less sustainable to an increasingly wider range of stakeholders.

Relatively wealthy Friuli Venezia Giulia and Veneto intervene 'on demand' in workforce-related matters if needed, but still value the role of a national level of collective bargaining. Consistent with what Regalia and colleagues (1998) found, in these two cases the regional governments seem to take advantage of the flexibility and adaptability of a possible regional level of regulation when needed and show an administrative style open to social dialogue. Coordination amongst different, neighbouring regions is also seen as functional to the achievement of efficiency, but not as central in the development of long-term strategy. While this partly confirms the tendency observed in 'dynamic' regions across different European countries (Regalia et al. 1998) it is found to be a viable option also in regions less well-performing, like Sicily and, to an extent, Puglia and Piedmont. Here too, an on-demand three-tier type of employment regulation (scenario three) was resorted to in order to face the organizational difficulties of the recovery plan.

In cases of financial constraints, such as in the regions under recovery plan, it was observed that the regional governments became, though perhaps not intending to, prominent actors of healthcare employment relations. The debt of Calabria, Lazio and Campania alone account for two-thirds of the entire national healthcare debt and they have been under administration for more than a decade. The research showed how this has led to a frustration of the governance capacity of the employment relations institutions in place. In particular, the effect of the tight

budget control has led to a 'squeeze' of the decentralized level of collective bargaining which, in turn, hugely affected the increasingly poor working conditions of health staff. Though more research would be needed, the greater efficiency of a regional level, instead of a decentralized one, envisaged in the scenario two, is debatable. Amongst the regions that are not under recovery plan, Marche is another example where the region has come to overlap with the organization level. The small size of the region is likely to have facilitated such situation and, in this case, it seemed justified by a search for greater efficiency.

The remaining ten regions raise questions about the proposition that regional governments would come to play a direct role in regional healthcare employment relations by virtue of their greater financial involvement. The analysis of the documentation of Tuscany and Emilia Romagna show how their substantial investments in improving the regional healthcare systems do not include any direct interventions on the workforce. The additional regional resources are managed at the organizational level and the division of competences between CB at the two levels is preserved. Indeed, formal procedures did not change as a result of the greater planning and commissioning role of the regions. However, in terms of territory, population and healthcare workforce, changes (scenarios from 1 to 3) have affected the majority of the country[5]. The extent to which regions have intervened in employment relations matters affected both the processes and the substantial outcomes of the established levels of collective bargaining, the decentralised one in particular, with effects on the access to care for a substantial share of the population, as well as with effects on the working conditions of the majority of staff involved.

Conclusion

The research highlighted that although a new, regional level of CB has not been

[5] Nearly half of the Italian population lives in Lombardy, Lazio, Campania, Sicily and Veneto alone (30 million out of 60).

formally recognised, in some cases, as a result of their increased involvement in the organisation and financing of local healthcare, regional governments have intervened - unilaterally, with *ad hoc* consultations or indirectly, as in the regions under recovery plans - in the substantive regulations of employment relations leading to rather uneven outcomes of its 'organised decentralisation'. This research, in particular, shows how the role of CB at the decentralized level was stretched in opposite directions: towards a further empowering in the better performing regions, and, by contrast, towards a frustration of its potential role in the health organisations of the less-well performing regions. This is of wider significance in terms of the diversified effects that nationally rolled out reforms can have on employment relations at the sub-national level. In particular, the combination of a centralised employment relations system faced with deep economic regional divides can undermine the effectiveness of the 'division of work' between national and decentralised levels of CB.

If the literature on the effects of NPM-inspired reforms on industrial relations show that we need to take into account the capacity of the organized relevant social actors to promote or frustrate change, the analysis of the effects of the concomitant territorial decentralization of public healthcare services shows that two other elements should be considered when assessing possible outcomes in terms of workforce governance. One is the possible effect of differences in economic performance of different regions or territorial units and, secondly, the degree of organisational change in the re-organisation of healthcare provision.

Only in one case, the shaping of what could be looked at as a new, regional level of industrial relations has been observed: Lombardy. It is the region that shows both the highest financial investment in healthcare and that has re-organised the provision of the service in a way that deviates the most from the original, pre-federalist reform.

In the rest of the 'well-performing' regions, whether with or without the mediation of the regional government, the decentralized level was further 'empowered' in its responsibility to deliver healthcare and manage the human resources associated

with it. By contrast, the financial difficulties of the 'less-well performing' regions acted as a bottleneck of the resources, ending up frustrating the project to give greater management responsibility to the organisations ('corporatisation') introduced with the reforms of the 1990s. The situation of regions going through financial hardship is much more diversified and has confirmed the importance of the role of national level CB in guaranteeing a minimum level of protection that would have been otherwise undermined by the severe cuts of resources to the local healthcare staff. An example of this emerged in the second round of interviews, which highlighted how the CB freeze in place since 2009 in the whole public sector as a form of austerity has more severely affected the workforce in the regions already struggling for resources.

The objective of a more efficient control of expenditure can be achieved to varying extents according to the resources and preferences of different territories in a given country. The transfer of responsibility in organising and financing healthcare from the national to the regional level needs to take into account the capacity of the regional governments to provide sufficient resources and to trust local organisations and their workforce in the implementation of the changes involved. Regions that will want to deviate more in the way they provide healthcare from the national model of health are found to seek greater discretion also in the management of the relevant workforce, undermining the established levels of regulation of employment relations but also the rationale of nationally-designed reform policies.

The case of Italy shows how a multi-tier industrial relations system can ensure a distribution of competences, even in cases of deep regional differences: minimum standards are guaranteed across the national territory via national sector level CB. This had the advantage of counter-weighing the inequalities caused by the increased decentralisation for health staff. On the other hand, however, CB at the organisation level had different outcomes in different regions. While the Italian industrial relations system was designed to minimise territorial differences, *de facto*, disparities in working conditions persist.

Further research on individual regional health systems, possibly across different countries, could shed light on various trajectories of change not only in terms of quality of service for the patients but also of quality of working life for the staff involved. This seems all the more relevant in times of economic crisis, when public expenditure, that of healthcare in particular, becomes a tool to correct public national debts.

References

Alessi, R. (2009) *Alcune considerazioni sul modello contrattuale nella sanita'. Le necessita' emergenti*, 293–309, in M. Carrieri and V. Nastasi (eds) Spazio e ruolo delle autonomie, (Bologna, il Mulino).

Bach, S., Bordogna, L. and Della Rocca, G. (1999) *Public Service Employment Relations in Europe: Transformation, Modernization or Inertia?,* (London, Routledge).

Bach, S. and I. Kessler (2011) *The Modernization of the Public Services and Employee Relations*, (Basingstoke, Palgrave Macmillan).

Bordogna, L. and A.M. Ponzellini (2004) *Qualita' del lavoro e qualita' del servizio negli ospedali. Organizzazione del lavoro e partecipazione dei lavoratori in Italia e in Francia* (Roma, Carocci).

Bordogna, L. (2008) 'Moral hazard, transaction costs and the reform of public service employment relations', European Journal of Industrial Relations, 14, 4, 381–400.

Bordogna, L. (2009) *Cambiamento, continuita' e incoerenze nella nuova regolazione del lavoro pubblico*, in M. Mascini (ed) Annuario del lavoro 2009, (Roma, Edizioni Il diario del Lavoro).

Carrieri, M. (2009) Il decentramento ridisegnato, 11–51, in M. Carrieri and V. Nastasi (eds) Spazio e ruolo delle autonomie, (Bologna, il Mulino).

Charron, N., Lapuente, N. and Nistotskaya, M. (2012) *The Wealth of Regions: Government Quality and Entrepreneurship in Europe*, QoG Working Paper Series, ISSN 1653-8919.

Corte dei Conti (2015) Rapporto 2015 sul coordinamento della spesa pubblica, (available at www.cortedeiconti.it).

Crouch, C. (1993) Industrial Relations and European State Traditions, (Oxford, Clarendon Press).

Crouch, C. and F. Traxler (1995) *Organised Industrial Relations in Europe: What Future?* (Avebury, Aldershot).

Cuccurullo, C., F. Ferre' and F. Lega (2010) *I piani di rientro della spesa sanitaria: un'analisi comparativa*, inAnessi Pessina,E., E. Cantù, C. Carbone and F. Ferrè (eds) *L'aziendalizzazione della sanità in Italia: rapporto Oasi 2010*, (Milano, Cergas Bocconi University).

Ferrera M. (1995) The Rise and Fall of Democratic Universalism: Healthcare Reform in Italy, 1978–1994, Journal of Health Politics, Policy and Law*,* 20, 2, 275-302.

Ferrera, M. and E. Gualmini (2004) Rescued by Europe? Social and Labour Market Reforms in Italy from Maastricht to Berlusconi (Amsterdam, Amsterdam University Press).

Formez (2007) 'I sistemi di governance dei servizi sanitari regionali', Quaderni Formez, 57, (Roma, Formez).

Galetto, M., P. Marginson and C. Spieser (2014) 'Collective bargaining and the changing governance of hospitals. A comparison between United Kingdom, Italy and France', European Journal of Industrial Relations*,* 20, 2, 131-147.

Greer, I., T. Schulten and N. Böhlke (2013) 'How Does Market Making Affect Industrial Relations? Evidence from Eight German Hospitals', British Journal of Industrial Relations, 51, 2, 215-239.

Grimshaw, D., Jaehrling, K., van der Meer, M., Mehaut P. and N. Shimron (2007) Convergent and divergent country trends in coordinated wage setting and collective bargaining in the public hospitals sector, Industrial Relations Journal, 38, 6, 591-613

Hood, C. (1995) 'The 'New Public Management' in the 1980s: Variations on a theme', Accounting, Organizations and Society, 20, 2/3, 93–109.

Keating, M. and J. Loughlin (eds) (1997) The Political Economy of Regionalism, Routledge, Oxon.

Marginson, P. (2011) (Re)assessing the shifting contours of Britain's collective industrial relations, Industrial Relations Journal, 43(3), 332-347.

Méhaut, P., P. Berg, D. Grimshaw, K. Jaehrling, M. van der Meer and J. Eskildsen (2010) Cleaning and nursing in hospitals: Institutional variety and reshaping of low wage jobs, In J. Gautié and J. Schmitt (eds) *Low-wage Work in the Wealthy World*. (New York, Russell Sage Foundation), 319–366.

Miles, M. A., Huberman, A. M. and J. Saldana (2014) Qualitative data analysis: a methods sourcebook, (Thousand Oaks, SAGE Publications).

Negrelli, S. and V. Pulignano (2008) Change in contemporary Italy's social concertation, Industrial Relations Journal, 39, 1 63-77.

Neri, S. (2006), La regolazione dei sistemi sanitari in Italia e Gran Bretagna. Concorrenza, cooperazione, programmazione, (Milano, Franco Angeli).

OECD (2015) 'OECD Health Statistics. Focus on Health Spending' (available at: www.oecd.org/health).

Pavolini, E. (2011) Il cambiamento possibile. La sanita' in Sicilia tra Nord e Sud, (Roma, Donzelli Editore).

Pavolini, E. and G. Vicarelli (2012) 'Is decentralisation good for your health? Transformations in the Italian NHS', Current Sociology, 60, 4, 472–488.

Putnam, R. (1993) Making democracy work: Civic Traditions in Modern Italy, (Princeton, Princeton University Press).

Regalia, I. (1998) 'Industrial Relations at Regional Level in Europe: Strengths and Weaknesses of an Intermediate Level of Social Regulation', European Journal of Industrial Relations, 4, 2, 157-176.

Regalia, I. (ed) 2006, Regulating New Forms of Employment: Local Experiments and Social Innovation in Europe, (London, Taylor and Francis).

Sabel, C. F. (1996) Experimental Regionalism and the Dilemmas of Regional Economic Policy in Europe, Columbia University paper.

Sarto, F., I. Kirkpatrick and G. Veronesi (2015) 'Exploring regionalism in public management reforms: the case of the Italian hospital sector', Policy and Politics – online July 2015.

Schulten, T., T. Brandt and C. Hermann (2008) 'Liberalisation and privatisation of public services and strategic options for European trade union responses', Transfer, 14, 2, 295–311.

Teague, P. (1995) 'Europe of Regions' and the Future of National Systems of Industrial Relations', Economic and Industrial Democracy, 16, 3, 327-351.

Traxler, F. (1995), 'Farewell to labour market associations? Organised versus disorganised decentralisation as a map for industrial relations', in Crouch, C. and Traxler, F. (eds.), Organised industrial relations in Europe: What future?, Aldershot, Avebury, 3–19.

Zoppoli, L. (2008) A dieci anni dalla riforma Bassanini: dirigenza e personale, *Il lavoro nelle pubbliche amministrazioni*, 1-36.

Table 1. Selected key characteristics of the twenty-one Italian regional health systems

Region	**Regional Health system (Classification by Formez 2007)***	**Regional Health system (Classification by Neri 2006) ******	**Share of public beds (in %) (Formez 2007)**	**% of HS funding coming from regional taxation (Formez 2007)**
Piedmont	Mixed (integrated)	(integration)	80	41.9
Valle d'Aosta	Integrated	(integration)	100	40.4
Lombardy	Separated	Competition	80	60.8
Bolzano	Integrated	(integration)	87	41.1
Trento	Integrated	(integration)	82	41.6
Veneto	Integrated	Integration	94	49.1
Friuli Venetia Giulia	Mixed (integrated)	Integration	89	40.9
Liguria	Mixed (integrated)	(integration)	99	33.6
Emilia-Romagna	Mixed (integrated)	Cooperation	78	48.8
Tuscany	Mixed (integrated)	Cooperation	86	39.9
Umbria	Mixed (integrated)	(integration)	93	30.8
Marche	Mixed (integrated)	(integration)	85	39.0
Lazio	Mixed (separated)	Bureaucratic	70	52.4
Abruzzo	Integrated	Bureaucratic	85	27.5
Molise	Integrated	Bureaucratic	89	12.0
Campania	Mixed (separated)	Bureaucratic	70	21.1
Puglia	Mixed (integrated)	Bureaucratic (integration)	86	23.7
Basilicata	Mixed (integrated)	Bureaucratic	98	11.2
Calabria	Mixed (integrated)	Bureaucratic	68	10.0
Sicily	Mixed (separated)	Bureaucratic (some competition)	79	23.9
Sardinia	Integrated	(integration)	81	28.9
ITALY			**81**	**39.6**

Sources: Formez (2007) and Neri (2006)

** Integrated*: Hospitals are under the direction of the local health unit (ASL); *Separated*: Hospitals and local health units are independent from each other; *Mixed (integrated)*: both integrated and separated options are available but with a tendency to integration of functions of hospitals and local health units; *Mixed (separated)*: both integrated and separated options are available but

with a tendency to separation of functions between hospitals and local health units.

** *Competition*: public, private, religious and not-for-profit providers are made competing for the provision of health services to the regional government; *Cooperation*: public, private, religious and not-for-profit providers cooperate in the provision of health services; *Integration:* the public provision of health services can be complemented by providers of different nature; *Bureaucratic:* financial constraints limit alternatives available and experimentations.

Table 2. Data collection

	Name	***Details***	***Years***
19 Interviews (semi-structured interviews; duration from 45 minutes to 2 hours; transcribed and manually coded)	- Cgil Sanità - Cisl Sanità - UIL Sanità - Cgil Sanità - Cisl Sanità - ARAN Sanità - Lombardy Sanità - CERGAS - Experts	- national level - national level - national level, telephone interview - regional level, Lombardy - regional level, Lombardy x 2 - national bargaining agent x 2 - regional healthcare officer - Researcher of CERGAS (Bocconi University, Milan) - Academic experts on ER in the public health sector x 3	2010–2011
	- Cgil Sanità - Cisl Sanità - Experts	- national level, telephone interview x 2 - national level, telephone interview - Academic experts on ER in the public health sector x 3	2015-2016
Collective agreements (CAs) of the public health sector	**CCNL** (*Contratti Collettivi Nazionali del Lavoro*) and the 'Coordinated Text' 2010	- individual National Labour Collective Agreements since early 2000s (CA 2002-2005 (and related economic renewals 2002/2003 and CA 2004/2005); 2006-2009 (and related economic renewals 2006/2007 and 2008/2009)); - The 'Coordinated Text' collects in a single text all changes and updates of all items of the national collective agreements of the sector, in this case from 1994 to 2009;	2000-2010
Collective agreements at organizational level	Relevant 'integrative collective agreements' at hospital or local health organisation level	Where believed useful (usually as a follow up on specific instances of relevant initiatives at organization/hospital level) the organization level collective agreements were looked at (13 hospital level CAs in total)	2010-2015
Regional health plans (programmatic documents of regional health plans drafted by the regional governments, sometimes in consultation – not negotiation – with relevant social	Systematic review of individual regions' health plans	Review of latest regional health plans – these were often associated with further 'reforms' or 'projects' documents that were therefore analysed.	2010-2015 (or most recent available)

partners)			
Reports and updates from national official offices' websites	**National Account Office** *(Corte dei conti)*	National central audit office	2013-2016
	AGENAS (*Agenzia Nazionale per i Servizi Sanitari Regionali*)	Non-profit national body that monitors regional health systems performance by collecting and presenting evidence on trends of expenditure mainly	2010-2015
	Conferenza Stato-Regioni	Permanent consultation body on implementation of the federalist reform	
	ARAN (Agenzia Rappresentanza Negoziale)	The negotiating body on behalf of the state in the public sector collective bargaining. Amongst other things, it publishes reports on public sector employees and national level collective bargaining	
Review of online news from healthcare sector dedicated websites and groups	*Osservatorio Sanità*	Daily news website linked to Ministry of Health and Federsanità	2010-2015
	Sole24Ore Sanità	Special weekly issue of the main Italian financial newspaper on the healthcare system	2010-2015
	Cittadinanza Attiva Sanità	Citizen and healthcare users-based interests group that monitors and carries out enquiries on the healthcare sector, has recently introduced an 'Observatory on the effects of federalism in healthcare' (*Osservatorio Civico su Federalismo in Sanità)*	2015-2016
Reports from specialized research centres	**CERGAS** *(Centro di Ricerche sulla Gestione dell'Assistenza Sanitaria e Sociale*, Bocconi University, Milan)	Bocconi University-based research centre that publishes yearly report on healthcare system performance via its 'Observatory on healthcare organisations' (OASI, *Osservatorio Aziende Sanitarie Italiane*)	2007-2015
	CREA Sanità (*Consorzio per la Ricerca Economica Applicata in Sanità*)	National research institute publishes regular reports on regional healthcare systems	2014-2015
	MeS Lab (*Laboratorio Management e Sanità,* Istituto Superiore di Pisa)	Pisa-based academic research center on Healthcare Management	2012-2015
	OECD	*'Health at a Glance'*	2005-2015

Table 3. Role of the regional government in the employment relations of their healthcare systems

	'Hollow out' national level (*scenario one*)	'Squeeze' local level (*scenario two*)	From two- to three-tier (on demand) (*scenario three*)	No regional intervention in ER matters (*scenario four*)
Regions under recovery plans			Piedmont	Abruzzo
			Sicily	Molise
		Calabria	Puglia	
(and under administration)		Campania		
		Lazio		
Well-performing regions	Lombardy	Marche	Friuli VG	Tuscany
			Veneto	Emilia Romagna
			Umbria	Valle d'Aosta
				Bolzano
				Trento
				Liguria
				Sardinia
				Basilicata