Healthcare Regionalisation and Patients Mobility: the Challenges for a Sustainable Italian Health Service

Silvia Bruzzi

Polo Interregionale di Eccellenza Jean Monnet - Pavia
Jean Monnet Interregional Centre of Excellence - Pavia

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Summary

Patients mobility represents one of the most important issues which the Italian Health Service, based on the typical solidarity principles of the Beveridgean model dating from 1978, is required to address today. The patients mobility issue began to emerge in Italy with the 1992 reform that assigned the Regions with the responsibility of safeguarding the population health, as well as being responsible for maintaining a balanced financial position. The article highlights the existence of a structural asymmetry among the regional health systems by analysing the flows of patients among the Regions. This scenario needs to be governed according to a national perspective in relation to the serious financial difficulties experienced by the Regions of South Italy, in order to avoid putting at risk the economic sustainability of the whole system, as well as the ability to provide services which are qualitatively and quantitatively adequate for the entire Italian population.

Note on the Author

Silvia Bruzzi, Ph.D, is Associate Professor at Department of Pharmaceutical and Biomedical Sciences, University of Salerno
email: sbruzzi@unisa.it

1. Introduction: the Institutional Framework

Patients mobility represents one of the most important issues which the Italian Health Service, based on the typical solidarity principles of the Beveridgean model dating from 1978 [1] and subject to reform starting from 1992 [2], is required to address today. The aim is to assure the economic sustainability and the ability to provide services which are qualitatively and quantitatively adequate for the entire Italian population [3,4].

The patients mobility issue began to emerge in Italy with the 1992 reform, based on decentralisation [5] in harmony with the principle of vertical subsidiarity that found a new marked appreciation in the European integration process during those years [6], assigning the Regions, institutions close to the citizens, with the responsibility of protecting their health, as well as maintaining a balanced financial position [7].

This accountability requirement assumed a marked economic and financial significance during this initial phase of reform, since Italy, like the other European countries, participated in the Monetary Union project and, over those years, pursued the priority objective of containing the rate of growth of one of the main components of public spending, namely that of healthcare [8]. Legislative Decree No. 502/92 introduced the first innovations in this sense and confirmed the principle of the Regions' responsibility concerning expenditure, by substituting the criteria of regional financing based on historical expenditure (and offsetting the deficits) with a capitation method.

According to this latter method each Region receives a given amount of resources established in relation to the resident population and the Region is required to offset the greater debt if this amount is exceeded.

More in detail, the capitation method was subject to a so-called pure application in Italy in the initial phase, envisaging that the Regions would receive an amount of resources commensurate to the resident population. The capitation was subsequently adjusted per age, in order

to assure that the Regions with an older population received an amount of resources commensurate to the corresponding greater request for services.

The application of age-adjusted capitation is a method broadly used at an international level [9], while its application in Italy, a country characterised by a population that on average is older in the North, has led to a scenario where the average financing was lower for the Regions in South Italy, Regions which are historically depressed and form part of the European Union's Objective 1. This aspect has been the source of continuous disputes in the Conference of Regions and Autonomous Provinces and then in the State-Regions Conference[1], with the presentation of a number of proposals by the Regions in South Italy – however, never approved – aimed at introducing weighting criteria which were also able to favour the inclusion of social and economic variables.

The Italian debate immediately highlighted the risk that the reform when based on the principle of regionalisation of a country like Italy, historically characterised by a strong North-South economic and social dualism, could worsen the imbalances of the services offered and the access to treatment [10].

The social insurance package, named *Livelli Essenziali di Assistenza* - LEA, was defined for the first time in Italy in 2001[2], to address the risk

[1] The "Conferenza Permanente per le Relazioni tra Stato, Regioni e Province Autonome di Trento e Bolzano" (Permanent Conference for Relations among the State, Regions and Autonomous Provinces of Trento and Bolzano) is the institution called to foster co-operation among the State and the Regions and Autonomous Provinces, forming the "privileged seat" of political negotiations between the central government and the Regions. The "Conferenza delle Regioni e delle Province Autonome" (Conference of the Regions and Autonomous Provinces) is the institutional body called to coordinate the actions between the Presidents of the Regions and Autonomous Provinces.

[2] Prime Ministerial Decree (DPCM) dated 29th November 2001 amended by Prime Ministerial Decree (DPCM) dated 28th November 2003 and 5th March 2007 and substituted in full by Prime Ministerial Decree dated 23rd April 2008. The definition of the LEA in 2001 follows the constitutional reform of Heading V of the Constitution of the Italian Republic that assigned the State

of a fragmentation of the National Health Service (NHS) into many regional health services, characterised by a different speed and degree of development.

The definition of the LEA was also determined from the financial aspect, since they have been used as a tool to harmonise the allocation of resources to the various types of services in the various regional territories. In fact, the health services have been divided into three large macro-categories (Prevention – Territorial Services – Hospital), and each Region is required to assign a specific % of the national financing to each of these macro-categories, and precisely 5% to Prevention, 44% to Hospitals and 51% to Territorial Services[3].

Moreover, the apportionment into three macro-categories established the basis to define a mixed capitation method based in part on a pure capitation and in part on an age-adjusted capitation. In particular, in 2010 resources were distributed on pure capitation for Prevention; for Hospitals 50% of resources were distributed on pure capitation and 50% on age-adjusted capitation; finally, Territorial Services were financed on pure capitation for General Medicine and Other Territorial Services, on age-adjusted capitation for outpatient services and on an imposed capping spending for pharmaceutical assistance[4] (see Table 1).

TABLE 1

According to a report prepared by the "Agenzia nazionale per i Servizi sanitari regionali" (National Agency for Regional Health Services) commissioned by the "Conferenza delle Regioni e delle Province

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the responsibility of defining the standard levels of social services and assigned the Regions the responsibility of organising the services.

[3] The percentage is established in order to increase the weight of Prevention and Territorial Services and to reduce the weight of the Hospital.

[4] Ministry of Health, *Riparto disponibilità finanziarie per il servizio sanitario nazionale nell'anno 2012. Richiesta di intesa Conferenza Stato-Regioni*, 9 November 2011, available at http://www.sanita.ilsole24ore.com/Sanita/Archivio/Normativa%20e%20varie/RIPARTO%202012c.pdf?cmd=art&codid=26.0.3846990333.

Autonome" (Conference of the Regions and Autonomous Provinces) [11], in 2010 the apportionment was implemented at a 58.9% level on the pure capitation and at a 41.1% level on the age-adjusted capitation; this Report highlights a substantial difference between the apportionment based on the pure capitation and the actual mixed capitation when referred only to the Liguria Region (positive) and the Campania Region (negative), which record the highest and the lowest per capita quota having, respectively, the oldest and the youngest population in the Country.

FIGURE 1

The cited Report concludes the following in relation to these considerations: "it appears that the difficulties experienced to define the adjustment parameters resulted in their abandonment, thereby worsening a drift of the system towards the pure capitation that is undoubtedly one of the easier solutions, but also one of the less fair solutions, above all in a situation like the Italian scenario with Regions which are very different from each other in terms of population, in socio-economic-cultural terms and in epidemiological terms"[5].

This consideration represents the introduction to a study aimed at assessing the applicability of alternative criteria compared to the criterion that has just been described and is extremely interesting from the Author's point of view, since it highlights how the problem of the criteria to apportion the financial resources for health services among the Regions in Italy is still an open issue, in search of solutions, which at the same time pursue balance and equity at a regional and national level [12].

This process, initiated in 1992 and still currently evolving, represents the framework in which the issue of patients mobility emerges; as we will see, it needs to be addressed with extreme urgency, since it has the effect of exacerbating the differences highlighted at regional level [13].

[5] Agenas, *Riflessione sui criteri da utilizzare per il riparto del fabbisogno sanitario*, 2010.

2. Materials and Methods: Patients Mobility in the Italian Experience

The phenomenon of patients mobility emerged in the '90s with the regionalisation of the healthcare system. Indeed, as has already been pointed out, the 1992 reform assigned the Regions the responsibility for the healthcare of the citizens resident in the territory, as well as compliance with the limits of the resources which the central government assigned to the Regions concerned.

In order to assure consistent treatment throughout Italy, Italian citizens are acknowledged the right to have access to hospital services throughout the Country, while the respective expense is assigned to the Regions of origin.

In 2003 the Conference of Regions and Autonomous Provinces defined a national Consolidated Tariff System (Tariffario Unico – TUC) for healthcare services in order to settle the financial relationships among the Regions; the Tariff System aimed at defining a single national tariff for every hospitalisation outside the Region, classified in accordance with the Diagnosis Related Groups (DRGs) system [14,15,16][6].

These tariffs represent the basis to determine the amount of additional resources to be assigned to the Regions which attract patients and to charge the Regions from which the patients migrate; in fact, patients mobility is financed at a central level by means of financial compensation among the Regions, when the annual financing to be allocated to healthcare is apportioned.

A national level compensation instead of a bilateral adjustment among the Regions was found necessary, since the phenomenon of patients mobility in Italy highlights a strong imbalance among the Regions, and in particular, between North and South[7]. One need only consider that the

[6] Hospitalisation is classified in accordance with the United States DRGs system, both at a national and regional level.

[7] It is important to clarify in this regard that patients mobility among non-adjoining Regions in Italy reaches 40% of the total and is not related specifically to highly specialised treatment. Refer to O. Checconi, "*Il quadro italiano della mobilità regionale*", Presentation at the Conference "Viaggiare

Lombardy Region reported the highest positive balance for patients mobility in 2009 (more than 400 million Euros) and the Campania Region reported the lowest negative balance (-303 million Euros). A gap between two Regions that symbolises Italian dualism and that appears substantially consolidated, considering the data to finance the patients mobility scheduled for 2012. Moreover, the South debt situation appears to be confirmed over time, with the Campania, Puglia and Sicily Regions which experience a deterioration of their negative position (see Tables 2 and 3).

TABLE 2
TABLE 3

Therefore, the patients mobility deficit appears to be structural for the Regions in South Italy, representing an expression of the broader difficulties which these Regions are experiencing to address the accountability process. Indeed, the cost of patients mobility represents a variable component in addition to the fixed costs which the Regions are required to sustain in order to maintain their service offer system, thereby moving in the direction of worsening the situation of the Regions – the Regions in South Italy – which are already structurally in deficit (see Table 4).

TABLE 4

per la Salute. La mobilità sanitaria in Italia", Agenas, Rome, 3-4 May 2011, available at the following Internet website:
http://www.agenas.it/Viaggiare%20per%20la%20salute.html.

3. Discussion and Conclusions

The considerations highlighted clearly show that the phenomenon of patients mobility represents one of the most urgent priorities of the Italian Healthcare Service.

The Government and the Regions included the agreements concerning patients mobility among the strategic sectors in the Agreement signed in 2009 referred to the 2010-2012 three year period (2010-2012 *Patto per la Salute* - Health Agreement), in order to qualify the regional health systems and to ensure that the population's needs are satisfied more effectively and at the same time achieve greater control over expenditure, inviting the adjoining Regions to enter into agreements to discipline patients mobility. The emphasis placed on bordering Regions appears to be in line with the initial experience that the European Union Member States have already gained during the '90s, when the cross-border patients mobility among countries such as Germany, Holland, France and Belgium acted as the driving force for initial European co-operation among the healthcare systems of these countries to then impose the problem for a broader European political debate [17,18,19,20].

Disciplining patients mobility as regards the Italian outlook represents one of the most important internal challenges for the future economic and social sustainability of the entire healthcare system. This aspect concerns the demand perspective, since disciplining patients mobility favours the guarantee of having access to appropriate treatment for all Italian citizens, and in terms of the offer, since it should contribute to creating a balanced offer system throughout the Country.

These considerations do not refer so much to cross-border patients mobility that should be included among the ordinary management of inter-regional relations, but rather to the flows from the South towards the North, which, as has been seen, represent a substantially extraordinary scenario in Italy.

This aspect cannot be neglected, especially when one considers the debate that has concerned Italy for many years regarding the suitability of introducing a system of fiscal federalism to the healthcare system, in the wake of regionalisation.

The first project in this direction dates back to 2000 when the abolition of the National Health Fund, financed by general taxation, and its substitution with the Regional Health Funds, financed by regional taxation, was envisaged with the approval of Legislative Decree No. 59/2000. The solidarity prospect should have been pursued through an *ad hoc* Fund (Fondo Perequativo) financed by the Regions with a surplus in favour of the Regions with a deficit. This Decree was never fully implemented and the Regions still receive their financing based on capitation and not in relation to their ability to produce wealth, as a system of fiscal federalism would impose.

The debate concerning the implementation of a fiscal federal system starting from the health service, conceived as an institutional laboratory, is however still open in Italy[8] and the initiatives launched by the Regions, following the logic of the cited "Patto per la Salute" (Health Agreement) are often defined by invoking the direction of a federalism based on solidarity.

These regional initiatives are currently in the start-up phase and are referable to two types of bilateral agreements:

- agreements among Regions which essentially envisage monitoring the cross-border flows and sharing the respective information;
- agreements among Regions which envisage the cooperation among facilities belonging to various non-adjoining Regions.

[8] The most recent initiative in this framework was introduced by Legislative Decree no. 68/2011, which provides for the application, starting from 2013, of the costs incurred by the most virtuous Regions (defined standard costs) as reference values to finance Regions for health services provided. For a critical analysis of this method see E. Caruso and N. Dirindin, *Costi e fabbisogni standard nel settore sanitario: le ambiguità del decreto legislativo n. 68 del 2011*, Working Paper no. 100, Dept. of Economics, Finance and Statistics, University of Perugia, December 2011, available at http://www.ec.unipg.it/DEFS/uploads/qd_100web.pdf.

With reference to the first type, the initial agreements which follow the *Patto per la Salute* (Health Agreement) concern the agreements entered into between Liguria and Tuscany and between Tuscany and Emilia Romagna, both for a duration of three years.

The agreement between Liguria and Tuscany was entered into in July 2011 and envisages the implementation of a system to monitor the hospital and outpatient services, the mutual flows of patients mobility and to promote actions for the direct and mutual audit and control in order to favour the suitability of the services provided. The aim is to assess the real needs of the regional population, giving priority to the bordering areas and also establishing cut-off points for the services and monitoring possible patients mobility phenomena not associated with real health needs. In particular, in the case of the Liguria Region that reports a growing exodus of its citizens, monitoring the patients mobility, first of all, aims to govern this exodus. In the longer term, the agreement aims to assess the opportunities associated with implementing an integrated system of services and a system of information and co-operation among the health facilities which have common specialities. In particular, this aspect is highlighted by the specific expectation of the involvement of two facilities of excellence in Italy in the paediatric field, the Gaslini Hospital of Genoa and the Meyer Hospital of Florence.

The second agreement signed at the end of December 2011 concerns the agreement entered into between Tuscany and Emilia Romagna. The first objective again concerns information, by establishing a system to monitor hospital patients mobility (concerning both ordinary hospitalisation and day hospital arrangements) and outpatients mobility. The monitoring aims to impact the offer systems in a longer term logic, through a gradual standardisation of the quality of both hospital and specialised assistance and to eliminate any tariff differences.

As already highlighted, the agreements among the Regions also concern cooperation among individual facilities to provide specialised

services. This applies to the agreement entered into between Emilia Romagna and Sicily that has a duration of nine years, to create an orthopaedic centre with 84 beds in Sicily, based on the collaboration between the "Istituto Ortopedico Rizzoli" (Ior) (Rizzoli Orthopaedic Institute) an excellence facility of Bologna and Villa Santa Teresa di Bagheria (Palermo), a facility confiscated from the mafia and that the Sicily Region undertakes to requalify in order to assure the standards of service provided by the Ior starting from 1st February 2012. The aim is to reduce the negative hospital patients mobility from Sicily, by requalifying the regional offer and importing the personnel and expertise of an Italian excellence centre.

These arrangements concern bilateral initiatives in the start-up phase, which require time to be accomplished and to produce results; they demonstrate how some Regions are working in the direction of knowing and governing the phenomenon, in relation to an emergency situation that emerged as a result of the accountability process ascribed to the Regions. It will be important to see which new initiatives will be associated with the initiatives already in progress, involving *in primis* the Regions of South Italy, according to a prospective that needs to assume, given the size of the phenomenon, a national political-institutional perspective, in order to establish a system that is financially sustainable and able to assure access to appropriate treatments by all Italian citizens.

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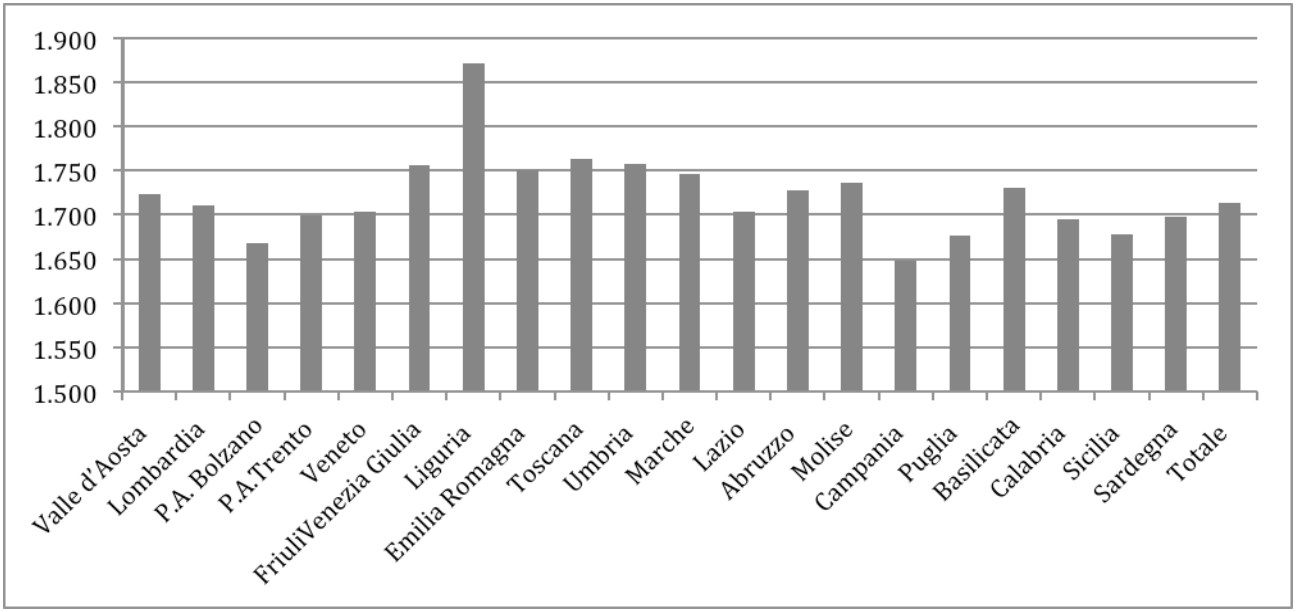
Figures and Tables

Figure 1 – 2010 Regional Quota



Source: Data from "Patto per la salute 2010-2012" (2010-2012 Health Agreement), Annexed *Riparto delle risorse finanziarie per la sanità dopo l'accordo delle Regioni, 2010*.

Table 1 - Patient care assistance levels: % weight and apportionment criteria to the Regions, 2010

	%	2010 Distribution criteria
Prevention	5%	Pure capitation
Territory	51%	
General Medicine		Pure capitation
Pharmaceutical assistance		Capping imposed on total requirement
Outpatient Services		Age-adjusted capitation
Other territorial services		Pure capitation
Hospital	44%	Pure capitation (50% of the amount)
		Age-adjusted capitation (50% of the amount)

Source: Data from Ministry of Health, *Riparto disponibilità finanziarie per il servizio sanitario nazionale nell'anno 2012. Richiesta di intesa Conferenza Stato-Regioni*, 9 November 2011, available at http://www.sanita.ilsole24ore.com/Sanita/Archivio/Normativa%20e%20varie/RIPARTO%202012c.pdf?cmd=art&codid=26.0.3846990333

Table 2 – Extra-regional Patients Mobility 2007-2009 (values expressed in Euro/million)

	2007	2008	2009
PIEDMONT	-3,399	-3,056	1,758
V. AOSTA	-16,387	-14,296	-16,182
LOMBARDY	441,008	445,735	437,601
AP BOLZANO	7,589	5,616	4,194
AP TRENTO	-16,993	-14,824	-15,773
VENETO	99,867	97,081	97,996
FRIULI	15,361	20,569	24,409
LIGURIA	-17,745	-20,136	-26,377
E. ROMAGNA	327,467	337,507	355,194
TUSCANY	106,589	102,274	115,054
UMBRIA	15,328	15,316	11,374
MARCHE	-43,212	-38,189	-31,722
LAZIO	44,548	44,919	65,311
ABRUZZO	-3,732	-29,640	-62,221
MOLISE	21,845	28,514	32,673
CAMPANIA	-280,472	-289,258	-303,507
PUGLIA	-174,977	-159,771	-169,265
BASILICATA	-39,079	-39,673	-35,649
CALABRIA	-223,069	-227,723	-223,810
SICILY	-198,697	-198,884	-205,720
SARDINIA	-61,841	-62,082	-55,340

Source: Ministry of Finance, *Relazione generale sulla situazione economica del Paese, 2010*, available at http://www.dt.tesoro.it/it/analisi_programmazione_economico_finanziaria/documenti_programmatici/relazione_generale_situazione_economica_paese.html.

Table 3 – Financing Proposed by the Central Government for Mobility 2012 (values expressed in Euro/million)

	2012
PIEDMONT	7,479
V. AOSTA	-16,051
LOMBARDY	441,836
AP BOLZANO	1,769.059
AP TRENTO	-15,775
VENETO	95,716
FRIULI	32,384
LIGURIA	-40,815
E. ROMAGNA	384,058
TUSCANY	123,437
UMBRIA	10,129
MARCHE	-20,264
LAZIO	-53,798
ABRUZZO	-125,595
MOLISE	38,221
CAMPANIA	-337,566
PUGLIA	-180,532
BASILICATA	-33,931
CALABRIA	-238,403
SICILY	-212,648
SARDINIA	-52,052
BAMBIN GESU'	157,854
ACISMOM	34,549

Source: Ministry of Health, *Riparto disponibilità finanziarie per il servizio sanitario nazionale nell'anno 2012. Richiesta di intesa Conferenza Stato-Regioni*, 9 November 2011, available at http://www.sanita.ilsole24ore.com/Sanita/Archivio/Normativa%20e%20varie/RIPARTO%202012c.pdf?cmd=art&codid=26.0.3846990333.

Table 4 – Financial year result per Region (in Euro/million and per capita)

	2007		2008		2009		2010	
	Financial year result (Euro/million)	per capita Euro	Financial year result (Euro/million)	per capita Euro	Financial year result (Euro/million)	per capita Euro	Financial year result (Euro/million)	per capita Euro
PIEDMONT	30,690	7	5,454	1	16,731	4	8,844	2
V. AOSTA	-13,527	-108	-12,723	-101	-0,982	-8	-6,918	-54
LOMBARDY	9,810	1	4,131	0	1,879	0	10,581	1
AP BOLZANO	22,403	46	15,293	31	37,177	74	1,953	4
AP TRENTO	-8,478	-17	-10,237	-20	-12,094	-23	-10,808	-21
VENETO	75,417	16	67,616	14	-27,145	-6	-72,666	-15
FRIULI	39,476	32	21,784	18	16,673	14	8,631	7
LIGURIA	-141,810	-88	-110,117	-68	-105,640	-65	-88,579	-55
E. ROMAGNA	25,926	6	26,501	6	22,437	5	26,454	6
TUSCANY	42,244	12	-3,360	-1	-6,882	-2	14,224	4
UMBRIA	6,886	8	8,523	10	4,760	5	10,424	12
MARCHE	15,022	10	36,806	24	16,554	11	27,591	18
LAZIO	-1.634,947	-296	-1.664,515	-298	-1.395,993	-247	-1.043,830	-184

(continued on next page)

ABRUZZO	-151,467	-115	-123,498	-93	-94,536	-71	-19,109	-14
MOLISE	-66,630	-208	-70,438	-220	-63,648	-199	-53,458	-167
CAMPANIA	-863,694	-149	-814,758	-140	-788,883	-136	-495,786	-85
PUGLIA	-312,846	-77	-358,167	-88	-302,474	-74	-335,378	-82
BASILICATA	-17,588	-30	-29,150	-49	-21,040	-36	-35,325	-60
CALABRIA	-169,838	-85	-65,438	-33	-118,794	-59	18,262	9
SICILY	-573,879	-114	-261,591	-52	-200,000	-40	-61,965	-12
SARDINIA	-22,483	-14	-130,788	-78	-229,744	-137	-228,720	-137
TOTAL	-3.709,313	-62	-3.468,674	-58	-3.251,643	-54	-2.325,578	-39

Source: Ministry of Finance, *Relazione generale sulla situazione economica de Paese, 2010*, available at http://www.dt.tesoro.it/it/analisi_programmazione_economico_finanziaria/documenti_programmatici/relazione_generale_situazione_economica_paese.html.
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