In Italy this happened simultaneously with the decline of the two main political parties (the Christian Democratic and the Socialist ones) due to bribes and corruption charges, in a quite novel but effective activity by the judiciary in order to make politics cleaner.

The regional political parties became essential in forming local governments in the northern regions and fluctuated between federalism and separatism. They stressed the inefficiencies of the central government and the excessive (in their opinion) transfer of funds from the North to the South. Another hot point they made was the centralisation in rules and bylaws: everything was decided in Rome, in the same way for every part of Italy. The examples of Germany and Switzerland – with large autonomies given to any *land* and canton – were taken as possible solutions for Italy too.

The mere administrative and operational decentralisation was not any more enough.

No political party could neglect this appeal to federalism and decentralisation. The Northern regions make up about 40 % of the population – and votes – and much more of the GDP – and taxes.

The result was a rather deep change in the *Costituzione* giving regions (but not provinces and municipalities) much wider powers. The shift was essentially from a positive list to a negative list: while previously regions could legislate on a given number of problems now they can decide on everything that is not excluded and reserved to the central government.

4 – Decentralisation and Devolution in the Nineties

The reform implemented in the nineties has radically reshaped the finance of both Regions and Municipalities. Here we focus on Regions as they represent at present the main counterpart of the central government in the political debate on fiscal federalism.

4.1 – The Enlargement of the Fiscal Autonomy of Ordinary Statute Regions

At the beginning of the Nineties Ordinary Statute Regions (*OSR*) have basically no fiscal autonomy. Up to 98% of total revenue are transfers from the central government. Further, nearly all of these grants are conditioned to the financing of the National Health Service (*NHS*) (which represents nearly 80% of total regional expenditure) and of other minor expenditure programs.

During the decade there have been several attempts to increase the fiscal autonomy of *OSR*. We can single out two phases in the reform process. In the first phase, the central government introduces the essential

instruments for fiscal autonomy through the devolution of relevant taxes to the *OSR*.

In 1993, Regions receive the yield of the health pay-roll tax, levied on salaries and on self-employed incomes. As a consequence transfers drop to 54% of total revenue. In 1998, the health payroll tax and some minor regional taxes are abolished and replaced by a new tax, named Irap (Regional business tax), and by a regional surcharge (0.5%) on the personal income tax. Irap is a value-added tax implemented through the subtraction method and levied on basically all business, both in the production of goods and services and in the financial sector. The base rate is 4.25%. The tax operates under the origin principle of taxation: the yield accrues to the Region where the value added is produced. [1] The actual Irap yield has been far lower than government's estimates (29 billions against the expected 34 billions of Euro). This explains why own revenues as a share of total regional revenues drop from 50% in 1997 to 44% in 1998.

In practice, this first phase of reforms has a small, if any, effect on Regions' fiscal autonomy. As to the health payroll tax, Regions have no control upon either the base or the collection procedures. They just receive the tax yield from the central government Treasury accounts as a part of a conditional grant, equal to each Region's health need. Actually, Regions do have the power to change the tax rate, in a given range around the base rate, but regional politicians have no incentive to propose unpopular tax increases given that health financing is secured by government transfers.

This state of affairs is only partially affected by the introduction of Irap. In theory, Regions have wide powers upon collection and auditing but, in fact, regional administrations lack the technical skills to manage any of the procedures involved and passively rely on the central government. As a consequence, all the information from the tax returns is in the hands of the Treasury, and is released quite parsimoniously in order to curb the call for greater political autonomy that comes from the Northern Regions. As to the tax rates, the 1998 reform confirms the right of the Regions to increase or reduce them[2] but it does not remove the disincentives to fiscal effort. On the one hand, the entire revenue from the personal tax surcharge and 90% of the Irap yield are still conditional to health financing. On the other hand, any gap between Regions' own revenue and health expenditure is filled by grants from the central government.

The second phase of the reforms, completed in March 2000, aims at introducing the right incentives to encourage active tax policies. As previously remarked, it was widely acknowledged that regional politicians

[1] The total value added of a firm is apportioned to Regions where the production plants are located on the basis of labour cost.

[2] The Irap tax rate can be increased or reduced by one percentage point, the regional surcharge on the personal income tax by 0.5 percentage points.

had no incentive to manage the taxes assigned to them for two reasons. First, they faced a soft budget constraint, as any deficit in the health sector was ex-post financed through State transfers. Second, almost all revenues were conditional to health financing.

Furthermore, the Regions claimed that the uncertainty surrounding the amount of transfers (recall that the transfers were discretionary determined by the central government, year by year, in the budget law) hindered any serious financial planning.

The 2000 reform tackles these issues by abolishing almost all existing grants and replacing them through the sharing of national VAT and the increase of the base rate of some other minor surcharges (personal income tax, excise on gasoline). The VAT sharing rate is fixed at 38,55% in order to leave unchanged the total amount of resources in regional budgets. The VAT is apportioned to Regions in proportion of the estimated consumption of their residents. Clearly, the distribution of the abolished grants is different from that of consumption. Therefore the substitution of the grants with the VAT sharing generates large fiscal imbalances in almost every Region. To correct these imbalances the reform draws a new system of equalisation transfers. In the first year (2001) the transfers simply redistribute regional resource in order to guarantee at each single Region the same resources it would have received from the old grants. After a long transition period, which will end in 2013, the new system of transfers will equalise resource across Regions according to a formula that takes into account fiscal capacity and health needs. In theory, the equalising transfers are horizontal: “rich” Regions give up some of their revenue to finance “poor” Regions.

Overall, the new system of regional finance should guarantee a hard budget constraint, as the central government does not finance anymore the Regions through discretionary transfers. Furthermore, in order to strengthen the incentives to autonomous tax effort, the reform abolished every constraint to the use of revenue: the additional yield generated by an autonomous tax increase can be spent freely to finance any regional expenditure programs.

Through the abolition of discretionary transfers, the new system of finance allows a normal financial planning as each Region can estimate future revenues, that depend on the dynamics of the tax bases and on the equalising formula.

4.2 – Equalising Transfers

As previously highlighted, the 2000 reform draws a long transition period from the present system of equalising transfers (which basically redistributes the regional VAT in order to meet historical expenditure in

each Region) to a new system where the transfers are determined according to a formula that takes into account the fiscal capacity, the health need and the economies of scale in the provision of public services. In particular, at the end of the transition period, the transfer to Region *i*, T_i, will be determined as the difference between the amount of VAT assigned according to an equalising formula (*EVAT*) and the VAT assigned to the Region on the basis of the estimated consumption of Region's residents (*CVAT*). Formally:

$$T_i = EVAT_i - CVAT_i \tag{1}$$

and

$$EVAT_i = n_i \left[\frac{RVAT}{\sum_i n_i} + \beta \sum_j \bar{t}_j \left(\bar{b}_j - b_{ij} \right) + \left(g_{hi} - \bar{g}_h \right) + \gamma \left(p_i - \bar{p} \right) \right] \tag{2}$$

where n_i is Region's *i* population, *RVAT* is the regional share of national *VAT*, $\bar{t}_j$ is the base rate for regional tax *j*, b_{ij} is the base of regional tax *j* in Region *i*, $\bar{b}_j$ is the average base of tax *j* over all *OSR*, g_{hi} is the expenditure required to meet the health need of Region *i*, $\bar{g}$ is the average expenditure to meet the overall health need of the *OSR*, p_i is an estimate of the standard expenditure but for health in Region *i* and $\bar{p}$ is the average of the p_i among the *OSR*. All variables inside the square brackets are in per-capita terms. The parameters β and γ are equal to 0,9 and 0,7 respectively.

By substituting (2) into (1) we get:

$$T_i = n_i \left[\underbrace{\left(\frac{RVAT}{\sum_i n_i} - \frac{CVAT_i}{n_i} \right) + \beta \sum_j \bar{t}_j \left(\bar{b}_j - b_{ij} \right)}_{\text{Fiscal capacity}} + \underbrace{\left(g_{hi} - \bar{g}_h \right)}_{\text{Health need}} + \underbrace{\gamma \left(p_i - \bar{p} \right)}_{\text{Economies of scale}} \right] \tag{3}$$

This formula highlights the three criteria that determine the size of the transfer received or paid by Region *i*.

The first two terms equalise fiscal capacity among Regions, the third redistributes resources according to the health need and the fourth corrects the distribution of resources in order to compensate smaller Regions that cannot fully exploit economies of scale in the provision of their services.

To evaluate the final impact of the equalisation formula on the distribution of revenues among Regions it is expedient to consider each of

the three corrections separately. Assume that Region i keeps its tax rates at base levels. The Region's own revenues are equal to

$$R_i = n_i \sum_j \bar{t}_j b_{ij} + CVAT_i.$$

If the region receives (or pays) a transfer, T^1_i, truncated to the first two terms in (3), total revenues are:

$$G_i^1 = R_i + T^1_i = n_i \left[\frac{RVAT}{\sum_i n_i} + \beta \sum_j \bar{t}_j \bar{b}_j + (1-\beta) \sum_j \bar{t}_j b_{ij} \right] \quad (4)$$

If β were equal to 1 each Region would have total per-capita regional revenue equal to the average per-capita yield of the VAT sharing and of regional taxes (e.g. Irap, regional surcharge on personal income tax) when levied at the base rates. In fact fiscal capacity is completely equalised only with respect to VAT, while the differences in all remaining regional revenue are equalised up to 90%, as β=0,9.

In order to describe the effect of the third component of (3) on regional total revenue it is convenient to rewrite equation (4) taking into account that the VAT sharing rate has been chosen in order to leave the total amount of resources that flows in regional budgets unchanged. Therefore, in the year when the reform is first implemented (2001), the following equality holds:

$$\frac{RVAT}{\sum_i n_i} + \sum_j \bar{t}_j \bar{b}_j = \bar{g} + \bar{p}. \quad (5)$$

In fact, as we will clarify in section 5.1, the reform is based on the implicit assumption that this condition will be nearly met also in subsequent years. We may therefore substitute (5) into (4) to get:

$$G_i^1 = n_i \left[\bar{g} + \bar{p} + (1-\beta) \sum_j \bar{t}_j \left(b_{ij} - \bar{b}_j \right) \right]. \quad (6)$$

When we add the transfers generated by the corrections for health need, total revenue becomes:

$$G_i^2 = n_i \left[g_i + \bar{p} + (1-\beta) \sum_j \bar{\tau}_j \left(b_{ij} - \bar{b}_j \right) \right]. \quad (7)$$

Were β=1 any Region would receive, at base rates, revenue equal to its health need plus the average per-capita expenditure of all *OSR* in programs different from health.

Finally, by adding the fourth component, we get:

$$G_i = n_i \left[g_i + \gamma p_i + (1-\gamma) \bar{p} + (1-\beta) \sum_j \bar{\tau}_j \left(b_{ij} - \bar{b}_j \right) \right].$$

Were β=γ=1, each Region would receive, at base rates, the money needed to finance its health need and standard expenditure in other programs. In fact, being β and γ smaller than 1, some Regions, the ones with tax bases and population larger than average, would enjoy revenue in excess of the amount required to cover health need and standard expenditure, while others, the ones with tax bases and population smaller than average, could not finance health need and standard expenditure at base rates.

In order to illustrate the impact of the transfers on the distribution of Regions' revenue we simulated the implementation of the new transfer system based on formula (3) in the year 2001. The results are reported in tables 1 and 2.

Table 1 contains data on the interregional transfers. The values in per-capita terms show that the sign and the size of the transfers are mainly driven by the fiscal capacity component due to the large divergence in tax bases across Regions. All Northern Regions, with tax bases larger than average, must give up some of their revenue, while all Southern Regions receive a positive integration to their own resources. The situation of the Regions in the middle of the peninsula is somewhat mixed: roughly, large Regions (like Emilia R. and Lazio) are contributors while small ones (like Marche and Umbria) are beneficiaries. The transfers activated by the correction for health need are in general smaller and they flow in quite different directions. The Southern Regions are now mainly contributors as their health need is lower than average due to a younger population. The main beneficiaries appear to be the Central Regions and Liguria, which is the Region with the higher percentage of aged people in population. The last term in the equalisation formula benefits the small Regions (Liguria, Marche, Umbria, Molise, Basilicata) irrespective of their geographic location.

In absolute terms, the total amount of money transferred from "rich" to "poor" Regions amount to 6,326 millions of Euro (10% of *OSR* total revenue). The flows are extremely polarised: the largest Northern Region, Lombardia, pays out more than half of total contributions and the two

largest Regions of the South, Campania and Puglia, receive nearly 60% of all positive transfers.

Table 2 and figure 1, show the effects of the implementation of the equalisation formula on the distribution of resources among Regions. In particular columns 3 and 6 of table 2 reports the percentage deviations from mean of Regions' total revenue in per-capita terms, respectively in the actual situation and in the simulated case where the equalisation formula is implemented in 2001. It is apparent that the equalisation formula mainly benefits the small Regions that experience an increase of their revenue in per-capita terms. Surprisingly, the largest Southern Regions are worst off, despite they are the main recipient of transfers. This is the final result of the combined effect of partial equalisation of fiscal capacity (b<1), and relatively low health need (as their population is younger than the Italian average). Apart from the small Regions, the new transfer system brings about a strong equalisation of resources, as the divergences from the mean are smaller than 10%.

5 – Open Issues and Perspectives

5.1 – The Uniformity of Health Standards Across the Country

As previously remarked, one of the main innovations of the 2000 reform is the abolition of any constraint on the use of regional revenue. Even if the transfer received or paid by each Region is calculated with reference to its health need g_i, the Region may well spend less or more than g_i in health. However, the reform confirmed the principle of the uniformity of health services provision through the national territory. In fact, Regions are compelled to provide health services up to specified levels, both in terms of quality and quantity. If effective, the control of the performances may provide additional incentives to efficient management of health expenditure. The more efficient Regions, that are able to meet the required standards at a cost lower than g_i may employ the money they have saved to finance other expenditure programs according to the needs and preferences of their constituencies.

Nevertheless the principle of uniformity in health services may be at odds with the new system of regional finance. As explained in sections *4.1*, the 2000 reform has formally abolished all vertical transfers from the central budget to the *OSR*. As a consequence, the Regions should now face a hard budget constraint as their total revenue, at base rates, depend on the evolution of their tax bases only. In the year when the reform was first implemented (2001), the VAT sharing rate has been chosen according to (5) in order to guarantee sufficient resources to finance the sum of all Regions'