



Italy's experience during COVID-19: the limits of privatisation in healthcare

POLICY BRIEF · 02 June 2021

Introduction

The first outbreak of COVID-19 in Europe was detected in the Italian town of Codogno, Lombardy, on 21st February 2020. The region quickly became the archetype of a failed response to the pandemic. Infected patients overcrowded hospitals, multiplying the spread of the virus. The scenario resembled a conflict zone,¹ with military trucks managing bodies and funerals without the bereaved. Frontline healthcare workers² at public hospitals were left inadequately protected in war-like triages. Meanwhile, the regional government paid private care homes to host COVID-19 patients, spreading the virus amongst the vulnerable elderly.³

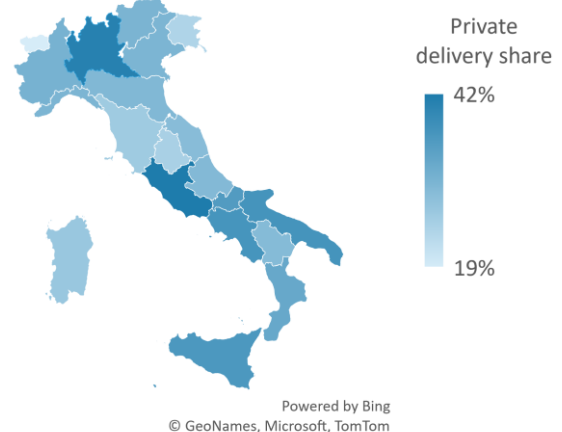
Lombardy, Italy's financial and fashion centre, has so far been one of the most affected regions in Italy – and one of the most affected in the world – both in terms of incidence and mortality. Lombardy's fatality rate – the proportion of COVID-related deaths compared to the total number of cases – was the highest in Italy (5,7%), more than doubling the national fatality rate (2,4%).⁴

How did such a public health tragedy⁵ occur in Lombardy,⁶ one of the wealthiest⁷ areas in Europe?

Lombardy has one of the most privatised healthcare systems in Italy and in Europe. It thus provides direct empirical data about the capacity of privatised health systems to respond to a shock such as a pandemic. It is also a region that was quoted as a positive example of private sector engagement in a recent report from the World Health Organisation (WHO).⁸

By comparing and contrasting the case of Lombardy to the neighbouring region of Veneto, which registered the first cases in the same month but fared significantly better in terms of health outcomes, it appears that Lombardy's poor health-policy response to the pandemic was likely due to higher levels of healthcare privatisation.

Figure 1: Private healthcare providers, share of total services delivered (%), Italian Regions



The privatisation of the healthcare system in Italy

The Italian national health system (Servizio Sanitario Nazionale – SSN) was founded in 1978 as a single-payer universal model, inspired by the British National Health Service, replacing pre-existing sickness funds. The system is funded by general taxation and provides automatic coverage to all citizens, foreign residents and migrants holding a residence permit. Anyone can obtain care for free or with a co-payment depending on the type of medical service.

Since 1992, the Italian Constitution has granted legislative autonomy to regions for the management of healthcare.⁹ The central State is responsible for collecting and allocating healthcare funds as well as setting essential levels of guaranteed medical assistance.¹⁰ In 1992, a national law also introduced the system of ‘accreditamento’ in healthcare, a form of market-based private sector contracting.¹¹ With this mechanism, the regional authorities can set criteria for private healthcare facilities to be eligible for public funding. Patients are then free to choose a public or private accredited provider, paying different levels of co-payments depending on the health facility. The co-payment is usually higher in private accredited providers. Higher fees act as a premium for accessing certain benefits such as reduced waiting times. Depending on specific regional norms and policy choices, private providers enjoy different levels of freedom regarding the services they deliver and the role they play in the overall regional system. As a result of these policies, the share of private hospital beds out of the total hospital beds in the country increased by 3.5% in 10 years, between 2007 and 2018.¹² In 2018, 26% of healthcare services in Lombardy were provided by private institutions, 22% by accredited private institutions, and 52% (the lowest in Italy) by public institutions.¹³

Contrasting privatisation of healthcare provision in Lombardy and Veneto

The growth of private healthcare provision has not been the same throughout the country. It has been more notable in certain regions, such as Lombardy¹⁴ or Lazio, than in others, such as Veneto or Emilia-Romagna, reflecting different policy choices between regions. Lombardy started to deregulate its health system¹⁵ in 1997,¹⁶ allowing private providers to freely choose which services to deliver and to compete with public facilities for public funds.¹⁷ This approach contrasts with the system in Veneto, where healthcare services are strictly controlled and administered by the central government.¹⁸ After regional autonomy was granted, Veneto did not implement the same marketisation reforms as in Lombardy, focusing more on public governance, and prioritising managed collaboration and coordination between providers rather than free market competition.¹⁹ This has led to a different organisation of the health system: in 2019, the private healthcare sector in Lombardy represented 41% of the total publicly funded health care services, as opposed to 30% in Veneto.²⁰

Table 1| Comparison of Lombardy, Veneto and Italy on some of the key indicators in private delivery, primary care and prevention, last available data.

	Lombardy				Veneto				Italy			
Private delivery, share of total (2019)	41%				30%				34.1%			
Public prevention departments (2018)	1	per	1.2	million	1 per 500,000 inhabitants				1 per 600,000 inhabitants			
General practitioners (2018)	1	GP	per	1,413	1	GP	per	1,342	1 GP per 1,232 inhabitants			
Home care (2018)	1,417	patients	per		3,000	patients	per		1,672	patients	per	
	100,000 inhabitants				100,000 inhabitants				100,000 inhabitants			
Data source: Ministry of Health ²¹ OASI Report ²²												

Lombardy’s health system, as thus constructed with a focus on market incentives, progressively favoured income-generating and low-risk sectors, such as long-term residential care, at the expense of sectors considered to be less profitable. For example, Lombardy has relatively low levels of home care

(medical assistance allowing individuals such as the chronically ill or disabled to receive assistance at home). This form of care enables patients to avoid paying for residential facilities, and it has also proved crucial in helping COVID-19 patients isolate at home without spreading the virus. Home care, which is difficult to manage and not financially rewarding, reached only 1,417 patients per 100,000 inhabitants in Lombardy, as opposed to 3,000 in Veneto.²³ Similarly, Veneto has one public department of prevention for 500,000 inhabitants, compared to only one for 1.2 million in Lombardy.²⁴ The difference is even greater when it comes to public health laboratories, which are essential for analysing new viruses and only number one for every three million inhabitants in Lombardy, compared to one for 500,000 in Veneto.²⁵ Lombardy is also one of the regions with fewer family doctors, with one family doctor for every 1,413 inhabitants against a national average of 1,232.²⁶

The COVID-19 pandemic: comparing outcomes

How did these different regional healthcare systems handle the COVID-19 pandemic? COVID-19 hit both Veneto and Lombardy in the month of February 2020. As shown in Table 1, however, Lombardy fared worse than Veneto both in terms of COVID-19 outcomes and health policy responses.

In April 2020, Lombardy had a COVID-19 case fatality ratio almost three times higher than Veneto and registered 14% of infections among frontline healthcare workers, in contrast to 4% in Veneto.²⁷ There was also a significant difference regarding testing. Between 1st March and 28th April 2020, Veneto tested 7% of the population, while only 4% were tested in Lombardy.²⁸ For example, in the rural town of Vo', in Veneto, a team of public researchers²⁹ led by Padova University eradicated the infection through proactive mass testing.³⁰ Two months after the first case, on 30th April, the number of people tested was 4.7% of the overall population in the Veneto region compared to the national average of 2.1%. In July 2020, a total of 21.6 tests per each positive case were performed in the Veneto against 5.5 in Lombardy.³¹ Veneto's epidemiological strategy, supported by public governance and provision and involving mass testing and collaboration between general practitioners and patients, was promptly praised by international scientific literature.³²

Table 2 | Comparison of Lombardy and Veneto on some of the main COVID-19 response indicators in the first two months of the pandemic (as of 1st April 2020)

	Lombardy	Veneto
First case of COVID-19 detected³³	21 February (city of Codogno)	21 February (city of Vo' Euganeo)
Total deaths	7,593	499
Cumulative case rate	455/100,000 residents	196/100,000 residents
Death-to-case ratio	17%	4%
Tests	12 per 1000 residents	23 per 1000 residents
Health workers infected (% of total COVID-19 cases)	14.3%	4.4%
Hospital admission (% of total COVID-19 cases)	51.5%	25.1%
Isolated at home (% of total COVID-19 cases)	48.5%	74.9%
Overall public health strategy	Hospital-centred	Community-centred
<i>Calculations from: Binkin, et al. (2020);³⁴ raw data available at: Italian Civil Protection Official Data³⁵; ISS.³⁶</i>		

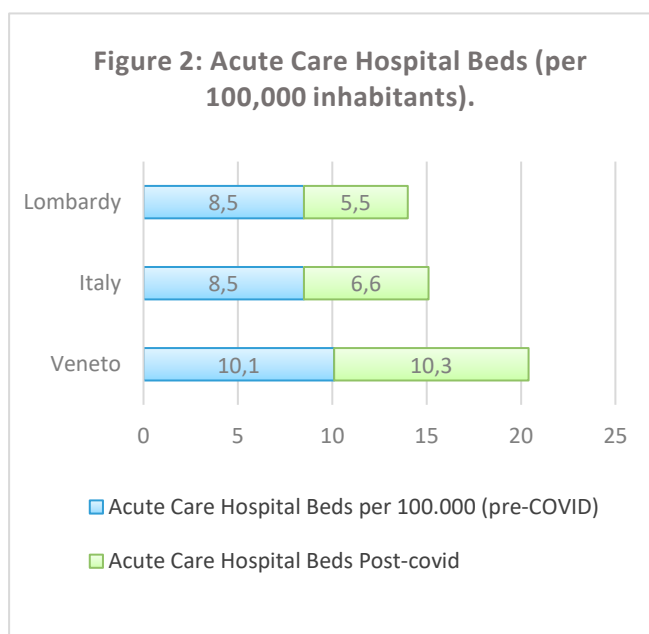
How privatisation failed in Lombardy

How to explain the striking differences between Lombardy and Veneto in COVID-19 outcomes? The answer is complex. The available data shows that Lombardy's failures in tracing, testing and treating³⁷ was a key factor,³⁸ rather than being due to higher population density in Lombardy in comparison to Veneto or a matter of bad luck. The other relevant demographic and social indicators are similar across

the two regions.³⁹ The question is why Lombardy did so much worse in this regard. The region's privatised health system could be a major factor.

Three main weaknesses can be detected in Lombardy's health response to the pandemic. First, in the first stages of the pandemic, only public hospitals were at the frontline treating COVID-19 patients. Private hospitals, which account for 30% of total acute-care hospital beds⁴⁰ in the region, had no obligation to accept these highly contagious patients, as this was not part of the *accreditamento* agreement between the Government and the facilities. To overcome this obstacle, on 8th March 2020, more than two weeks after the first case, Lombardy's regional government authorised,⁴¹ for a limited amount of time and as an emergency option, the purchase of health services from private providers beyond what was stipulated in the initial *accreditamento*. At a time where even hours were crucial, contracts nonetheless had to be re-negotiated with each private provider in order to enforce this decision.⁴² As noted by academics and civil society, there was also a lack of information and transparency over the negotiations between the authorities and the private sector in a context of emergency,⁴³ as a direct consequence of the fragmented healthcare system created by Lombardy's market approach.

Second, Lombardy's response was largely focused on treating acute cases in large hospitals, as opposed to trying to prevent the spread of the pandemic, a strategy that quickly proved to be much more effective in other regions. Lombardy stuck to this narrow strategy until very recently.⁴⁴ Yet, this was not entirely by design, but largely by default, as the region lacked the health services needed to proactively test, trace and treat at home its population. This incapacity was the direct result of the destruction of the network of local primary and preventive care services, which progressively disappeared in the gradual privatisation of the health system due to their lower profitability leaving the region unprepared to bear the weight of the pandemic.⁴⁵



Adapted from AGENAS elaboration on Ministry of Health Data, latest available, available at: <https://www.agenas.gov.it/covid19/Web/Index.php?R=Site%2Fgraph3>

Third, Lombardy was able to activate only 14 acute care beds per 100,000 inhabitants, compared to 20 per 100,000 in Veneto and an Italian average of 15 per 100,000. Given that Lombardy is amongst Europe's wealthiest areas, a potential explanation is, again, the high presence of private provision in the overall health system: as acute care beds tend to correspond to less remunerative treatments,⁴⁶ private facilities might invest less in this sector. For instance, in 2017, private providers in Lombardy covered 74% of overall beds in rehabilitative services and 68% in long-term residential care. By contrast, in the same year, private hospital beds covered only 7% of pneumology and 6% of infective disease overall beds.⁴⁷

Implementing the right to health implies re-investing in quality, non-commercial healthcare

The Italian Constitution guarantees the right to health (Article 32) as a “a fundamental right of the individual” as well as a “collective interest”, enabling “free medical care to the indigent”.⁴⁸ Italy is also obliged by the International Covenant on Economic, Social and Cultural Rights (ICESCR, ratified in 1978) to take steps towards “the prevention, treatment and control of epidemic, endemic, occupational and other diseases” (Article 12).⁴⁹ Thus, Italy has legally-binding obligations to ensure quality health care for all, including in situations of pandemics, to the maximum of its capacities and available resources (Article 2, ICESCR).

Despite being one of the richest regions in one of the largest and most advanced economies in the world, Lombardy failed or at least did not respond as effectively as it could have, as the comparison with Veneto reveals. One of the main reasons for this is the marketised health system, which is particularly developed in the region. Before COVID-19, Lombardy's system of "competitive care" was praised for "pitting private hospitals against public ones" resulting in a "dramatic rise" in healthcare quality.⁵⁰ However, as described by a medical practitioner, Lombardy's poor response to COVID-19 was the logical endpoint of a system that "transformed health into a commodity, ignoring prevention because it does not produce profits".⁵¹

What lesson can be learnt?

The immense tragedy in human and social losses of the deaths occurred in Lombardy should prompt Italy and other countries to learn some lessons. Ensuring that future pandemics do not have such dramatic mortality rates requires a new approach to healthcare systems. What is valid for a wealthy Italian region, with capacities to regulate and/or pay for private healthcare providers, is even more valid in less developed countries, with fewer capacities.

At the very minimum, the following lessons can be drawn from this experience:

- Privatised and commercialised healthcare systems are less effective in responding to crises such as a pandemic, and could put at risk the health and lives of the population they serve.
- States must ensure that their healthcare systems are built on a strong, quality, coherently regulated non-commercial sector. Any commercial private actor may only supplement and not supplant the public and non-commercial actors.
- Commercialisation of healthcare, as it happened in Lombardy, could constitute a violation of States' human rights obligations enshrined in the Constitution and national law as well as in international human rights treaties ratified by the country.
- Human rights monitoring bodies, such as the United Nations human rights treaty bodies, should also play a more active role in assessing whether States' health systems, including potential marketisation reforms, comply with their human rights obligations, in particular in the context of the pandemic. International development actors, including international and philanthropic organisations, should focus their efforts on supporting strong public healthcare and stop the promotion of market approaches. This will be particularly critical to respond to future crises that are likely emerge from the ecological breakdown.

Endnotes

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About GI-ESCR

The Global Initiative for Economic, Social and Cultural Rights (GI-ESCR) is an international non-governmental human rights advocacy organisation. Together with partners around the world, GI-ESCR works to end social, economic and gender injustice using a human rights approach.

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