Decades of Tight Fiscal Policy Have Left the Health Care System in Italy Ill-Prepared to Fight the COVID-19 Outbreak

The Sars-CoV-2 pandemic and the resulting COVID-19 disease is overwhelming some European health systems in an unprecedented manner. The situation remains particularly serious in Italy. In the most affected regions, the Italian national health system (Sistema sanitario nazionale, SSN) has been unable to cope with the care of COVID-19 patients. This article takes a closer look at the connection between health care and strong budget consolidation in the case of Italy. Although austerity was particularly strong in the aftermath of the economic crisis of 2008 and its consequences in the euro area, Italian fiscal policies have been characterised by tough consolidation peri-

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what the government extracted from the national economy in terms of taxes has been larger than what people received in public services for almost three decades. Figure 1 also shows that periods with cuts in real health care expenditure tend to correspond with or follow periods of strong budget consolidation in the first half of the 1990s and in the euro crisis after 2010.

The development of Italian health care expenditure is reported in Figure 2 together with data for selected European countries and the euro area average. Three phases can be observed in the evolution of Italian expenditure. In the 1990s, unlike most other industrialised countries, Italy experienced a decline in public and compulsory health care expenditure (measured in constant euros per capita). It was not until the end of the 1990s that a slight upward trend began when spending increased in parallel to the other European countries until the late 2000s. From 2010 onwards, a new phase of spending containment began, lasting until 2015. In this period, public health care spending was similarly affected in Portugal and Spain and to a larger extent in Greece, i.e. the countries hardest hit by the euro crisis and the subsequent austerity policies. By contrast, in this period a rapid increase in public and compulsory healthcare spending per capita took place in Germany, France and Belgium.

Italy’s SSN was founded in 1978. Based on the national constitution (Article 32), the state guarantees the universal right and largely free access to health care services. During the 1990s, a first series of far-reaching reforms was implemented in an attempt to contain costs in the face of the growing healthcare needs of an ageing population and rapidly improving technologies (Pavolini and Vicarelli, 2013). These reforms were largely in line with the market-liberal ‘New Public Management’ approach and their primary objective was to limit Italy’s public deficits and debt (Pavolini and Vicarelli, 2013). Cost containment was therefore motivated by the macroeconomic context of the time, characterised by Italy’s efforts to meet the Maastricht criteria and the requirements of the Stability and Growth Pact, which led to an overall tightening of public spending. More recently, the global financial crisis and the policy response to the euro crisis put a further strain on the Italian economy and significant restrictions on health care spending returned to the national agenda (De Belvis et al., 2012). Since the early 1990s, the Italian government has registered almost 30 consecutive years of primary budget surpluses (Figure 1). This signals that

1 The European Commission (2019) in its Country Report Italy 2019 finds the SSN to be generally efficient and its outcome in terms of health indicators good, albeit with regional disparities in the provision of health services affecting equity and efficiency.
From 2011 to 2018, cuts in public hospital services have contributed substantially to the negative dynamics of the percentage growth rate of the total public expenditure for health care (Figure 4b). Although austerity policy placed a great burden on the health care system, the share of health care expenditures in total government spending

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2 The Classification of the Functions of Government (COFOG) health aggregate (GF07 and relative groups) classifies all types of government expenditure for the purpose of health (including expenditure on employees, intermediate consumption, government expenditure on gross capital formation, etc.). The delineation of government expenditure in the COFOG classification differs from the System of Health Accounts.

3 According to the COFOG classification, day hospitalisation is classified under hospital services.
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of acute care hospitals in Italy fell below the EU average. The trend continued to decline throughout the years of the euro crisis.

The availability of acute care beds was reduced even more drastically than hospital capacity (Figure 6). Although a pronounced trend towards reducing acute care beds can be observed in many European countries, few European countries have reduced the number of available beds as much and to such a low level as Italy. In 1990, Italy had seven beds per 1,000 inhabitants, a value close to Germany and above the EU average. In 2017, the number of acute care beds had dropped to 2.6 per 1,000 inhabitants, significantly lower than in Germany with six beds available per 1,000 persons and much closer to the historically low value of Spain. Thus within a rather short time period, Italy found itself at the lower end of the spectrum in Europe.

In the EU, almost one-third of public health care expenditure is used to cover the running expenses of inpatient curative institutions (European Hospital and Healthcare Federation, 2018). Over the years, hospitals have been subject to increasing pressure and have often been seen as a major potential source for cuts in public health systems (see McKee, 2004; Popic, 2020). Cost containment strategies revised the use and provision of inpatient hospital care in favour of day hospital and outpatient services, thereby consistently sacrificing hospital capacity. Data from the World Health Organization (WHO) show that since the beginning of the 1990s, the number of hospitals has been drastically reduced throughout Europe, but particularly in Belgium and Italy. Acute care hospitals are currently a central element in the fight against COVID-19. A higher number of acute care hospitals could have also facilitated the isolation of infected patients, reducing the risk of contagion. Figure 5 shows that after starting from a level similar to Germany in 1990, Italy has reduced per capita hospital capacity much more than many other countries within two decades. From 2010 on, the number of acute care hospitals in Italy fell below the EU average. The trend continued to decline throughout the years of the euro crisis.

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There is also a considerable difference in the provision of intensive care beds, with Italy again at the tail end in Europe (Rhodes et al., 2012; OECD, 2020). Although in recent years the number of intensive care beds in Italy has remained relatively constant (Figure 7), intensive care capacity has not been expanded (in contrast to e.g. Germany) despite warnings of possible bottlenecks in accommodation capacity of intensive care patients (Rhodes et al., 2012).
Italy, as well as other European countries, would have been better prepared for adequate treatment of COVID-19 patients in severe and critical condition if the capacity of acute and emergency care had not been reduced. Oxygen-assisted beds are particularly relevant for the inpatient treatment of COVID-19. For some patients, breathing difficulties worsen in the course of the illness, making intensive medical care necessary. The public discussion therefore focuses primarily on the availability of intensive care capacities and mechanical ventilation equipment. However, the speed at which machine ventilation should be provided is a matter of controversy among lung specialists and intensive care physicians (Gattinoni et al., 2010). The current research gap on COVID-19 may therefore also require a comprehensive diagnosis of patients by lung specialists, which could lead to better treatment outcomes (see also Begley, 2020). In this context, the substantial reduction in the number of pneumological beds during the phase of intensified austerity after 2010 in Italy is particularly tragic. According to the data of the Italian Ministry of Health, the number of pneumological beds has decreased from 4,414 in 2010 to 3,573 in 2018 – a reduction of 19%.

The reduction of resources in the public health system and in particular in the operation of public hospitals in Italy has been going on for almost 30 years. The Italian population is currently paying the price of prolonged tight budget policies in the SSN. The one-sided focus on fiscal constraints and debt reduction has deprived the Italian health sector of an important part of its capacity to offer adequate protection to the population. The sizeable reduction of resources has caused severe difficulty to the SSN in effectively tackling the consequences of COVID-19. The outbreak of the health crisis has sounded a wake-up call that cannot remain unheard.

Figure 5
Acute care hospitals per 100,000 inhabitants, eight largest EMU countries and EU average

Source: WHO; authors’ calculations.

Figure 6
Acute care beds per 1,000 inhabitants, eight largest EMU countries and EU average

Note: EU membership as of 2020 with country data available.
Source: OECD; authors’ calculations.

Figure 7
Total number of intensive care beds and pneumological beds in Italy and Germany

Source: Italian Ministry of Health; Destatis.

References
Begley, S. (2020, 8 April), With ventilators running out, doctors say the machines are overused for Covid-19, STAT, https://www.statnews.com/2020/04/08/doctors-say-ventilators-overused-for-covid-19/ (14 April 2020).
De Belvis, A. G., F. Ferrè, M. L. Specchia, L. Valerio, G. Fattore and W. Ricciardi (2012), The financial crisis in Italy: Implications for the healthcare sector, Health policy, 106, 10-16.

Gattinoni, L., S. Coppola, M. Cressoni, M. Busana and D. Chiumello (2020), Covid-19 Does Not Lead to a “Typical” Acute Respiratory Distress Syndrome, American Journal of Respiratory and Critical Care Medicine, advance online publication.

European Commission (2019), Country Report Italy 2019: Including an In-Depth Review on the prevention and correction of macroeconomic imbalances, SWD(2019) 1011 final.

European Hospital and Healthcare Federation (2018), Hospital in Europe, Health care data 2018.

McKee, M. (2004), Reducing hospital beds: What are the lessons to be learned?, European Observatory on Health Systems and Policies Policy brief, 6.

OECD (2020), Beyond Containment: Health systems responses to COVID-19 in the OECD, https://read.oecd-ilibrary.org/view/?ref=119_119689-ud5comtf84&Title=Beyond%20Containment:Health%20systems%20responses%20to%20COVID-19%20in%20the%20OECD (2 April 2020).

Pavolini E. and G. Vicarelli (2013), Italy: A Strange NHS with Its Paradoxes, in: E. Pavolini and A. M. Guillén (eds.), Health Care Systems in Europe under Austerity, Work and Welfare in Europe, Palgrave Macmillan.

Popić, T. (2020), European health systems and COVID-19: Some early lessons, EUROPP blog, https://blogs.lse.ac.uk/europpblog/2020/03/20/european-health-systems-and-covid-19-some-early-lessons/ (29 March 2020).

Rhodes, A., P. Ferdinande, H. Flatten, B. Guidet, P. G. Metniz and R. P. Moreno (2012), The variability of critical care bed numbers in Europe, Intensive Care Medicine, 38, 1647-1653.