The Italian National Health Service: universalism, marketization and the fading of territorialization

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Abstract

At the time of its inception, in 1978, prevention and primary care were set as fundamental pillars of the Italian National Health Service (NHS), emphasizing the collective and social dimension of health. These principles were progressively neglected over the following four decades. Marketization, managed competition and managerialization privileged the individualized, highly specialized healthcare services mainly provided in hospitals, to the detriment of local outpatient and primary care services. After 2008-09, austerity policies exacerbated this situation determining under-financing as well as structural and staff shortages, while increasing tensions arose between the central government and Regions in the decentralized NHS. In 2020-21, the pandemic highlighted these critical issues. The need to develop a universal and strong outpatient, primary and community care system became evident in order to ensure the appropriateness and quality of foundational health services. This requires the State to play a more prominent role in the NHS governance.

KEYWORDS: Covid-19; Italian National Health Service; Territorial Health Services; New Public Management

Introduction

This article focuses on the Italian National Health Service (NHS). It investigates problems raised by the Covid-19 health emergency by adopting a historical-sociological perspective, which analyses processes and dynamics of development of the NHS in the medium-long term, from its inception in 1978, when it took the place of the previous social insurance system, to the present. These dynamics comprise a founding phase, characterized by universalism and the adoption of planning as the main form of regulation of the healthcare system, and subsequently a development phase, started in the 1990s, based on the introduction of market-forms of regulation and on decentralization models, as happened in other European healthcare

systems (Saltman, Figueras, 1998). In the last two decades, decentralization and market mechanisms were matched with austerity policies, especially after the beginning of the economic crisis in 2008-09.

In the following pages, the analysis will show that, over time, the regulatory and organizational models relating to the protection and production of health have changed, even in a radical manner. In particular, the territorial dimension of health services, which had been a core principle of the NHS at the time of its inception, has significantly changed in terms of importance, resources and meanings. This dimension meant the end of hospital centrality, the creation of decentralized services networks and the development of prevention functions and structures, as well as primary and community care. However, NHS implementation and subsequent reforms neglected these objectives and seriously undermined territorial services, focusing on highly specialized hospital services.

This result is consistent with the healthcare reforms adopted since the 1990s: the Italian NHS has been considered a 'paradise' by neo-liberal reformers, who have seized extraordinary opportunities to strengthen the marketization of public services. It is all too obvious today to fear that this heaven could turn into hell. Along with the public health system, the importance of primary care in tackling the Covid-19 pandemic was highlighted in international documents (Oecd, 2020a). In the case of the Italian NHS, the inadequate development and the weakness of the public health system, as well as the lack of coordination between the primary care system, territorial services and hospital services, have been unanimously considered among the main factors of vulnerability of the healthcare system during the pandemic, strongly contributing to serious difficulties in facing the spread of the infection.

Actually, the historical evolution of the NHS, especially after 2000, is at the root of several critical issues which emerged during the pandemic. As happened in other healthcare systems such as that of UK (Froud et al., 2020), the austerity policies aggravated the pre-existing underfinancing of the Italian NHS, depriving it of financial, staff and structural resources, crucial in the pandemic. Even the NHS governance was increasingly characterized by tensions and conflicts in the last two decades, which were exacerbated by the pandemic, frequently making the management of the emergency slower and more difficult.

A perspective and analysis that help to contextualize facts and problems are now essential. Hence, we begin with some history and then discuss how the dynamics of marketization and managerialization have influenced the current weaknesses of the healthcare services and the critical issues in management of the pandemic.

1. The Italian National Health Service: the origins

The Italian health system is organized according to the model of the National Health Service (NHS) introduced in 1978 by law 833 to replace the compulsory Social Health Insurance (SHI) system (de

Leonardis, 1990, Vicarelli, 2015). The law marked the introduction in Italy of universalism and social citizenship, that is, recognition that health is a social right for all citizens throughout the country.

The NHS was born with a decentralized structure replicating that of the Regions established a few years earlier. In the years between 1978 and 1992, the powers and responsibilities in planning, organization and management of the health system were divided among the State, Regions and local authorities. The State had general legislative powers, as well as responsibility for the national planning, financing, coordination and control of the system. The Regions had detailed legislative functions in programming the NHS at local level. In particular, they were responsible for instituting the operating structures of the system, namely the Local Health Authorities. Municipalities were assigned all administrative functions in the field of health and hospital assistance not expressly reserved to the State or the Regions. Therefore, they had a fundamental role in ensuring democratic participation in the functioning of health services (Berlinguer, 1982). Decentralization, of course, raised several problems. In particular, the distribution of power between the central tier of government (national government and Parliament), the intermediate tier (Regions) and local government institutions (especially municipalities) were flawed by ambiguities and overlapping competencies: consequently, there was an evident lack of accountability in the NHS (Vicarelli, 2015).

As regards regulation, the original institutional structure of the NHS provided for the dominance of the public entity and attributed to the private sector only an integrative and complementary role. This role was nevertheless important because of agreements between public and private actors whereby the citizen's payment to the private healthcare provider was reimbursed by the NHS.

Furthermore, public regulation was lacking in the planning and coordination of the health system. The main planning instrument, the National Health Plan, was approved for the first time only in 1994. The State governed the NHS mainly through annual financial laws or through regulatory acts mostly issued on a contingent basis. The regional planning obligations were often fulfilled by the Regions with severe delays.

A central component of the reform was the territorial architecture of the healthcare system, which distinguishes the Italian welfare state, for once, with an almost pioneering urge to change. This new architecture primarily implements a principle of integration between the social and health dimensions consistent with the multidimensional approaches to health ratified by the World Health Organization. The idea is the centrality of health, not of disease. This entails building healthy relationships between people and their physical and social environment, and integrating the different spheres of social life in which the conditions of well-being – or of malaise – are produced: the workplace, the neighborhood, etc. Intervening at local level also means integrating skills and resources that are otherwise separate and fragmented (Bifulco, 2015). The end of hospital centrality is the fulcrum of this perspective, which envisages a radical reorientation of how treatment is conceived and implemented. This entails the superseding of clinical intervention models – centered on the repair of sick bodies, and on the separation between life and care –

in favor of preventive strategies close to people and contexts. Public Health assumes a pivotal role in the Italian NHS, with prevention becoming the institutional duty of a broad and composite system of new functions and services in Italy: public hygiene, counseling centers, school and occupational medicine. Therefore, decentralization and territorialization jointly define a direction of change aimed at assigning centrality to local contexts and their governance structures.

But there is a premise to bear in mind: the universalist nature of the reform. From this point of view, the territorial system of services is conceived as a device able to concretize formal social rights to health into (foundational) services and goods that are actually enjoyable and enjoyed, precisely because it enables them to be exercised on a local scale: that is, on the scale of the proximity between life and health and of the contiguity between governors and the governed.

2. Market reforms in a decentralized National Health Service

2.1 Structural reforms and the new governance of the NHS

In the 1990s, structural healthcare reforms significantly changed the organization and regulation of the NHS, following an international trend aimed at introducing institutional reforms in most of the European national health services such as those of UK, Spain and Sweden (Saltman, Figueras, 1998). Although the reforms confirmed the option for a NHS system, they directly or indirectly promoted a transformation in some of its fundamental principles, causing neglect of the priority previously attributed to prevention as well as to primary and community care. After all, the 1978 implementation had progressively paid less attention to these fundamental principles and dimensions of the healthcare system during the 1980s (Vicarelli, 2015).

Several intertwined factors determined the 1990s reforms: the adoption of neo-liberal principles and theories in economy and in public administration reform; the increasing perception of inefficiency and poor quality in the NHS; the intention to reduce the influence of politicians and political logic on the NHS, which had become pervasive not only at national but also at local level (Paci, 1989; Ferrera, 1996).

These considerable sets of needs and objectives, which emerged in the political and scolarly debates during the 1980s, were translated into the 1992-93 reforms. These were approved in the context of the financial crisis of late 1992, as well as of the collapse of the political system of the so called “First Republic” (1946-1992), overwhelmed by the judicial inquiries unveiling the spread of bribery and corruption within parties and by the impressive rise of autonomist parties, such as the Northern League. The economic and political context created a window of opportunity for the reforms, undermining veto points and actors that had made their approbation impossible in the previous decade (Maino, Neri, 2011).

The 1992-93 reforms were based on decentralization, managerialization and managed competition. Decentralization identified the 19 Regions and two Autonomous Provinces of Bozen and Trento as the level of government able to balance two contrasting needs in service planning, which had to be rational and efficient but also respond to local population needs. Managerialization introduced principles and techniques imported by private companies in the internal governance and management of the NHS organizations. Healthcare was one of the main sectors of public services in Italy where the principles of the New Public Management were implemented.

The introduction of managed competition (Enthoven, 1985) in 1992-93, then converted in managed cooperation (Light, 1997), was inspired by the same logic of promoting and spreading principles and operation mechanisms of the markets and the private sector within a public service. As implementation of competition was largely attributed to Regions, "regional models" of healthcare systems emerged over the 1990s and proved very enduring in time. These models showed relevant differences in terms of service organization and regulation, but they all attribute an important role to marketization (Crouch, Eder Tambini, 2000) by means of arrangements such as "quasi-markets" (Le Grand, Bartlett, 1993), purchaser-provider split and prospective payment systems for providers, in particular based on DRGs (Diagnosis-Related Groups) in hospitals[1].

Decentralization, managerialization and managed competition were motivated by the search for efficiency in the management of public expenditure resources and must be considered in the light of the EU integration process. In the early 1990s, the situation of public finance was rapidly worsening. The adoption of the Maastricht Treaty (1992) and the decision to enter the European Monetary Union, with its financial requirements, called on the Italian government to adopt structural welfare reforms to ensure welfare state sustainability, while cost-containment policy became a constant priority throughout the decade.

2001 Constitutional reform strengthened regionalization. While the central level of government is in charge of defining "the essential levels of care" to be ensured (and financed) all over Italy, Regions are responsible for the management and organization of the healthcare system, with a high level of autonomy. This balance of powers needs joint policy-making, which is carried out by a set of "Agreements", "Ententes" or "Pacts" signed in the State-Regions Conference and then translated into legislation by the Parliament.

[1] A Prospective Payment System (PPS) is a method of reimbursement in which the provider payment is made based on a predetermined and fixed amount for a particular service. The amount is calculated according to the classification system of that service. "Diagnosis-related groups" is a method of classification used for inpatient hospital services, which was first introduced in the US Medicare program in 1982 and then adopted in many other countries. It provides strong incentives for providers to control costs, either by managing the number and type of services being provided or minimizing the length of hospital stay. However, it may have negative consequences on the quality of care, because providers could excessively reduce the length of stay or the delivery of necessary services in order to increase profit from the fixed reimbursement (Fetter, 1991).

Institutional arrangements designed for joint policy-making have become increasingly ineffective since 2007- 08, when contrasting trends emerged: they were highlighted by the consequences of economic and financial crisis. Under the pressure of financial markets and the EU, austerity policies gave scope to an increasingly central regulation, especially after the sovereign debt crisis of 2010-11. The re-assertion of the role of the State (Frisina-Doëtter, Neri, 2018) was evident for most of the Regions, which initiated severe financial recovery plans from their healthcare debts. Since 2007 the plans have involved 10 Regions (mainly located in the Centre and South of Italy) and are still in place in seven of them. They were approved by the Treasury and attributed significant control of regional health policy to central government. Conversely, some Northern Regions called for "forms of differentiated autonomy" in 2017, followed by many other Regions. A negotiation process started in 2018 and was suspended after the outbreak of the pandemic. However, the presentation of a Bill by the national government on differentiated autonomy is expected in 2022.

2.2. The emerging regional models of healthcare systems

As mentioned, since the 1990s, some regional models have emerged with important differences in the organization and regulation of the healthcare services. These differences had been somewhat neglected over the last 10-15 years, but have proved very important in the pandemic, as regional responses and ability to tackle the emergency differed.

Literature about regional healthcare systems identifies three models (Mapelli, Boni, 2010; Neri, 2011). The first has its clearest example in Lombardy. In this Region, since 1996 the regional government has created a "quasi-markets" system based on competition between public and private providers within the regional territory (with nearly 10 million residents). Institutional arrangements adopted by the Region included an almost complete purchaser-provider split, an almost complete freedom of choice by patients, a highly extended use of the prospective payment system for providers based on DRGs.

Competition was mitigated after 2001, in order to pursue cost-containment and to break even. However, the system maintained its tendency to privilege private and third sector provision, also by extending the quasi-markets systems to social care. Purchaser-provider split focused on Autonomous Hospital Firms. Large private provider groups, as well as the extended use of DRG systems brought the Lombardy Health Service to emphasize highly specialized hospital care to the detriment of primary and community care. Hospital care was oversized, serving also residents from other Regions, with very high rate of patient mobility from the South. Primary and community care were severely under-developed, compared to other Italian Central and Northern Regions. 2015 regional reform tried to balance this disequilibrium but it showed an extraordinary endurance.

The second model was adopted by Regions such as Veneto, Emilia-Romagna, Tuscany. Although there are important differences among these Regions, they share some institutional arrangements aimed at promoting negotiated integration between public and private provision instead of competition. Common arrangements include limited purchaser-provider split, which preserved many hospitals and community and outpatient services within the purchasing organizations (the Local Authority Firms); some restrictions to patient freedom of choice; a less extended use of prospective payment systems and DRGs. These features did not prevent an increase both in the recourse to market tools and in private provision, especially in outpatient care. However, they preserved a greater role in prevention as well as in primary and community care services within their regional NHSs compared to Lombardy. This included the attempt to introduce organizational innovations aimed at creating integrated inter-professional networks of care, involving general practice, primary and community care as well as hospital care.

Other Regions, mainly in the Centre and South of Italy, implemented hardly any of the new legislation introduced by 1990 reforms, preserving for many years what was called a traditional, bureaucratic regulatory model (Mapelli, Boni, 2010). During the 2010s these Regions were overwhelmed by financial problems and undertook recovery plans. This caused a strong centralization in policy-making, dominated by cost containment policies. Along with official monitoring financial institutions such as the Corte dei Conti, in many cases the recovery plans were effective in reducing public debts, but service rationalization and cuts determined a shortage in structural resources, which may have affected local responses to the pandemic in the South.

3. Market and territory

As we have seen, territorialization is the core of the integrated approach to healthcare instituted by the 1978 reform. It was intended not as a mere territorial redistribution of hospital care but as a radical change in care models. Behind this ramification of both service and government functions lie the 'social determinants of health approach' (Marmot, 2016), which by focusing on health inequalities takes into account the intertwining of individual and social dimensions and the importance of factors such as the social and policy context, living and working conditions, accessible and available services, and socio-economic position. Moreover, territorialization takes advantage of the theoretical debate on the topic of well-being that in recent decades has stressed the dimensions of multidimensionality, intersubjectivity and interactivity (Bifulco, Bricocoli, Monteleone, 2008).

However, over time this original intent has encountered various problems, as already outlined. Between 2008 and 2015 (latest available data), spending on collective prevention and public health always remained around 4% of the national government budget for healthcare (traditionally named "National Health Fund").

This share is well below the standard 5% set by national planning and regulation. Primary care and general practice, which were attributed a prominent role in prevention in the Italian NHS, were also progressively undermined (Genova et al., 2021).

The weakening of the territorial services system is closely linked to the assumption that the relationship between supply and demand is the main mechanism able to ensure the effectiveness and efficiency of the system. This assumption, constitutive of the market model, acts as a very powerful filter: it excludes from the field of action the social conditions – context factors, determinants and collective dimensions – relevant to health. The supply/demand mechanism assumes that demand is a given. This means ignoring all situations of malaise, which, due to the joint effect of various constraints and impediments, fail to constitute themselves as demand (de Leonardis, 1990; 1998). Conversely, it is precisely on these situations that local and prevention-oriented strategies should act. The related problem is that this mechanism tends to shape consumer demand (Gimbe, 2019).

Again: the supply/demand mechanism is inconsistent with health promotion strategies, which by their nature should mainly affect the territorial component of services. Promotion is the natural evolution, so to speak, of the philosophy of prevention into perspectives that enhance an active or proactive position on the part of institutions and services and at the same time – through a wide range of tools such as information, participation, integration among policies, etc.– involve citizens and communities in the construction of conditions and contexts of well-being, supporting their role and powers in defining problems even before responding to them. It goes without saying that the assumption that the demand for health and healthcare services as a given, linked to the market paradigm, clashes with proactivity understood in these terms.

4. Austerity policies and the under-financing of the NHS (2008-2019)

In the last decade, economic crisis and then prolonged stagnation and weak recovery, along with the financial crisis in public finance which culminated in 2010-11, pushed the national government to adopt austerity policies in the whole public sector, under the pressure of the European Union (EU) and the lack of confidence by international financial markets (Jones, 2012). From 2009 to 2012, several austerity packages were implemented, including a variety of measures taken to control the budget deficit and reduce expenses. The austerity measures then continued roughly until 2018-19, albeit with less intensity in most recent years. One of the main consequences of these policies was the very serious under-financing of the NHS.

Cost containment has been a permanent objective for policy makers in the Italian NHS. After having strongly affected the 1990s reforms, it further increased its importance with the entry into the European

Monetary Union (EMU), eventually becoming the dominant element of Italian healthcare policy after 2008-09, up to the explosion of Covid-19 pandemic in early 2020.

According to Oecd data (2020b), public health expenditure as a percentage of GDP in Italy is 6.4% in 2019. This share is 3-3.5 points less than the shares reported in France and Germany in 2019 and it is also lower than the 6.6% registered in Italy in 2008. Moreover, and even more important, expenditure gaps with these countries all increased in the 10 years before the Covid-19 outbreak (table 1), showing the considerable under-financing suffered by the NHS. According to Gimbe (2019), from 2010 to 2019 public financing in the NHS globally increased by 8.8 billion euro (+0.9% as a yearly average, which becomes + 0.1% in real terms).

Table 1 – Current public and total expenditure on health, % of Gross Domestic Product (selected European countries)

	Current public health expenditure (% of GDP)			Current total health expenditure (% of GDP)		
	2008	2019	Diff. 2018-09	2008	2019	Diff. 2018-08
Italy	6.6%	6.4%	-0.2%	8,5%	8.7%	0.2%
France	8.0%	9.4%	1.4%	10,5%	11.2%	0.7%
Germany	7.7%	9.9%	2.2%	10,3%	11.7%	1.4%
UK	7.5%	8.0%	0.5%	9.2%	10.3%	1.1%
Spain	6.2%	6.4%	0.3%	8.4%	9.0%	0.6%

Source: elaborations from Oecd (2020b)

Also current total health expenditure has increased slightly, being lower, in terms of percentage of GDP, than that registered by all other selected countries in 2019 (table 1). This means that current private health expenditure had a limited growth in the last decade. However, given the restrictions in public funding, the share of current private health expenditure out of current total health expenditure passed from 22.3% in 2008 to 25.1% in 2019 (Oecd, 2020b), which is a very considerable share for an NHS system. Within the private health expenditure, out-of-pocket expenditure remains dominant (23.1% of total health expenditure in 2019), with all the related consequences on the inequalities in service access and quality. This picture would not change if we considered current expenditure on health per capita (Oecd, 2020b). Among selected countries, only Spain presents similar values to Italy.

In spite of the persistent prevalence of private out-of-pocket expenditure, corporate healthcare funds increased in the last 15 years to unprecedented levels, exceeding 10 million enrolled people in 2017 according to official data. The great expansion is explained by both the financial restrictions (and related service cuts and long waiting times) in the public NHS and with the large fiscal incentives attributed to employers (Ascoli, Pavolini, Natali, 2018). On the one hand, corporate health funds express the increasing penetration of financial logics in the healthcare system; on the other hand, they represent a source of potential inequalities, since the great majority of enrolled people are permanent employees of the medium and large size private enterprises concentrated in the North and in the Centre of Italy.

Under-financing also affected public investments. The expenditure for investments in healthcare decreased from 3.4 billion euro in 2010 to 1.4 billion euro in 2017 (Viesti, 2020). This brought the Italian NHS to search for alternative sources through increasing recourse to project financing or forms of public-private partnerships for building and refurbishment of hospitals and other healthcare structures, or for technological innovations. In the partnerships, beyond providing the financial capital and managerial or technical skills in the projects, the private partners are usually assigned the management of ancillary services. In some cases, the partnerships entailed the creation of public-private societies, following public or private law.

In connection with under-financing, the NHS suffered from an increasing lack of human and structural resources. In particular, staff shortage has become evident over the last decade, as highlighted also by specialized literature (Vicarelli, Pavolini, 2015; Neri 2019a; 2019b); this and other dimensions of the NHS under-resourcing were destined to emerge significantly during the pandemic.

5. When problems come to a head

As many other European and Western countries, the outbreak of the Covid-19 pandemic found Italy and its public health system extremely unprepared. Italy had not been significantly affected by previous recent pandemics such as SARS in 2003 or H1N1 in 2009. A national Plan against pandemics (focused on influenza) dated back to 2006 and had never been updated, despite WHO recommendations. Following the news from China and the report of infected Chinese tourists in Italy in January 2020, the first reaction of the government was to deny and then to normalize and downplay the risk (Capano, 2020), showing that the situation was under control. These attempts failed and were replaced by a national lockdown, progressively introduced from 23 February to 11 March 2020 and strengthened on 22 March 2020: all non-essential production, industries, commercial and retail businesses as well as schools and other public services were halted. The lockdown was maintained until 17 May 2020, marking the end of the first phase of Covid-19 pandemic and responses in Italy.

Apart from the unpreparedness and lack of experience of the public health system, the outbreak of Covid-19 pandemic highlighted all the shortcomings and problems accumulated in the NHS during previous decades. In particular, three critical issues were revealed by the evident difficulties in tackling emergency: the shortage of financial, staff and structural resources, such as hospital beds; the tensions and conflicts between State and Regions, which often complicated and slowed the decision-making process; the deficiencies and inadequacy in non-hospital services, such as primary and community care, and the lack of coordination between hospital and non-hospital services.

5.1. A lack of resources

In the Northern Regions, which were overwhelmed in the first months of the infection, the difficulties of the healthcare system to manage the pandemic and treat patients demonstrated a shortage in the financial, staff and structural resources attributed to the NHS. These difficulties were quite remarkable, as those Regions, and in particular Lombardy, were considered the best equipped in terms of healthcare services and available resources. The low level of financial resources, compared to other European countries, is evident in the data about current expenditure and the lack of investments reported in the previous paragraph. This factor was soon reported on the media, in order to explain the difficulties of the NHS to tackle the pandemic. This had already been underlined by specialized literature as a critical issue even in ordinary conditions (Vicarelli, Pavolini, 2015).

One of the main targets of austerity policies in the public sector was the containment and gradual reduction in the expenditure and the number of staff in the public sector (Bordogna 2016). This target included the NHS. Severe restrictions and constraints imposed on staff expenditure and turnover inevitably caused a drop in the number of healthcare personnel. According to official data (Mef-Rgs, 2019), from 2009 to 2018 NHS staff 693,600 to 648,507 units, decreasing by 6.5%, while the decrease in the public administration as a whole was 4.5%. The reduction continued without interruption until 2017.

Staff reduction in the NHS considerably affected healthcare staff which, from 2010 to 2017, decreased by 21,813 units (Vicarelli, 2020). Moreover, nearly 50% of doctors are aged over 50 and a large number of retirements are expected in the near future. In 2019, Anaao-Assomed, the main hospital doctors union, estimated an increasing doctor shortage in the following years in many specialties, including some of the most affected by the Covid-19 emergency such as anaesthesiology, internal medicine and the Emergency area. Total shortage of specialist doctors was calculated to be about 17,000 in 2025 (Anaao-Assomed, 2019).

Staff reduction concerned mainly permanent staff. After a decline at the beginning of the economic crisis, temporary staff started increasing. As a result, it passed from 33,356 units in 2009 to 35.481 units in 2018

(+6%), leading the NHS to employ 45% of all temporary staff in the public administration (see also Vicarelli, 2020). The NHS is also one of the few public service sectors using a relevant amount of temporary agency workers and "socially useful workers", which increased for 6,221 to 6,830 between 2009 and 2018 (Mef-Rgs, 2019).

As for structural resources, the shortage in acute hospital beds emerged very quickly after the pandemic breakdown. The bed occupancy rate in wards such as intensive and sub-intensive care, infectious disease or internal medicine rose to levels reputed unsustainable in March 2020, then representing a constant source of worry for health policy makers throughout the pandemic. Table 2 shows the number of acute hospital beds per 1,000 population in the same Western European countries previously selected in Table 1.

Table 2 – Acute hospital beds, per 1,000 population (1980-2018)

	1980	1990	1995	2000	2005	2010	2015	2018
Italy	**9.3**	**7.0**	**6.1**	**4.2**	**3.5**	**3.0**	**2.6**	**2.6**
France	=	=	4.3***	4.1	3.7	3.5	3.2	3.0
Germany	=	8.3**	7.5	6.8	6.4	6.2	6.1	6.0
UK	=	=	=	3.2	3.0	2.4	2.2	=
Spain	3.5*	3.3	3.0	2.9	2.7	2.5	2.5	2.5

*1985; **1991; ***1997. Source: elaborations from Oecd (2020b)

Data shows that hospital beds have considerably decreased over the last four decades in all the countries under consideration. However, both the extent of the decrease and the number of beds in 2018 are different. Italy emerges as the country affected by the largest reduction and, along with Spain, by the lowest number of acute hospital beds per 1,000 inhabitants in 2018. In this year, acute hospital beds amount to 2.6 per 1,000 inhabitants in Italy. The most relevant cuts were reported in the decades 1990-2000 (-40%) and 2000-2010 (-31%), but they were maintained until very recent years. The picture does not change if considering the number of total hospital beds, which is 3.1 per 1,000 population in 2018, in Italy. This share is considerably lower than the share registered in Germany (8.0) and in France (6.0).

Hospital bed reduction is a longstanding process, which is motivated by epidemiological, economic and also quality factors. However, the number of beds has probably been excessively reduced in Italy compared to other countries. Official data by the Minister of Health (2010; 2020) show that before 2020, the bed occupancy rate had reached excessively high levels in some of the wards that were mostly involved in

treating Covid-19 patients. In 2018, the average occupancy bed rate in pneumology was 101.2% (+6.1% compared to 2008), that in internal medicine was 97.5% (+6.2%) and the rate was also very high in infectious disease (+10.3%, compared to 2008). Therefore, the inability of these wards to face the extraordinary overflow of patients determined by the Covid infection was predictable (Neri, 2021).

However, the number of hospital beds and structural endowment within hospitals depends significantly on the strength of non-hospital healthcare at local level, from general practice to primary and intermediate care, and on the ability to coordinate hospital and non-hospital services. The scanty development of non-hospital services as well as the lack of effective integration between hospital and non-hospital care in many Italian Regions contributes strongly to the overload of the hospital system, making it unable to tackle the pandemic emergency.

5.2. State and Regions in the pandemic

The pandemic exacerbated the pre-existing tensions and conflicts in the NHS governance, which was shared by central State and Regions and based on joint policy-making between the two levels of government (see par. 2.1). Three phases can be identified in the State-Regions relationships in health policy, from the outbreak of the pandemic in February 2020 to the beginning of 2022.

As already mentioned, in the first phase of the pandemic (February-May 2020), the rapid spread of contagion of a largely unknown and mysterious disease surprised public institutions as well as the media and the public, calling for an urgent initiative to tackle it. The central government, supported by doctors and other experts, was the key player in this phase, imposing the lockdown all over Italy, without significant resistance by the Regions.

Even those Regions that had not been significantly affected by Covid accepted the closure of schools and economic activities, except for essential services. This behavior was probably due to the fear of a rapid diffusion of the pandemic. Conflicts were not lacking, but they often concerned what level (and what responsibility) the initiative should take, more than the decision itself.

In the first phase, the importance of regional models emerged, with very different performances by Northern Regions such as Veneto and, by contrast, Lombardy, in their ability to tackle the pandemic, as mentioned in paragraph 5.2. In the second part of 2020 and in 2021 other Regions, such as Lazio, were very effective especially in the vaccination campaign.

The second phase covers the period from the end of May 2020 to the beginning of March 2021. Two overlapping trends emerged in the State-Regions relationship. First, the Regions became prominent actors in negotiating and jointly defining the national regulation against pandemic. In this role, they negotiated

the rules for the gradual end of lockdown and the reopening of economic activities, at the end of Spring 2020, and the new closures and restrictions introduced to face the second wave of Covid-19 in Autumn and Winter 2020-21.

Secondly, Regions increasingly tried to introduce autonomous regulation, often in contrast with the national regulation, causing increasing conflicts with the central government. On the one hand, autonomous regulation, mainly intended to reduce restrictions to economic activities, was taken by Regions ruled by Centre-Right coalitions, which showed their dissent with the national government ruled by a different coalition between the 5-Star Movement and the Democratic Party (DP). On the other hand, even Regions ruled by the DP introduced autonomous regulation from the national one, but, at least in the South, they showed a tendency to adopt stricter limitations, especially in school closures.

The nature assumed by the relationship between State and Regions in this phase made the management of the pandemic very complicated. On the one hand, concerted national policy-making slowed all the decisions and contributed to the frequent delays in adapting the regulation to the evolution of the Covid-19 contagion. On the other hand, the autonomous regulation by Regions often created inter-regional differences in the restrictions imposed on citizens' rights and on the freedom of economic activities, which did not always seem justified by differences in the incidence of the disease or in the ability of Regional Health Services to tackle it.

The third, current phase started in February-March 2021. The previous national government, supported by the Five Stars Movement and the center-left parties, was replaced by a new government, which is strengthened by a larger coalition including also the center-right parties. This political change helped the cooperation between the national government and the Regions, which are mostly ruled by center-right party coalitions. However, the ability of the central government to use its Constitutional supremacy seems to be highly conditioned by political opportunity: in this arena, Regions can strongly affect the choices by central government, as they did especially in the second and third phase of State-Regions relationships during the pandemic.

5.3 The fading territorial health services

In Italy, there is still heated controversy about how the weakness of territorial health services has diminished the ability to respond to the Covid-19 pandemic.

Although the regional architectures share the influence of the market model, they are differentiated. Their differences were overwhelmingly apparent at the outbreak of the pandemic. It was in fact evident that the Regions in which there had been greater investment in territorial health services and hospital/territorial services integration (or at least, where these matters had been less neglected) proved better able to cope

with the emergency: most patients were treated at home, so that it was possible to limit the number of severe cases and hospitalizations (Sanfelici, 2020; Calafati et al., 2021). By contrast, where the system was more centered on the hospital, a larger number of patients were taken directly to the emergency rooms and hospitals, in the absence of the 'filter' function performed by the local area. The debate on healthcare at the time of COVID has highlighted in various ways that the better stability of regional systems like those of Veneto and Emilia Romagna is linked to a wider and more solid territorial system of health-care provision. A contrasting case is exemplified by the situation in Lombardy, where the reorganization implemented in the past years has exasperated the 'hospital-centered' architecture of the health system and further impoverished the endowment of community based services (Arlotti, Marzulli, 2021). As already said, it is the regulatory model on which Lombard healthcare is based that explains the massive disinvestment in the territory: competition as a guiding principle of the architecture of the supply system strongly discourages investment in less profitable 'markets' – such as, precisely, prevention and community health – and which are therefore less attractive for individuals.

It should be pointed out that there are some possibilities as well as experiences that differ from the abovementioned, which is obviously patchy and closely dependent on contextual factors and contingent variables (typically, the investment by local decision-makers). One of the best-known schemes is that of Micro-Areas, a program launched in Trieste in 2005, promoted by the Local Health Authority and based on the idea that on a small scale it is possible to embody both the integration of skills and the involvement of services, the third sector and citizens in choices relevant to well-being (Bifulco, Bricocoli, Monteleone 2008; Bifulco, 2017; Di Monaco et al., 2020). This idea was formalized through an agreement among the Health Authority, the Municipality and the Regional Agency for Public Housing which defined the guidelines for actions in neighborhoods counting on average between 1000 and 2500 inhabitants and characterized by the prevalence of public housing. The actions were designed by pursuing several objectives jointly: improving knowledge about people's health problems; favoring the permanence of citizens in their homes; increasing appropriateness in the use of drugs, diagnostic and therapeutic services; promoting collaboration and coordination between actors and services. The organizational framework of the program is very complex. Each micro-area has a contact person and its own headquarters, usually located within a public residential complex, where various types of activities are carried out in regard to the design of personalized intervention projects (for example, home assistance, job insertion interventions, etc.), the everyday flow of life in the buildings (for example, gentle gymnastics and cooking classes self-managed by the inhabitants), and collective initiatives.

6. Conclusion

This article has sought to show how the evolution of the Italian NHS after its inception led to neglect of the collective and social dimension of health and healthcare. Individualized, highly specialized health-care services, mainly provided in hospitals, were given priority at the expense of preventive, primary and community care. Neo-liberal policies based on managerialization, marketization of healthcare services, as well as under-financing and austerity policies in public finance marked this lengthy process, which culminated in the last decade.

The outbreak of Covid-19 revealed all the critical issues that had progressively arisen in the NHS. Regionalization exacerbated them by making the management of the pandemic more difficult and complicated, and by evidencing the weaknesses and contradictions of a fragmented citizenship. At the same time, emerging differences in the ability of the regional healthcare systems to cope with the pandemic highlighted the importance of prevention, primary and community care. Regions that had at least partially preserved these dimensions and settings of health-care services were better able to tackle the pandemic.

The emergency highlighted the importance of redundancy in health-care services. Under-financing and austerity policies, in close connection with the managerialization and rationalization of the health-care services, had progressively deprived NHS organizations of any form of redundancy and organizational slack. These were considered a waste of money and resources. This trend had created increasing difficulties for the NHS in ordinary times, but it had particularly serious effects after the outbreak of the pandemic.

Changing this situation certainly needs much more investment in staff, equipment, healthcare facilities and services as a whole. It requires that priority be given to the development of primary care and non-hospital care, as well as to prevention. Indeed, due to the problems that have emerged during the pandemic, the demand for territorial healthcare services has recently grown significantly in public opinion among technicians and politicians.

The National Recovery and Resilience Plan, presented to the EU in 2021, has moved in this direction, although it is not clear whether it would be sufficient to trigger structural changes. A revision of the State/Region relationship is also necessary, since it appeared severely dysfunctional in 2020-21. Besides clarifying the relationships among the different levels of government, the ‘new’ NHS governance should restore the principles of universalism and solidarity. These are intrinsic to the nature of the NHS and were neglected by the evolution of the fragmented regionalization in the last two decades. In this regard, the salience of the FE approach is evident, since it is closely consistent with the profound structural and cultural change required by the situation.

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