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Comparing Hybrid Welfare Systems: The Differentiation of Health and Social Care Policies at the Regional Level in Italy

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Abstract

Welfare-state research has traditionally been centered on national states, while regional differences have received less attention. This article analyzes local welfare policies in 20 Italian regions using data in 2005 and 2010. We use factor and cluster analysis and typological classifications on institutional data concerning two areas of intervention, social care and healthcare policies. The results show that the Italian welfare system is a hybrid and is differentiated both across regions and policies. By using a regional perspective, we highlight the need to consider the subnational level as central to the construction of descriptive welfare typology.

Keywords: welfare typologies, intra-country comparison, hybrid welfare system.

1. Introduction

The second half of the last century saw the consolidation of interventions and policies striving to provide the solutions to risks linked to economic growth and to economic crisis (Andreotti, Mingione, 2014; Van Kersbergen,

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Vis, Hemerijck, 2014). Starting from the perspective of Western countries, a number of studies attempted to construct a classification of the different forms of welfare system. The emphasis had been placed on the specificity assumed by the individual national situations, thus demonstrating the diversity between them. From this perspective, Western countries seem to be characterized more by their differences than by their common factors. The European debate (by Titmuss [1976] and Esping-Andersen [1990]) was thrown into crisis by three additional concepts.

The first was globalization. The analyses of the welfare models had only addressed the countries of the West and had focused on the role played by the state in the management of welfare policies. The use of a global perspective demonstrated that a classification centered on the state's role is reductive and that the response to social risks is always the combined result of the different dynamics of the market, the state, and the community. The second concept was the opposite: 'localization' or territorial differentiation. In all European countries, both the consolidation and the crises of the welfare systems are accompanied by dynamics of localization, as well as by attempts to re-centralize the governing processes and the management of welfare policies. The third perspective could be defined as 'specification'. Research into the welfare systems of different countries has shown how it is excessively simplistic to speak about national welfare systems. In some countries (e.g., Italy and Great Britain), the healthcare policies are of a universalistic type and are still strongly anchored to the central role of the state; while in the same countries, policies that support employment or pensions have different characteristics. In other words, the systems that protect against social risks take on different forms in relation to the type of risks faced, and so countries can end up being very similar with respect to some policies (the greatest homogeneity regards healthcare policies) and strongly differentiated with respect to others (the greatest homogeneity regards employment policies). The effect that these dynamics have on welfare systems is twofold. The first two aspects raise attention to the local and regional dimension, in particular to the comparability of different systems; the third raises the question whether, in addition to the territorial dimension, we should not consider the presence of differentiation due to the characteristics of the different policies that define the welfare systems.

In the analysis on the territorialization of social policies, Kazepov (2009) argues that starting from the Eighties of the Twentieth century in Europe increases the relevance of the local dimension of social policies, but that this dimension is recognized and institutionalized only in the second half of the Nineties. According to the Author this process involved, with different speeds and diffusion, all European countries. Moreover, the literature that analyzed

the restructuring processes that have been active in European countries at the end of the last century shows that the changes are the result of the dynamics between different actors in various local contexts and the characteristics of the socio-economic context in which they relate to each other.

This paper contributes to the debate in comparative policy analysis by analyzing the characteristics of two different policies, healthcare and social care, in Italy and by highlighting how these policies follow different logics according to the local context, actors, and governance processes. From this point of view, the study of the Italian case is particularly interesting.

Moving from this case, we confirm the results of previous research showing that we can no longer speak of a single national welfare system but of different regional systems. Furthermore, we aim to understand if the regional welfare systems are consistent within the individual regions. We analyzed the internal differentiation of local welfare systems in order to understand whether the term *Mediterranean welfare*, used for the classification of the Italian system, represents a sufficiently homogeneous label, or if the differences are such as to indicate that the fragmented nature of the Italian system includes systematic differences related to territorial policies.

The paper begins with a critical review of the literature on welfare classification and the identification of several problems both at the theoretical and empirical level, suggesting that a review of terminology and a refocusing on local policies are needed. The following sections, methods, and results present the regional classifications according to the two policies analyzed. The concluding discussion highlights the difficulty in classifying the different policies provided by each regional context as part of a single homogeneous welfare regime and proposes the use of the term *hybrid* with regard to the differentiation of logic that in the same region leads to the different policies.

2. Theoretical framework: Debate on classification

The last 20 years have changed the characteristics of the context that defines social risks (Kemshall, 2002; Bonoli, 2007; Harsløf, Ulmestig, 2013), the knowledge and technology to provide welfare services, the economic and social resources to cope with social risks, and the dynamics and roles that institutions play in the care process. These changes highlight some critical elements in the Esping-Andersen classification (1990, 1999, 2002). The recent debate has highlighted some problems related both to the theoretical and empirical framework.

On the theoretical level, critical attention should be placed on

- the broad nature of the concept of welfare system. The term *welfare*

includes all policies that contribute to the well-being of a population. Many studies have used this classification to compare very different policies: health, pension, social security, welfare, or employment and housing policies. But their development was influenced by different systems and logics (Arts, Gelissen, 2002; Jensen, 2008).

- the term *regime*. Regime is used to represent all the social, political, and economic agreements that develop a particular welfare system, which supports a model of stratification and thus allows its stability (Taylor-Gooby, 1996). This approach underestimates the importance of local dynamics that oversee the development of individual policies. Consider, for example, that health systems in different countries, characterized by a corporatist or liberal welfare, have adopted universalist logic typical of social democratic regimes (Bertin, Robertson, 2013).

On the empirical level, research has demonstrated the difficulty of continuing to analyze welfare systems in light of the classification used by Esping-Andersen (Powell, Barrientos, 2004; Hudson, Kuhner, 2009). The results of these recent studies do not confirm the typology constructed when observing the phase during which welfare was expanding; thus, the processes of diversification require that a more sensitive classification be constructed. The evidence indicates that the four welfare regimes proposed by Esping-Andersen should be broken down and reviewed. This process of diversification characterizes all welfare regimes.

There are two elements that we emphasize in the present work:

- The importance of the local dimension. The localization process has led to a strong differentiation within the countries that make it difficult to use the term *welfare regime* when referring to the territories. Analyzing the individual countries, the most recent studies (Scruggs, Allan, 2009; Arts, 2013; Scruggs, Allan, 2009; Vrooman, 2013) show that heterogeneity exists even within the individual welfare regimes and that these highlight the presence of diversification processes that call for a review of the welfare system classifications. Moreover, Hjerm and Schnabel (2012) analyzed the results of a number of studies and showed that very little homogeneity exists within the singular national welfare regimes (Craw, 2010; Kammer, Niehues, Peichl, 2012; Bertin, Robertson, 2013; Jensen, Lolle, 2013; Beatty, Fothergill, 2014).
- The hybrid character of the welfare system. The different policies that set up the welfare state are developed according to logics not always consistent with the regimes of Esping-Andersen: labor policies (Powell, Barrientos, 2004; Burau, Blank, 2006; Hudson, Kuhner, 2009; Pfeifer, 2012), health policies (Giarelli, 2006; Sang-Yi, Chang-Bae Chun, Yong-Gab, Nam Ky, 2008; Rothgang, Schmid, Cacace, Götze 2010), family

policies (Blum, Formánková, Dobrotić, 2014; Glassmann, 2014), gender policies (Gálvez-Muñoz, Rodríguez-Modroño, Domínguez-Serrano, 2011). In this case, the term welfare is too large for a comparative classification. The protection systems assume hybrid characteristics and consequently lose the distinctive features at the base of the traditional classifications.

The problem of differentiation between single policies is not new to the comparative analysis. A wide literature, largely on family policy, has shown that, when zooming into one policy area, different country clusters may emerge, opposite to looking at the welfare system as a whole. A substantial number of studies (Leitner, 2003; Bettio, Plantega, 2004; Bambra, 2007; Jensen, 2008; Boje, Ejrnæs, 2012; Ruby, Chau, Sam, 2013) show how the different classifications on family policies differ, also significantly, from the Esping-Andersen's one (1990, 1999). Looking only at family policies, the countries become part of different clusters than those which belong if classified as welfare systems as a whole. The analysis shows that some countries tend to remain together, while others are grouped into different clusters. Our work makes a zooming into two social policies, social and health care, and then merges these contiguous policies to see whether the developments in the twenty Italian regions has followed homogeneous paths.

Starting from these two policy areas, the study of the Italian case is interesting. In general, the development of social care policies has Bismarkian roots, while the healthcare reform of the 1970s has universalistic features. The establishment of the National Health System (1978) constituted a turning point for Italian health policies. This change has been characterized by a gradual decentralization of responsibilities from the state to the local governments (the Regions) and by the redefinition of the state's role of coordination to ensure uniform protection of citizens' rights throughout the country. The social care policies were reformed in 2000, after welfare systems had finished their flourishing phase. This reform was soon nullified by the constitutional reform of the following year that allocated responsibilities regarding social care policies to the regions and local authorities; here the state's role was marginal (merely economic regulation).

The different dynamics of the reform processes have increased the heterogeneity between individual policies. In order to theorise this intra-country variation it would be useful to put forward some hypotheses around some key factors. The research on the reorganization processes of welfare system revealed the complex and multifactorial nature of change. According to Hemerick (2012), has never dealt with the implementation of a clear reforms' plan, but with the combined effect of the dynamics among the social actors and the specific nature of the welfare policies in each individual

territory. The literature suggests three analytical perspectives (Jensen, 2008), namely: the 'ideological' perspective, that relates the change to the comparison between the value systems and ideologies of welfare actors; the 'neo-institutional', which stresses the institutional capacity to consolidate roles and purposes of systems; the 'neo-functionalist', which interprets the change in welfare systems as the ability to adapt to the evolving dynamics of socio-economic systems.

The fragmentation of the paths that have built the welfare system cannot be regarded as a set of policies constructed from homogeneous values and logic but requires a breakdown of the systems in relation to the territorial dimension and the characteristics of individual policies.

The matter of local or regional welfare models is well debated in the Italian literature; many scholars (Pavolini, [2011], Bertin, [2012], Fargion, Gualmini, [2012], Kazepov, Barberis, [2013]) have underlined the importance of analyzing the welfare differences between the Italian regions. By analyzing the welfare systems as a whole, these studies emphasize the strong differentiation between regions (Caltabiano, 2004; Maretti, 2008; Chiatti, Barbabella, Lamura, Gori, 2010; Madama, 2010; Carradore, 2014). On these aspects, the studies basically agree; however, the classification of the cluster presents some elements of homogeneity and others of differentiation. All studies show a north-south gradient in which the regions of the south have the most critical and worst welfare systems; but clusters are partially different in relation to the emphasis placed on each policy and consequently to the variables considered. The research in the Italian context report that the differences are due mainly to the wealth of the territories and the degree of social cohesion. In short, we can assume that the differentiating factors can be attributed to: the level of economic development of individual territories (the richest contexts also have a higher level of social protection); the intensity of the solidarity networks, the social capital and the degree of social cohesion; the degree of legitimacy of public action; the local autonomy.

In this work, we show that the Italian welfare system cannot be regarded as a national homogeneous system. We hypothesize that the long process of development has produced an internal differentiation:

a. vertical, with reference to the relation between center and periphery and the territorial dimension (local welfare);

b. horizontal, with reference to the characteristics of individual policies underlying the concept of welfare (hybrid welfare).

With the term *hybrid* as the character of welfare policies, we refer to the presence in the same territory of the typical elements of different welfare regimes. In this logic, we talk about hybrid systems when, for example, some policies (e.g., healthcare) have similar characteristics to those of the social-

democratic regime, while others (e.g., social care) have characteristics typical of the liberal or corporative regimes. In addition, by separately analyzing the individual clusters within each policy, different shades of hybridity emerge in relation to the combination of actors, logics, and governance systems.

Our hypothesis considers that the local dimension defines the cultures, the actors and their roles, the action systems, and the relationships that contribute (and contributed) to defining welfare policy courses. The concept of regime should therefore be attributed to the local system that influences each policy. Our aim is to understand whether local differences are so strong as to make predominant the regional dimension in the comparison or if, on the contrary, are irrelevant and do not justify the change of the level of analysis.

3. Data and Methods

Two studies have been analyzed, one relating to regional social care systems (a) and the other to regional health systems (b). The data used came from the database of the Italian National Institute of Statistics (Istat), which carries out national surveys into many different topics (health, education and training, family, welfare, social security).

a) Differentiation of social care system: The case of Italy (Bertin, Carradore, 2015).

The data cover the period spanning 2005 to 2010, and the units of analysis are the 20 regions of Italy. The Authors first identified an extensive list of variables useful for describing the two dimensions that best characterize the social care system types: bodies providing the services and service diffusion. A secondary data analysis was carried out with an explanatory factor analysis in order to reduce the variables identified into a small number of independent factors. They identify two factors for each dimension (those with the highest eigenvalue) and labeled them according to the implication of their underlying variables: 'mixed structure' and 'mixed toward corporatism' in the first dimension; 'diffusion of traditional social services' and 'diffusion of innovative social services' in the second (see the Appendix, Table A, for the indicators used by Authors in the analysis of the Italian social care system classification).

The first dimension describes the combination of subjects involved in social care provision. The factor 'mixed structure' stands for the public, private, and third-sector organizations and the family and indicates their collaboration in the production of social services. The factor 'mixed toward corporatism' outlines the cooperative dimension through a set of variables

that describe services produced by third-sector organizations or cooperatives. The second dimension describes the diffusion of traditional or innovative social services. Traditional services are, for example, the number of old-age pensioners, the number of older guests in public residential care accommodation, and the percentage of older women receiving screening services. Innovative services describes the diffusion of innovative services across Italy, such as integrated social care services provided by different actors (public and private) and the use of private crèches.

Thus with hierarchical cluster analysis, starting from the four factors, similarities and differences among the various regions were identified and grouped together. Cluster analysis was used because it is an explorative method appropriate for investigating structure typologies that is based on the use of empirical data (see the Appendix, Table B, to know the score per region of k-Means factor analysis).

b) Regional healthcare systems in Italian regions (Bertin, 2013).

Unlike social policies, health policies are ruled by a national health system managed through the coordinate action of the state and regions. The presence of a national health system has certainly played a role in standardization with respect to some elements of service provision, but the role of public and private actors in service delivery is different due to the action of single regions.

Consistently with many other comparative studies, the Author decided to classify the regional health systems according to three dimensions:

- funding system: The system was considered 'public' when public resources exceeded 75% of the total resources used by the healthcare system; 'mixed' when public resources were between 75 and 50% of the total resources; 'private' when public resources remained below the threshold of 50% of the total resources;

- service provision (inpatient and outpatient) (Sang-Yi, Chang-Bae Chun, Yong-Gab, Nam Kyo 2008): This analyzed hospital services (percentage of beds of total public beds) and local services (general practitioners, specialists, and laboratory examinations). The system was considered 'public' when the offer was managed by public bodies for at least 75% of hospital services and at least 50% of local services; 'mixed' when at least 75% of hospital services was managed by the public but below the threshold of 50% at the local level; 'private' when the public hospital services were below the threshold of 75% and territorial public under the threshold of 50%;

- governance approach (Reibling, 2010): No region is characterized by a governance system centered exclusively on market logic, but all regions have mixed forms with typical mechanisms of the market (cost-sharing function) in co-existence with others typical of public programming (gate-keeping function). Concerning the gatekeeping function, the Italian case is

homogeneous. All citizens enrolled in the health service are entitled to choose a general practitioner (or pediatrician) in the municipality of residence, and the general practitioner (or pediatrician) is paid per patient. Thus, the importance assigned to the dynamics of the market or those of public programming defines the type of governance approach. The analysis classified the governance as 'hybrid' when it had established mechanisms both for the gatekeeping function (average of patients followed by a general practitioner or a pediatrician) and the cost-sharing function (share of ticket revenues on total revenues and share of intramural revenues on total revenues). Governance was considered 'hybrid with public prevalence' when there was a prevalence of the gatekeeping function, despite the weaker dynamics of the cost-sharing function. Finally, governance was considered 'public-hierarchical' when the gatekeeping function was strong and the cost-sharing function was weak.

The regions were classified relatively to each of the three dimensions and then brought back to an overall typology on the basis of the amount of attributes. Bertin found eight types when considering the logical differences between the individual regional systems. The decision to use a typological classification system was made because attempts to use models based on cluster analysis were useless in the presence of substantial homogeneity of some variables relating to service provision and because the literature presented interesting classification works based on typological approaches (Sang-Yi, Chang-Bae Chun, Yong-Gab, Nam Kyo 2008).

4. Results

Here, we present the classification results of social care and health system of 20 Italian regions. They confirm the hypothesis of dual internal differentiation, vertical and horizontal.

The empirical analysis proceeds in two steps. First, we separately analyze the social care and health system classifications. Finally, we cross the typologies to see if they were consistent.

4.1 Regional social care systems

Bertin and Carradore (2015) focused their attention on the two dimensions that best characterize the social care system types: bodies providing the services and service diffusion. If we analyze the distribution of the regions on the axes of ownership (bodies providing the services), we note that even in terms of this dimension, the difficulty of representing the regional welfare systems as belonging to the same model is clear. The distribution of regions on the axes of the extension of the protection system (service

diffusion) shows a similar situation. Furthermore, looking at the distribution of the main variables of each latent factor, there are significant differences between regions. For example, the analysis of the elderly in nursing homes (65+) shows a clear division of Italy into two parts: the northern regions with high values and the southern regions with significantly lower percentages.

Hierarchical cluster analysis revealed six typical regional welfare regimes (Figure 1):

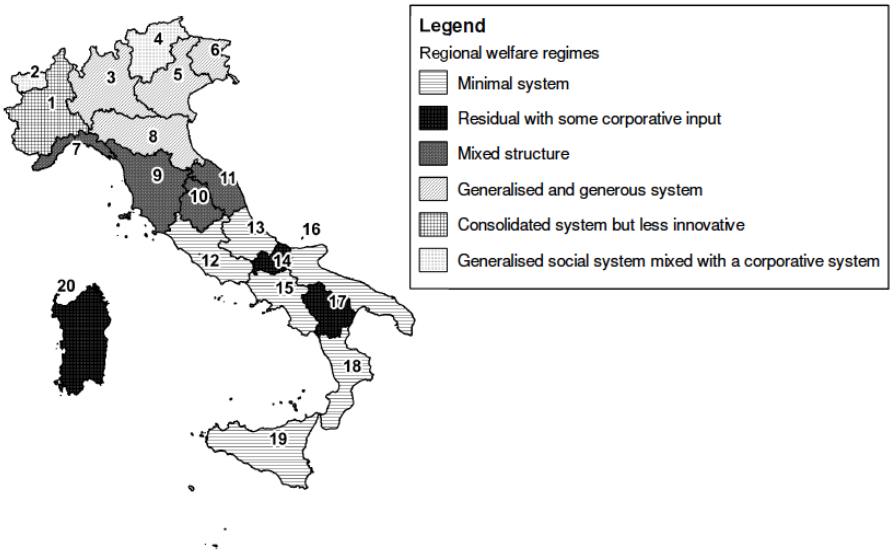
1. Minimal system (Abruzzo [13], Apulia [16], Calabria [18], Campania [15], Lazio [12], Sicily [19]): This regime has difficulty in providing assistance; public and private actors rarely collaborate to provide social care assistance, thus providing few innovative social policies.
2. Residual with some corporative input (Basilicata [17], Molise [14], Sardinia [20]): This model has a limited presence of public services while having a discrete presence of corporative actors providing assistance.
3. Mixed structure (Liguria [7], Marche [11], Tuscany [9], Umbria [10]): This regime presents a discrete but not completely developed integration between public and third-sector actors with a good diffusion of innovative polices.
4. Generalized and generous system (Emilia-Romagna [8], Friuli-Venezia Giulia [6], Lombardy [3], Veneto [5]): With high integration between public, private, and third-sector actors, this regime has widespread innovative social policies and developed services for elderly and young people.
5. Consolidated system but less innovative (Piedmont [1]): This model has a low presence of third-sector subjects, and the collaboration between public and private sector is high with underdeveloped services for the elderly.
6. Generalized social system mixed with a corporative system (Aosta Valley [2], Trentino-Alto Adige/South Tyrol [4]): Regime with high presence of public and corporate actors who provide widespread social assistance; presents high municipal social expenditure but few innovative social policies.

This classification highlights the difficulty in identifying a system unequivocally attributable to a single and homogeneous welfare regime. Each cluster has very different characteristics. The differentiation between the northern and southern regions is confirmed, but the north-south gradient cannot explain all the differences. In the northern regions, the prevailing regime is basically generous and integrated between public and private actors and characterized by innovative policies, while the south has minimal characteristics and a residual nature. Moreover, remarkable differences can be observed even between the northern regions and among those in the south.

The Authors also tried to compare the services offered with social risks in individual territories, but they found no correlation between these two variables. Regions with more social problems and less social cohesion are those where the social care system is weaker (with fewer services and less innovation). The main variables that can be considered to analyze the differentiation are

- the degree of service diffusion managed by the public or by the private profit and nonprofit;
- the coverage against social risks (for how many risks and how much of the population; universalism vs. particularism).

FIGURE 1. Thematic regional map of regional social care regimes.



From: Bertin, Carradore, (2015).

The research highlights the differences between the social care systems of the Italian regions and how these differences do not allow reference to a single national system.

4.2 Regional healthcare systems

The analysis of the indicators used in the study (Bertin, 2013) confirms that it is valid to speak of a national health system with regard to the Italian situation. Taking the thresholds used by Sang-Yi and colleagues (2008), we confirm that the Italian healthcare system belongs to this typology. If,

however, we extend the analysis to regional services, we can see how public provision is definitely under this level. We can also visualize the development of different models that perhaps require a further category made up of situations with public funding linked to general taxation and service provision characterized by a significant presence of private subjects. Thus, analyzing the situations of the individual regions and applying the same classification system, it is easy to note that the situations are different.

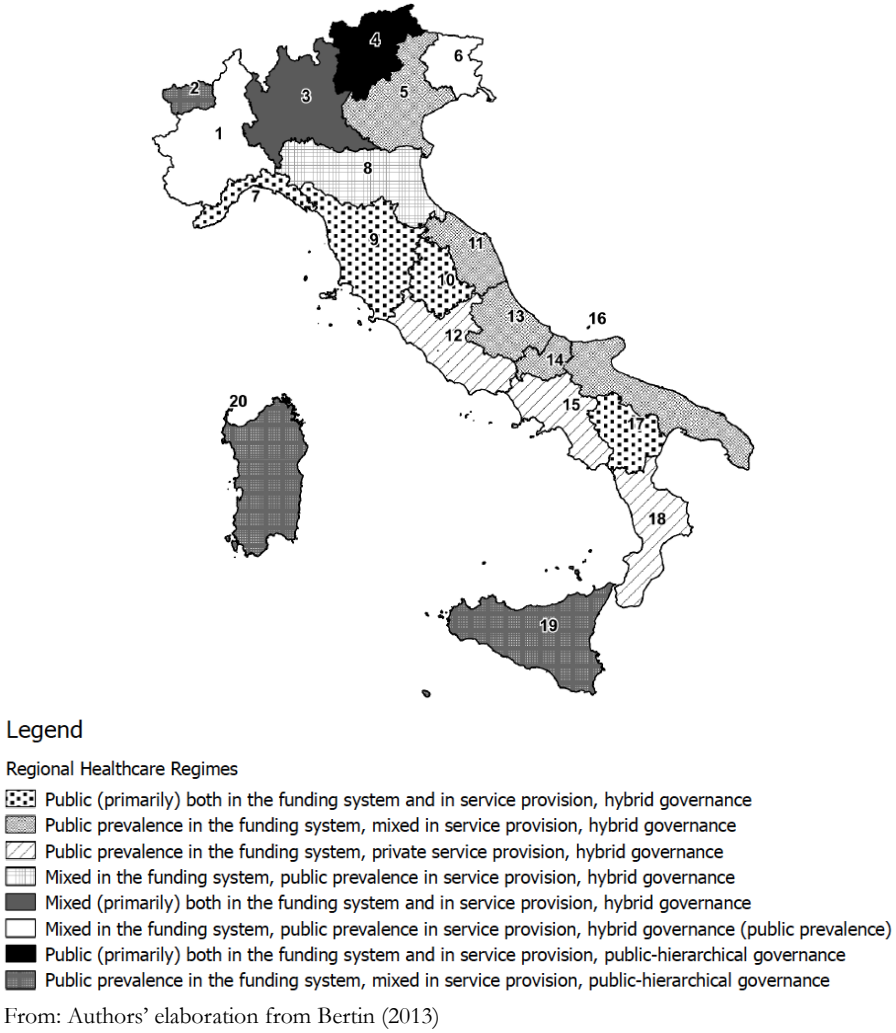
Combining the three dimensions, eight are the types of a regional healthcare system (Figure 2):

1. Public (primarily) both in the funding system and in service provision, hybrid governance: Tuscany (9), Liguria (7), Umbria (10), Basilicata (17);
2. Public prevalence in the funding system, mixed in service provision, hybrid governance: Veneto (5), Marche (11), Abruzzo (13), Molise (14), Apulia (16);
3. Public prevalence in the funding system, private service provision, hybrid governance: Lazio (12), Campania (18), Calabria (15);
4. Mixed in the funding system, public prevalence in service provision, hybrid governance: Emilia-Romagna (8);
5. Mixed (primarily) both in the funding system and in service provision, hybrid governance: Lombardy (3);
6. Mixed in the funding system, public prevalence in service provision, hybrid governance (public prevalence): Friuli-Venezia Giulia (6), Piedmont (1);
7. Public (primarily) both in the funding system and in service provision, public-hierarchical governance: Trentino-Alto Adige/South Tyrol (4);
8. Public prevalence in the funding system, mixed in service provision, public-hierarchical governance: Aosta Valley (2), Sardinia (20), Sicily (19).

This research shows that only in the regions of Trentino, Liguria, Tuscany, Umbria, and Basilicata can we clearly speak of the National Health System typology. The majority of the other regions are characterized by a funding system that is still of a public type, but healthcare services are provided by a mix of actors (public, private for profit, and private nonprofit). In this group we find: Aosta Valley, Veneto, Marche, Abruzzo, Molise, Apulia, Sicily, and Sardinia. On closer inspection, this group does not fall into any of the types used in the literature for the classification of national healthcare systems. The situation of regions like Lazio, Calabria, and Campania is different once again. These are characterized by a quota of public funding above 75% but with a greater presence of private service providers. These elements bring these regions close to the National Health Insurance typology, but in this case public resources are not derived from obligatory insurances but from general taxation. Finally, the presence of two other specific

situations is highlighted. On one hand, the regions Emilia Romagna and Piedmont present a public contribution to funding of less than 75% and a significant public presence in service provision. The reference typology that is closest is that defined here as National Health System. Lombardy, on the other hand, apart from presenting a public funding quota of less than 75%, is also characterized by a system of service provision of a mixed type and by a significant proportion of services being managed by private entities.

FIGURE 2. Thematic regional map of regional healthcare regimes.



From: Authors' elaboration from Bertin (2013)

Between all these factors of differentiation, it is difficult to identify clear and homogeneous patterns; moreover, the north-south gradient is less strong than that of social care policies (e.g., Veneto and Apulia belong to the same cluster, likewise the Aosta Valley and Sicily). The presence of a national health service has produced some elements of homogeneity (with regard to the presence of hospital doctors and general practitioners, to the territorial dimension of the local districts and to the development of activities in day hospitals) and some elements of differentiation in relation to the funding, provision, and governance system.

As for the welfare system, even for the healthcare system, we cannot refer to a single regime: the regions differ (and are further differentiated) in their funding systems, service provision, and governance of policies and services.

4.3 The differentiation of policies: Hybrid welfare

After separately analyzing the welfare and the healthcare system in the Italian regions, we wondered if the differences have occurred consistently in connection with the cultural and political contexts.

Crossing the typology of social care and health systems (Table 1), no correlation is evident between the evolutions of the models.

Consider the two clusters that in social care policies have the best and worst case scenario: the regions belonging to the 'generalized and generous system' and the 'minimal system'. In both cases they follow very different logics in health policies. The regions belonging to the generalized and generous system followed different paths for healthcare policies. None of them has a predominantly public healthcare system, but the regions have different combinations of public and private actors in service provision and a funding system with different uses of private resources. Furthermore, governance, while combining different processes, is characterized by a different role in public planning. Likewise, the regions belonging to the minimal system cluster are characterized by health systems with prevalence of public funding but with a mixed or mainly private service provision and hybrid or hierarchical governance systems; here also we find different combinations.

If we analyze the Trentino-Alto Adige region, we note that the social care system based on cooperation between public and private actors is counterbalanced by a healthcare system firmly anchored to the public. In this sense, we speak of hybridization with reference to different logics that have led to the establishment of regional systems and with reference to the

different logic that governs the functioning of the two policies – logic that is not always consistent with each other.

TABLE 1. A comparison of regional social care and healthcare systems.

REGIONAL SOCIAL CARE SYSTEMS	REGIONAL HEALTHCARE SYSTEMS								
	Public (primarily) both in funding system and in service provision, hybrid governance	Public prevalence in funding system, mixed in service provision, hybrid governance	Public prevalence in funding system, private service provision, hybrid governance	Mixed in funding system, public prevalence in service provision, hybrid governance	Mixed (primarily) both in funding system and in service provision, hybrid governance	Mixed in funding system, public prevalence in service provision, hybrid governance (public prevalence)	Public (primarily) both in funding system and in service provision, public-hierarchical governance	Public prevalence in funding system, mixed in service provision, public-hierarchical governance
Generalized and generous system		Veneto		Emilia-Romagna	Lombardy	Friuli-Venezia Giulia		
Generalized social system mixed with a corporative system							Trentino-Alto Adige/South Tyrol	Aosta Valley
Mixed structure	Liguria Tuscany Umbria	Marche						
Consolidated system but less innovative						Piedmont		
Residual with some corporative input	Basilicata	Molise						Sardinia
Minimal system		Abruzzo Apulia	Calabria Campania Lazio					Sicily

On a closer inspection, hybridity is also present within the individual clusters. Consider the cluster 'Public prevalence in funding system, private service provision, hybrid governance' in health: the presence of a predominantly public funding system is accompanied by a private service provision. In this case, it moves away from both the liberal and corporative model; hybridization refers to the different logics that co-exist within the same policy.

Regarding governance, note that the regions that follow the logic of public governance are (consistently) the same that also have a public

(primarily) service provision (Trentino-Alto Adige) or have public prevalence in the funding system and mixed service provision (Aosta Valley, Sicily, Sardinia). The latter situation has less consistency between service provision and governance process because private actors who provide services have an ancillary role as service providers. This situation can withstand as long as the funding system is public, but with the increased diversification of funding sources (linked to the development of private insurance or the direct purchase of services by citizens), the incomplete overlap between funding system and governance models can be a source of criticality in government processes. The scenario is changing, rendering the differences between the types of reference systems increasingly unclear; new systems with characteristics that are less defined and are more hybrid interpose between the reference ones, bearing characteristics that belong to theoretically different models.

All these elements highlight the impossibility of finding a single classification for the welfare system as a whole. The variables that characterize the health systems of the single regions are different from those that characterize the social care systems in the same regions (as the many cells of Table 1 show). An overall classification would require to accept in a single typology highly differentiated aspects which hardly allow the identification of a key to understand the real characteristics of the systems. The complexity of the systems cannot be oversimplified: the risk is to lose the explanatory power of the variables. This difficulty in the construction of a single classification is the result of the development process of the welfare systems in their horizontal (between policies) and vertical (between regions) diversification. Our research leads us to suggest to develop the classification process of national welfare systems, starting with a preliminary check of the differences' intensity both vertical and horizontal. Where, as in Italy, the differences are marked, it would be preferable to classify regional systems in a differentiated way focusing on the individual welfare policies.

5. Conclusions

The present paper makes two important points: it sets out 1) the *vertical* differentiation of welfare with regard to the regional dimension (health and social care); 2) the *horizontal* differentiation with regard to the characteristics of different policies (hybrid).

Regarding the vertical differentiation, the two studies analyzed have highlighted strong differences between regions. This differentiation has distinct characteristics for the two welfare policies. With regard to social care policies, dissimilarities emerged on the social services diffusion and on the

legal form of the subjects that provide these services. Such differences affirm that the local systems, in relation to social care, differ on the basis of being universalistic or not and on the role that the public actors play in the social protection system. In confirmation of the different degrees of social protection, it should be noted that regions with less service provision are also those that have a higher degree of social criticality. Surely the central role assigned to local authorities has helped to develop this strong vertical differentiation scenario. Even the healthcare system shows a vertical differentiation but also some elements of homogeneity between the regions. Given a similar distribution of some services (e.g. primary care), there are other services highly differentiated and dependent primarily on the legal form of the subjects that manage the services and on the financial contribution required from citizens for access to the services. In this case, the presence of a national health system and coordination between state and regions produced a more complex scenario, hardly traceable to clearly definable patterns.

As regards the horizontal differentiation, the research analyzed show that in the same regions the welfare policies have assumed typical characteristics of different welfare regimes. The different culture that characterized the reform processes, the different distribution of responsibilities between state and regions, and the socioeconomic conditions of each local context are the factors that should be studied to explain the emergence of hybrid local systems.

From a theoretical point of view the process of differentiation appears to be linked to many variables: the strength of the local economy, the density of relational networks and the social capital, the development of local policies, the characteristics of the third sector and the uprise of a managerial culture in public actors. All these factors lead to the hypothesis that the more these variables show significant differences at local level and the more the sub-national areas have decision-making autonomy, the more likely it is that the forms of local welfare are significantly different. So different as to make the analysis focused on the national level unable to represent the features of the welfare system as a whole.

All these elements allow us to reflect on the methodological aspects of comparative research on welfare policies. For the national context we studied, the sub-national dimension is crucial and the definition of the unit of analysis in comparative studies must take into account the articulation of territorial responsibilities and the degree of differentiation of the local contexts. A second important aspect is the opportunity to focus the comparison not on the whole welfare system but at least on some policy areas that can represent the welfare policies (e.g., social and healthcare policies). This is just as important as we are dealing with territorial contexts in which the policy-

reform processes have taken place at different times and by following specific and differentiated patterns – similar to the policies we have studied.

In order to do this it could be useful a preliminary check of the internal consistency for the individual states. In fact, an excessive internal variability leads to the impossibility of a national classification. In this regard the degree of internal differentiation could be introduced as a classification variable (always referred to single policies).

A final observation concerns the perspective for comparative research. A first challenge concerns the definition of the territorial dimension to be compared: the countries have different administrative levels with different degrees of autonomy and responsibility (e.g. regions, cantons, landers). A second challenge is the need to investigate the development of a data collection system at the local level that could lead to the comparison between states and, as consequence, the characteristics of the social indicators used by each territory to monitor its welfare areas. This problem, also present in the comparison between national contexts, assumes greater importance when the analysis concerns the local dimensions for which the international comparison is less consolidated.

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Appendix

TABELLA A - Indicators used in the analysis of the Italian welfare system classification (Bertin, Carradore, 2015: 153)

Dimensions	Variables	Factors
Bodies providing the services	Number of cooperatives with an annual turnover greater than 500,000 euros/total number of cooperatives Families who have received free child care help on at least one occasion during the last 4 weeks from individuals not living in the same household Family average monthly healthcare expenditure (euro) Percentage of beds for the older adults in residential public services Percentage of beds for the older adults in residential non-profit services	Mixed structure
	Number of cooperatives/total resident population Number of public crèches/total number of crèches Percentage of families who have received free help to perform housework on at least one occasion during the last 4 weeks from individuals not living in the same household Number of voluntary associations/total resident population Number of employees and collaborators in cooperatives/number of resident population Number of beds in private hospitals/total number of beds	Mixed towards corporatism
Service diffusion	Number of older guests in the residential care accommodation/population aged ≥65 years Number of older guests in the public residential care accommodation/population aged ≥65 years Municipal social expenditure per capita Percentage of women (aged ≥65) who have had a mammogram in the absence of any disease symptoms or ailments Number of 'old-age' pensioners/total number of people receiving pensions Percentage of municipalities with active services for children (e.g., kindergarten, crèche and additional services, innovative services)/total number of municipalities in the region Number of days of residential and semi-residential care accommodation/1,000 residents (aged ≥65) Number of invalid pensioners/total number of pensioners	Diffusion of traditional social services
	Integrated social care services for older people Number of potential users and percentage of children admitted to public and private crèches	Diffusion of innovative social services

TABELLA B – k-Means cluster analysis, k = 6 (Bertin, Carradore, 2015: 157)

Regions	k-Means cluster analysis	Distances
Piedmont	1	0.000
Aosta Valley	2	0.691
Trentino-Alto Adige/South Tyrol	2	0.691
Liguria	3	0.621
Tuscany	3	0.585
Umbria	3	0.718
Marche	3	0.262
Lazio	4	1.072
Abruzzo	4	0.815
Sicily	4	0.570
Campania	4	0.661
Apulia	4	0.798
Calabria	4	0.749
Lombardy	5	0.744
Emilia-Romagna	5	0.959
Veneto	5	0.620
Friuli-Venezia Giulia	5	0.500
Molise	6	0.296
Basilicata	6	0.734
Sardinia	6	0.608