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Challenges for the welfare state and the right to health after the pandemic: The Italian case

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Abstract

The COVID-19 pandemic affected an already critical state of the Italian National Healthcare System and of the Welfare State in general. The aim of this work is to describe how the challenge imposed by the pandemic has been faced, and the possible directions that social and health policies could take in the country, also in light of the adoption of the National Recovery and Resilience Plan. Through the analysis of the deep-rooted contradictions in public policies and of the areas where the intervention is more urgent, the work underlines the structural factors which are leading to a progressive shift in the vision of health, from a perspective centred on the role of the State and the protection of the public interest, to one where the role of the private sector and the idea of individual interest are ever stronger, with a consequent change in the balance between economics, legal and political systems.

Key words

COVID-19; right to health; health policies; welfare; NRRP

Resumen

La pandemia de COVID-19 afectó a un estado ya crítico del Sistema Nacional de Salud italiano y del Estado del Bienestar en general. El objetivo de este trabajo es describir cómo se ha afrontado el reto de la pandemia, y las posibles direcciones que podrían tomar las políticas sociales y sanitarias del país, también a la luz de la adopción

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del Plan Nacional de Recuperación y Resiliencia (NRRP, por sus siglas en inglés). A través del análisis de las arraigadas contradicciones en las políticas públicas y de las áreas en las que la intervención es más urgente, el trabajo subraya los factores estructurales que están conduciendo a un progresivo cambio en la visión de la salud, desde una perspectiva centrada en el papel del Estado y la protección del interés público, a otra en la que el sector privado y la idea del interés individual son cada vez más fuertes, con el consiguiente cambio en el equilibrio entre los sistemas políticos.

Palabras clave

COVID-19; derecho a la salud; políticas sanitarias; bienestar; Plan Nacional de Recuperación y Resiliencia

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1. Introduction

In the first year of the COVID-19 pandemic (2020), the Italian gross domestic product fell by 8.9%, compared with a drop in the European Union of 6.2%. This meant a significant increase in the requests for help and support, both from companies and from citizens, in particular the economically weaker ones. It must be noted that, from a historical perspective, social spending in the country has typically been characterised, from the one hand, by an imbalance between social benefits in cash and those provided in-kind, and from the other hand, by a strong imbalance between the different areas involved (retirements, health, social services, etc.). In 2019, shortly before the pandemic, the distribution of expenditure in Italy was characterised by the strong prevalence of Social Welfare (retirements pensions; 50.7%), followed by Healthcare (21.5%), Social policies (15.5%) and Education (12.3%) (Unipol and The European House-Ambrosetti 2022). In 2020, during the pandemic, the public expenditure on health relative to gross domestic product (GDP) in Italy was 7.3%, quite lower than other European countries like Germany (10.9%), France (10.3%) and Sweden (9.9%) (OECD 2022). However, in 2023, it decreased again (6.8%) (GIMBE 2023) – while the imbalances between social sectors remained.

COVID-19 imposed an unpredictable shock on the National Health Service (SSN-Sistema Sanitario Nazionale) with serious consequences: a forced stop of periodical check-ups for the chronically ill patients, but also of routine and preventive tests, of the regular monitoring of patients and the elderly population, and so on. In other words, the normal functioning of medicine in the public sector (but also in the private one) was undermined. Healthcare had to slow down, reducing and re-adapting its therapeutic, diagnostic and preventive services. However, while these problems did not vanish automatically with the official end (WHO 2023) of the pandemic, they could be seen as the tip of the iceberg of structural issues that threaten the national healthcare system. For example, even during the first administration of vaccines, the different services among Regions were prominent in terms of speed of administration and availability of different vaccines. In fact, the autonomy that the Regions gained with the reform of Title V of the Constitution (2001) gave them a strong freedom of action in terms of legislation and financial management. However, this led to strong inequalities in performance – for example, Caesarean sections, share of childhood vaccinations, average waiting time for ambulances (Ministero della Salute 2023) –, to the detriment of an equal access of citizens to right to health. In this sense, during pandemic too much longer waiting lists, the availability of centres of excellence, shortages of professionals and hospitals and other problems, were not new issues, but just more evident than usual. Moreover, precisely where regional systems developed according to some specific characteristics – for example by favouring centres of excellence over a widespread local net of small hospitals and clinics, or by delegating a long series of services to the private sector – the effects of the pandemic were heavier. Then, if there is no doubt that the pandemic represented a specific, unexpected and very serious emergency, it is possible to state that the Italian NHS has been suffering for a long time already a deep crisis that affects its functioning and in particular today, its sustainability, generating a large dissatisfaction among citizens/users (Cittadinanzattiva 2023). Just to mention two widespread phenomena –, which represent clear symptoms of this dissatisfaction –, we could refer to aggressions to physicians and nurses, on the one hand, and defensive medicine on the other.

To cope with these situations, during the pandemic it was decided to increase the resources of the Social Funds in order to strengthen territorial interventions. Then, with the resources (750 thousand billion Euro) provided by the program NextGenerationEU (2020), Italy approved the National Recovery and Resilience Plan (NRRP). The idea is that it should accomplish a strong improvement in many areas (energy, digitalisation, justice, public administration, tourism, culture, inclusion, among others). In relation to public healthcare, this extraordinary plan has different goals: strengthening the territorial services, and building both new hospitals and community homes; improving digital medicine; renewing and modernising technological and digital structures; enhancing research and technological modernisation.

The primary objective of this work is to illustrate how the COVID-19 pandemic affected the Italian welfare and healthcare system (already in a critical situation), triggering a series of challenges which imply a reorganisation of the system as a whole. This process should be started by the NRRP, addressing both structural changes in the overall national context (in particular the population ageing and the increase in life expectancy), and new demands and claims (related to health and well-being) coming from individuals. In other words, pandemics seem to have raised awareness of some problems and contradictions implying the survival of the public health system itself: when the access to health services is strongly limited and, at the same time, the right to health is both legitimised (by legal system) and claimed (by individuals and collectivities), the risk of contradict the expectations is so high that the traditional balance between the role of the State and the influences of the market ends up being called into question. In this sense, we can see a relation between the structural crisis of health system (as organisation) and the evolution in semantics related to health (both as value and as theme of communication). In fact, the difficulties in guarantee the access to health lead to question the health itself as a concrete an effective dimension of social life, as right but also as a public good. In turn, the way health is discussed as a theme of communication, affects the claims to the system and to the State and triggers for changes, involving both the State and other actors.

2. Social Policies in Italy in last 30 years

2.1. Welfare State

As is well known, if social welfare policies have their traditional origin in the 1600s with the English *Poor Laws*, the Welfare State systems full development is related to the processes of modernisation, urbanisation and industrialisation from the 19th century onwards (Flora and Alber 1983).[1] Thus, if on the one hand industrialisation implied new social risks, such as unemployment and poverty (Mollat 1978, Geremek 1986), on the

[1] For example, the event that allowed healthcare to take off in the modern sense, was the devastating cholera epidemic in 1832.

other hand, the acceleration and spread of urbanisation processes[2] led to a worsening of living conditions and overcrowding of cities, increasing the risks of epidemics.[3]

The Welfare State, therefore, aims to reduce the effect of the inevitable inequalities emerging during life, which origin, following Dworkin (2000), could be "natural" (*brute luck*, e.g.: congenital disabilities and abilities; economic lineage; gender or ethnicity) or "social" (*option luck*, e.g.: education and professional career; life choices and so on).

In the third millennium, the importance of welfare policies is evident than ever, due to global phenomena as financial (2001 and 2008) and pandemic crisis, international migrations, spreading economic inequalities,[4] ecological threats, changes in families and gender relations.

However, in the last fifty years there has been a clear reversal from the welfare policies experienced up to the 1980s. The changes introduced could be seen as a sort of counterbalance to the "Glorious Thirties" (1945–1975) (Fourastié 1979), leading to the "silver age of permanent austerity" (Pierson 1994, 2001; Taylor-Gooby 2002). Due to changes in demographic and family structures (Ascoli 2011, Ferrera *et al.* 2012) and production (Accornero 1997, 2007), work is no longer sufficient to guarantee social inclusion (Saraceno 2015): this undermined the traditional welfare systems, giving rise to a new social question (Rosanvallon 1995/1997). The European welfare crisis is, in this sense, the crisis of social insurance, which cannot keep pace with the rapid change in society (Ferrera 1998, 8).

Since the 1980s, first in England and the USA and then in the rest of the western countries, programs to revise, rethink and even reduce spending on social policies were approved. In Italy many aspects were reformed: social security (the most significant cost item in welfare spending), through regulatory and structural changes (retirement age, counting system, social security parameters and models); healthcare, through the *managerialisation* of the system and the shift to a businesslike logic (e.g. from Usl-Local Healthcare Unities to Asl-Local Healthcare Companies); labour sector, through new flexible or precarious (depending on the political perspective of analysis) contractual forms.

The Italian welfare system was conceived, based on the Bismarckian model, with a strong occupational mark, in order to integrate the industrial working class into the political and institutional system through a top-down logic, with interventions "granted" from above, to those who belonged to specific categories. Then, the first peculiar element of the Italian welfare system is *particularism*: benefits were strongly

[2] Globally, there are more people living in urban areas (55% of the world's population in 2018; while they were 30% in 1950) than in rural ones. By 2050, 68% of the world's population will live in urban areas (United Nations 2018).

[3] The Welfare State came into being with the aim of coping with the risks consequent on the advent of industrial society: the core is social insurance, which provides protection against a predefined set of risks – ageing, disability, death of the partner, sickness, unemployment, accidents at work, and so on injury and care of dependents (Ferrera 1998, 8). Or, as Lord Beveridge wrote: "Social insurance fully developed may provide income security; it is an attack upon Want. But Want is one only of five giants on the road of reconstruction and in some ways the easiest to attack. The others are Disease, Ignorance, Squalor and Idleness" (1942, 6).

[4] While pertaining to different dimensions – territory, gender, age, etc. – inequalities are always also economic (Esping-Andersen 2009).

differentiated according to the subject to which they refer (Ascoli 2011). Then demercification and destratification (Esping-Andersen 1990) had little effect, while *familism* was fundamental (Banfield 1958, Ferrera 1996). The majority of benefits and programs were regulated on the basis of the "status" of the worker in the labour market, with the consequence that the system did not have a real redistribution effect. On the contrary, it consisted of a mechanism for perpetuating wage gaps even when after retirement.

Another relevant characteristic of the Italian system, closely connected to the first one, is *territorial dualism*. On the one hand the North, rich and in full employment, endowed with wide and diversified protection interventions, "from cradle to grave", due to the regular contribution guaranteed by the income collected; on the other hand the South, with large pockets of poverty, high unemployment rates (especially among women), very limited protection services.

A third peculiar dimension consists in the *clientelistic* character of Italian protection policies, often subject to forms of "political exchange" (benefits in exchange for votes), both at the "high" level of Parliament and at the "low" local level.

The fourth characteristic of Italian welfare system is the *dominance of income transfers* (especially pensions) on services (especially proximity and care). It is related not so much to the amount of expenditure,[5] but to its allocation – the so-called "allocative distortion" of the Italian Welfare State (Gori 2022). However, there is also a "functional distortion" (Ferrera 2019): as can be seen in the figure below, almost half (47.3%) of the total expenditure concerns old-age pensions,[6] while 23% addresses healthcare and 6.5% unemployment.

FIGURE 1

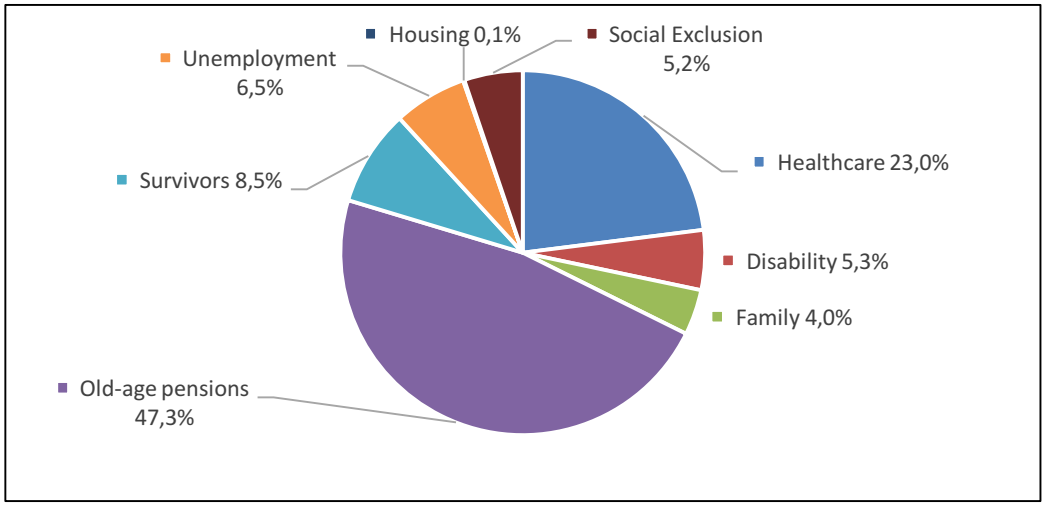

Figure 1. Expenditure on Social Protection (Healthcare, Welfare and Social Welfare) by user area - Italy year 2021 (% values).
(Source: Istat).

[5] In comparison with the other G20 countries, in 2018 Italy was in 5th place, with 27.8% social expenditure in relation to GDP, after France (31.1%), Finland (29.3%), Belgium (28.8%) and Denmark (28.7%).
[6] While in most OECD countries pensions represent the largest area of expenditure, in English-speaking countries and most other non-European countries, it is health (OECD 2019).

On the other hand, at a local level (municipalities), the expenditure on social welfare favours monetary transfers to a few specific areas: old-age pensions, disability, family (and minors).

FIGURE 2

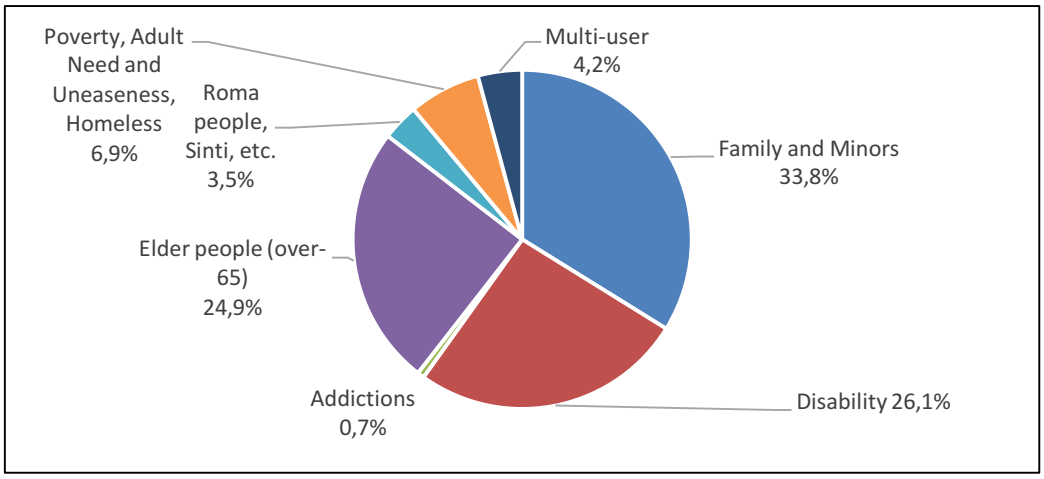

Figure 2. Expenditure on Social Services of municipalities by user area - Italy year 2018 (% values).
(Source: Istat).

The fifth characteristic dimension of Italian welfare consists in the fact that it has always been affected by on a deeply *patriarchal and paternalistic family culture*. In particular, females have to meet the needs of their family related to care, because they are traditionally conceived as "naturally prepared" for it. Moreover, care work is considered a less relevant task than those assigned to men, and therefore is generally excluded from pay recognition (Esping-Andersen 2009).

In light of what has been said above, it emerges that the Italian system, compared to the others most advanced European countries, has to face at least two challenges. The first concerns the need to reduce territorial differences, in two different directions: between the North and the South of the country and between central and peripherical areas, equipped with a complex network of services. This would counteract particularism, territorial dualism and clientelism. The second challenge concerns the level of healthcare spending, both the overall one – given that in Italy it is below the European average, both in terms of per capita value and in relation to GDP (see Introduction) – and in terms of remuneration of healthcare workers – also lower than in the main European countries (OECD 2022) – who more and more abandon Italy to migrate in countries where salaries are higher.

2.2. Health Reforms and Policies

The Italian National Healthcare System (SSN) has gone through a slow and long process of reform started in the late 1970s and continued until the beginning of the new millennium. Changings involved all its structural dimensions:

- Financing: moving from a Bismarckian (occupational-mutualistic) to a Beveridgian (universal) welfare model.
- Functioning: moving from an organisational model closer to State-centred positions (with strong political responsibility in management control) to one

closer to liberal positions (managerialisation, budget control, cost reduction, liberalisation).

- Organisational power: moving from a centralised to a localised system (through the reform of Title V of the Italian Constitution).

The first major structural reform occurred with the transition of the SSN from an occupational to a universal model. Indeed, in 1978 (Law No. 833) was created the National Health Service, which led to the elimination of all corporate mutual funds (an effect of the previous occupational social policy model) and the institution of a unique national insurance extended to all citizens. The administrative structure of the new SSN took on a decentralised configuration, and the system was reorganised on three levels: State, Regions and Municipalities, each of them with different tasks and functions and political-institutional autonomy.[7]

During the 1990s, a wide-ranging and ambitious project of administrative decentralisation had the aim of carrying out a reform of the social protection system, with the introduction of local administrations fiscal responsibilisation and duties of transparency. However, a quasi-market logic started to affect both private and public healthcare, as it occurred in the U.S. as early as the 1980s, thanks to economist Enthoven (2012). In the following decade, the Italian healthcare system underwent a profound transformation aimed at its *rationalisation* and an increasingly central role in decision-making for Regions.

A first milestone was Legislative Decree 56/2000 on "fiscal federalism", created to give a stronger managerial autonomy to the Regions (also on tax financing). The norms introduced brought about a profound change in the financing mechanism of health policies, which today, for about 95%, is financed by general taxation. In 2001 was approved the reform of Title V of the Constitution: it implemented the devolution of healthcare matters from the State to the Regions, and reclassified matters of public intervention into three groups: a) exclusive State legislation; b) exclusive legislation of the Regions; c) concurrent legislation between the State and the Regions (as for healthcare). Now Regions have legislative power, while the State is responsible to determine the fundamental principles governing the system and setting throughout the country standards and uniform levels of services and benefits (the so-called Essential Levels of Care or LEA), in order to guarantee the constitutional right of health protection for all citizens.[8]

3. The Challenge of Pandemic

The Italian healthcare system has been hard hit by the pandemic, since Italy was one of the first countries affected by the Sars-CoV-2 infection and, therefore, suffered the impact and spread of the epidemic before it was recognised as a dangerous infection other than a simple flu.

[7] While the State had the legislative function and defined the legal and operational framework of healthcare, the Regions received the responsibility for planning the actions locally and for the management of the health service, but without financial autonomy. The Municipalities had the task of the basic organisation of services through the USLs, governed by a general assembly and special management committees (Ferrera 2019).

[8] However, this process of "regionalisation" led to different problems and difficulties in cooperation between different levels of Italian healthcare government and administration (Vicarelli 2021).

As previous epidemics had already shown, health is not only an individual right, but is also a collective good. Although political philosophy over the past three hundred years has depicted the construction of individuality and the recognition of individual rights as a fundamental characteristic of Western culture (Morris 1972), COVID-19 pandemic highlighted another dimension, related to public ethics, that is, responsibility. In fact, personal freedom collides with the duty (not simply the need) not to be a danger to others. At the beginning of the pandemic, this implied the need to accept preventive controls based on the presumption of social dangerousness (for example, people could be asymptomatic positive). Here we can see, as Lemert (1967/2019) shows, that even primary deviance becomes secondary, that is, one is stigmatised even if the objective fact (here: contagiousness) has not yet been verified.

From a sociological perspective, the crucial implication – in addition to the concept of responsibility no longer based on the awareness and voluntariness of individual action – is that the protection of individual health does no longer consists merely in the individual right to health, but it rises to the social duty of not to harm others. In fact, the possibility of being unwittingly a vehicle of infection makes it necessary to adopt an ecological and macro-sociological level of analysis, relating to an idea of health primarily as a collective right/duty, and no longer just as an individual right/duty.

This approach goes beyond the national dimension: an effective "health alliance" would require global agreement, that is, coordinated actions and – at least – international cooperation, since in a globalised world the scope of local initiatives is very limited, as Beck (1997) pointed out almost forty years ago about contemporary social risks. Then the pandemic obliged Western political systems to face a momentous challenge. In fact, at the heart of welfare there is the idea of social justice (Rawls 1971, Sen 1992, Dworkin 2000), implying the reconciliation between the idea of equality and the idea of freedom. Precisely freedom is at the centre of debate today: on the one hand, it has always been conceived as an attribution of the individual (that is, individual freedom); on the other hand, freedom could be conceived as relational (everyone's freedom not only has to reckon with that of others, but above all not to be harmful to anyone).

In this sense, we can distinguish two different ideas of health, which in turn consist of two poles: one conceived as a *subjective right* (that could be claimed by law), but also as an *individual freedom* (to be cared or not); the other, conceived as a *collective right* and also as an *interest* (the former could by claimed by groups, communities, populations; the latter means the need to protect society as a whole). Here are involved both a "communitarian" perspective, and the very idea of *ecology* – that is, the relationship between human beings and the external environment, thus the planet as a whole. This imply to make possible, at the same time, the conditions of survival for humanity, animals and the planet, and it is precisely the focus of the "One Health" approach (WHO 2017).

This is the result of a historical path: on the one hand, in the last century health in the Western world has been conceived more and more as a subjective right, that is, the possibility of access to healthcare and benefit treatments that could ensure an overall "well-being" (WHO 1948). This perspective places a strong emphasis on disease prevention and on individual self-representation as "healthy" subjects. On the other hand, a more recent but increasingly relevant idea emphasises also the importance of

prevention, conceived as the need to ensure the maintenance of that balance necessary to make the possibility of the future possible, in the face of catastrophes, climate change, and ultimately the increasing likelihood of epidemics and pandemics.

In this sense, a balancing and even a harmonisation between the subjective right to health and the public interest can be found in the Italian Constitution: this makes it an *already* available tool for dealing with contradictions and problems clearly emerged with pandemic. In fact, the Article 32 of the charter defines health as a "basic right of the individual", but at the same time also an "interest of the community" (note well: not "of the individual"!). Moreover, the State is committed to guaranteeing "free medical care to the poor".[9] However, this does not mean an unconditional possibility to make claims about health: in fact, "the fulfilment of the inalienable duties of political, economic and social solidarity" (Art. 2)[10] is also required. From the combination of the two articles follows that the individual right to be cared (as well as refusing care) entails the commitment to behave in a way that ensures the safety of others, for the purpose of collective prevention (Florio 2017, 402).[11]

These are concrete examples of the prophylactic measures taken during the pandemic, implying the compression of some fundamental rights (primarily, that of free movement), and some obligations (to wear protective equipment and to have a "vaccine passport"). Pandemic obliged to balance two fundamental rights: the limitation of individual freedoms was justified by the protection of the freedom of others (wearing a mask protects not only who dress it, but also others). This means conceive public health as collective good (limiting the spread of contagion, masks and vaccines protected the community as a whole).

If pandemic showed the fragility of human life, our nature of "dependent rational animals" (MacIntyre 1999/2001), and the co-implication between individual, sociality and environment, more than ever it is clear how health is always a social issue, not reducible to subjective claims. Then the "challenge" activated by COVID-19 is not the fight against it (basically, already won), but to rethink the welfare policies, because them characterise open societies: they widen freedom and break down the barriers of social exclusion – gender, ethnic, health (Tuorto 2017) –, allowing people to be re-included, along the entire life, in the different spheres of society; also, they increase spaces and contexts for the exercise of *capability* (Sen 1992), that is, the freedom to choose, to develop themselves, once basic needs are satisfied.

Beyond the specific tools (e.g., basic income, lifelong education, expansion of access to health services, acceptance of a culture of differences, etc.), welfare serves precisely to

[9] Article 32: "The Republic shall protect the health as a basic right of the individual and as an interest of the community, and shall grant free medical care to the poor. No one shall be forced to undergo any medical treatment, except as provided for by law. In no case shall the law violate the limits set by respect for the human being".

[10] Article 2: "The Republic recognizes and guarantees the inviolable rights of man, both as an individual and in the social formations where his personality takes place, and requires the fulfilment of the inalienable duties of political, economic and social solidarity".

[11] It was evident with vaccination: the Constitutional Court (Judgement No. 307/1990) explained that the protection of public health can justify the compression of the right to self-determination, counterbalancing this limit with the recognition of fair compensation, when "someone suffered damage to his or her own health as a result of the compulsory health measure" (Florio 2017, 402).

combine the responsiveness to individual needs and the legitimated claims with collective wellbeing.

4. Next Generation UE. The Italian National Recovery and Resilience Plan (NRRP): Social and Health policies in Italy after COVID-19

The global economic crisis resulting from the pandemic (in addition to those of previous years) and the need to help the people affected by it, led in many countries to make very substantial investments. For this purpose, through the NextGenerationEU plan, the European Union allocated over 723.8 billion euros to the member states. Italy obtained more than a quarter of the total resources (amounting to 191.48 billion euros), setting up the National Recovery and Resilience Plan (NRRP).[12]

Mission 5 of the plan (entitled "Inclusion and Cohesion"), concerns social interventions. It deals with a series of sensitive issues in Italy: support for women's empowerment and hindering gender discrimination; increasing the employment possibilities for young people; rebalancing the local inequalities and promoting the development in the South and inland areas. Particular attention is devoted to the transition to a knowledge-based economy (with investments in upskilling, reskilling and lifelong learning activities), to be achieved through active policies, boosting training, and the implementation of policies to support families, minors, people with severe disabilities and non-self-sufficient elderly.

With regard to health (Mission 6), the Plan aims in particular to provide tools to modernise the healthcare system and cope with the progressive population ageing.[13] The first point is addressed by investments on technologies for monitoring data on morbidity, services provided, and effectiveness of treatment. This imply financing digitalisation, education and training about professional and managerial skills. The investment on health (15.63 billion euros) is divided into two different areas:

- Proximity networks, intermediate structures and telemedicine for territorial healthcare: the goal is strengthening local services, creating and developing territorial facilities (such as Community Houses and Hospitals), improving home care, telemedicine, home care teleassistance, artificial intelligence and promoting a more effective integration with all social and health services.
- Innovation, research and digitalisation: it aims to the renewal and modernisation of existing technological and digital structures, the completion and dissemination of the Electronic Health Record (Fascicolo Sanitario

[12] Out of the total, 31% was allocated to Green Transition, 21% to Digital Transition, 16% to Education and Research, 13% to Sustainable Mobility, 10% to Inclusion and Cohesion and 8% to Health (The European House-Ambrosetti 2022). For a short description of the NRRP, see: PNRR 2022. For further details on the investments planned, see: https://www.italiadomani.gov.it. However, such a big plan has strong delays, particularly relating to the policies for frail persons (Foschini 2023). In the first eighteen months (December 31, 2022) only 6% of the available resources had been spent and only 1% of the projects had been completed (The European House-Ambrosetti 2022). In the health sector, the situation is even more serious: as of June 30, 2023, less than 79 out of 15,625.5 million available (0.5%), would have been spent (Avvenire 2023). Italy then risks losing 4.6 billion in funding (3 for new territorial facilities and 1.6 for earthquake-resistant hospital upgrades). Moreover, the new facilities would need new personnel, which is already lacking (G. Riva 2022; Russo 2023a).

[13] On the problems related to population ageing, see paragraph 6 of this article.

> Elettronico-FSE),[14] and a better capacity of delivering and monitoring the Essential Levels of Care (Livelli Essenziali di Assistenza-LEA) through more effective information systems. Significant resources are also earmarked for scientific research and technology transfer, as well as for strengthening the skills and human capital of the SSN (Presidenza del consiglio di ministri 2021, 226).

The second point (population ageing) is addressed at two levels. *Integrated home care* is oriented to elder people who are cared at home. It is based on telemedicine tools for the diagnostic monitoring of patients and provides for the activation of 602 Territorial Operating Centres (COT), which would coordinate home services with other healthcare services, ensuring the link with hospitals and the emergency-urgency network. On the other hand, elderly that need external care would benefit of *Community Houses* (facilities with a multidisciplinary team of health professionals and welfare workers, in order to guarantee social and health integration) and *Community Hospitals* (facilities with 20-40 beds for short-stay hospitalisation at medium/low clinical intensity care).

However, the question whether the Plan could really help to solve some of the structural problems of the Italian health care system remains. In fact, beyond the "classic" – albeit undeniable – problem related to lack of resources, there are deep contradictions and long-standing features that characterise the Italian National Healthcare System.

5. The Italian National Healthcare System and its structural problems

5.1. The old/new crisis

Beyond the effects of pandemic,[15] the SSN is going through a crisis from many points of view: firstly, there are longer-standing institutional and organisational problems (including high degrees of bureaucratisation[16] and politicisation), and an insufficient public health expenditure.[17] Then, over the last decade, financial difficulties and inequalities in the services provided by the Regions[18] led to a dissatisfaction among users/patients – emphatically represented with the formula "social resentment" (RBM-Censis 2018) – due to what Welfare State is no longer able to provide. Especially the excessive waiting lists produce effects such as the growth of *out-of-pocket* expenditure

[14] It is an electronic registry that allows citizens to access and share with health professionals their health life history. The data contained is provided and managed by each Region.

[15] However, these effects were different in the different Regions, because they adopt different healthcare models (quasi-market, integrated, and bureaucratic) (Quaglia *et al.* 2021).

[16] On this, it is interesting the proposal to remove the National Health System from the control of the public administration, establishing foundations (Garattini 2023).

[17] Italy is 13th in the EU ranking for spending per capita, and 10th for spending relative to GDP (Osservatorio Nazionale sulla Salute nelle Regioni Italiane 2023). Also, in 2023 the incidence of expenditure on GDP is expected to fall to 6.5% (the European average is 7.9%) (CERGAS-Bocconi 2022).

[18] They derive from what has been called a "State of Autonomies" in which regional differentiation coexists with both institutional and administrative asymmetry (Vicarelli 2021). In particular, there are: (i) local disparities in the delivery of services; (ii) significant differences and contexts characterised by a strong inadequacy with respect to the integration between hospital, territorial and social services; (iii) waiting times for the delivery of certain services; and (iv) different capacities to achieve synergy in the definition of strategies to respond to environmental, climatic and health risks.

(i.e. the money spent by citizens for the private sector when public is not available)[19], and the renouncement of treatments.[20]

Also healthcare personnel show clear signs of discontent, facing excessive workloads;[21] inadequate remuneration (significantly lower than in many other European countries);[22] a high risk of aggression and of being sued by users (a phenomenon that leads to so-called *defensive medicine*, the costs of which are obviously public) (Grima 2023).

Moreover, there are unacceptable contradictions and structural problems, such as: the possibility for doctors to carry out private activities within public facilities (the so-called *intramoenia*) (AGENAS 2023); the shortage of nurses; the high average age of doctors and their shortage in some sectors[23] and in peripheral areas with low population density; the recourse to freelance – often not specialised – doctors (the so-called "medici a gettone").[24]

All this is leading to: a) an increasing relevance – in quantitative terms – of the private sector over the public one – also considering the increase in accredited private facilities, which can be accessed at the expense of the SSN; b) a growth in supplementary healthcare programs (corporate welfare, mutual societies, and insurance companies). In this sense, the growth of a "second pillar" in healthcare, within a *de facto* "mixed" system (as the Italian one),[25] is seen by some observers as a desirable path, which could help to contain territorial inequalities (Vecchietti 2019, 25).

If it is true that the topic "crisis" is a permanent reference in communication (crises of all types are denounced: economic-financial, political, labour-market crisis, etc.), and that it constitutes a distinctive characteristic of modernity (Koselleck 2012, 52), at the same time it is also true that, beyond the "alarming use of an alarming terminology" (Luhmann 1984b, 59), the use of this concept itself can represent a tool for the critique of society and then an opportunity for radical change.

[19] While public expenditure amount to 126 billion Euros, private one amount to 41 billion – without taking into consideration the assistance to the disabled, the elderly, and the direct transfers from the National social security institute (INPS). It means that each family spends an average of 2,200 Euro per year (CERGAS-Bocconi 2023).

[20] Here the influence of COVID is evident: between 2020 and 2022 3.5 to over 4 million people (i.e. 7% of the population) renounced to check-ups and examinations (Istat 2023), with potentially serious consequences for those who had to postpone a surgery (Spadea *et al.* 2021).

[21] General practitioners, on whom territorial healthcare hinges, have an average of more than 1,200 patients each (but 42% of them have more than 1,500) and are increasingly older.

[22] In Germany, doctors could earn as much as 93.6% more than in Italy (Gabanelli and Ravizza 2023).

[23] According to the National Federation of Physicians (Federazione Nazionale Ordine Medici) there would be a shortage of 20,000 doctors (4,500 only in emergency rooms). Today there are 4 doctors per thousand inhabitants, when the European average is 3.8. In contrast, there are 6.2 nurses per thousand inhabitants (while in Germany there are 13) (AGENAS 2023), but there are 48.9 nurses for every thousand elderly people over 75, while in France they are 113.4 and in Germany 106.7 (Russo 2023b).

[24] The use of freelancers has become common due to the obligation to respect the "expenditure ceiling" for the recruitment of staff. Paradoxically, freelancers are considered as "goods and services" in the budget.

[25] The private sector plays a role in financing, in the production of services and in the provision of care. Moreover, in some areas it is normal to turn to the private sector, such as dentists; purchase of lenses, glasses and prosthetics; diagnostic tests (RBM-Censis 2018).

5.2. Critics: for a new idea of healthcare systems

Nowadays media are giving great attention to the SNN crisis, and recently several public demonstrations were held under the slogan "Save public health" (Negrotti 2023). The fundamental idea is that health is a right and not a *commodity* (Remuzzi 2018, 27), to be left to the dynamics of free market (Remuzzi 2018, 10). From this perspective, the contrast between public and private services is truly ideological, but not in the negative sense: while the State is called to operate only and exclusively for the interest of patients, the aim of privates is primarily to make profit.

In this sense, the right to health depends on the political system, not on the legal one. The former decides what is legal and what is not (through laws, rules, regulations, etc.), while the latter has the function of "immune system" for society: it guarantees over time an intervention when norms would not respected. Doing so, it prevents disruption and bind the future (Luhmann 1984a, 1993). Then, when policies that should protect health lack, this right is weakened, becoming more flexible and interpretable (Cavicchi 2023), "relative and subordinate" (Cavicchi 2022c).

The main reason used to justify the impotence or impossibility of political action is the scarcity of available resources: in fact, the relationship between social policies and the economy is crucial. It is no coincidence that in recent years the call for "sustainability"[26] has become a "mantra": what is not financially sustainable – i.e. not aimed at making a profit or at least avoiding losses – cannot be done, and this also is true for health. Often this call is just an "empty slogan" to justify political inaction. Instead, if taken seriously, it could help to adopt strategies to govern healthcare system, particularly with respect to the relationship between rights, resources, means and people (Cavicchi 2022a).

To do so, it would be necessary to make health and economy "compossible", that is, to remove all the contradictions existing between them (Cavicchi 2023). This would require radical choices: not only to reform historical health spending or increase available resources, but also, among other things, to abandon a fiscal policy that has favoured the private to the detriment of the public (Cavicchi 2022b).

Then reorganising, rationalising and improving critical aspects is not sufficient. More radically, it is necessary to face the original contradictions of the SSN, concerning the relationship between apparently opposing values or dimensions: that is, public/private, rights/available resources, universalism/inequalities, central government/local autonomies, medicine/health in the broadest sense, efficiency/results, etc. (Cavicchi 2021, 22).

However, the main contradiction is related to the relationship between health expenditure and GDP, which presumed compatibility defines the concept of sustainability. Nevertheless, this is just and ideology – in the negative sense – concealed behind the appearance of a purely rational criterion to govern public spending. This ideology – which even the Constitutional Court embraced, placing the question in terms

[26] Traditionally there are three dimensions of sustainability: economic, social, and environmental (United Nations 2017).

of the "balancing" between rights and available financial resources[27] – considers health an expense (therefore "reducible by definition") instead of "a capital worth investing in": hence the legitimisation of the public healthcare decapitalisation (Cavicchi 2021, 26).

The pandemic has also thrown into crisis the naturalistic legal idea of protection as "defence against disease": since we are all potential victims of viruses that can circulate very quickly, we should adopt a "constructivist" approach based on new visions of the ideas of citizen, patient, prevention, etc. In other words: health should be *protected*, but also *constructed* (that is, make it possible).

In order to do so, it must be abandoned the idea that health is primarily a *right*: on the contrary, it should be considered also a matter of *duties* – something that the legal system has not considered enough. Health is an individual, collective and social responsibility: it depends on every individual as much as on the community. This implies the duties of solidarity, to realise the minimum distance between health demand and health supply. Community should also be recognised as a real agent, with a specific role alongside institutions, with power in the governance of health (Cavicchi 2021).

6. Health and Social Services in Italy between Present and Future

In addition to the aspects described so far, there are also conditions external to health system, which cannot disregarded: in particular, demographic processes and specific characteristics of economy and labour market determine long-term trends that aggravate the burden of health and social services. These phenomena call for a constant adjustment of welfare policies in Italy. Here we highlight two fundamental challenges:

- the *integration of social and health services*: health policies are social policies, then assistance should be conceived as a service which must take charge of the person in his or her entirety. This is both because sometimes it is impossible to establish a clear limit between assistance interventions in the strict sense and health interventions; and because the problems of one kind influence, when not determine, those of the other as well (and therefore solving only one or the other is not decisive).
- The combination of the increase in life expectancy[28] – hence the fall in premature mortality – and the decrease in the birth rate :[29] this leads to a *constant population ageing* and hence to a high burden for social services. In order to face these phenomena, it would be necessary, from the one hand, migration policies aimed to accept more people, enabling them to live and work in safety and to form their own families (Zanfrini 2023); and on the other hand, policies and programmes to bring the number of children per woman

[27] See Constitutional Court rulings 355/1993, 267/1998, 509/2000 and 248/2011. More generally, according to Cavicchi (2021), Legislative Decree 229/199 ("Norms for the Rationalisation of the National Health Service") would "translate" the concept of *economic conditioning* into that of *economic subordination*.

[28] Since the mid-20th century the development in medical and hygienic knowledge, the changes in lifestyles and the favourable economic and social situation produced a substantial increase in life expectancy in most countries. In Italy it was progressive: at the beginning of the 20th century life expectancy was 43 years (regardless of gender), while today it exceeds 80 years for men and 85 for women.

[29] A constant trend since the 1970s, but particularly strong in the last two decades: in 2021, women residing in Italy had an average fertility level of 1.25 children (as in 2001). Today the fecundity of foreign women too is declining: in 2020 it was 1.89 children (Istat 2022c, 149).

as close as possible to the average 2,[30] as has been done recently in France (P. Riva 2022) and Germany (Bonomi 2022).

It is not possible to analyse both these aspects here, so we will only focus briefly on the second and its effect in terms of non-self-sufficient elderly.

While population ageing is a global phenomenon,[31] Italy is nevertheless the oldest country in the world after Japan. On 1 January 2022, the elderly over-65 years-old were more than 14 millions, that is, 23.8% of the total Italian population (Population Reference Bureau 2019). This result is the evolution of a trend of the last sixty years,[32] only partially curbed by the lower average age of foreigners, 35.7 against 46 of Italians in 2021. With respect to the economic dimension, there is a potential effect on the characteristics – quantity, quality and availability – of the human capital in labour market, and also on the country's economic growth potential, which should inducing a re-organisation of the production processes.[33]

However, while the increase in life expectancy[34] is undoubtedly a positive fact, medical knowledge and improvements in the hygienic conditions of the population cannot guarantee equal levels of improvement in people's physical condition, given the chronic or disabling nature of senile morbidity. This led to a "medical paradox" consisting in the tendency to increase the average rate and intensity of morbidity within the general population, because medical developments end up by increasing the dependence on the healthcare system for an ever-increasing number of people. This is the result of a "J-shaped" relationship between age, on the one hand, and morbidity and use of services on the other (Ferrera 2019, 194).[35]

The condition of the elderly population in Italy thus imply to devise policies that could pursue this twofold need: a) contrasting the risk of morbidity among elderly; b) bringing relief to the non-self-sufficient.

[30] It is currently 1.25 (Istat 2022b), while the so-called "replacement level fertility" is 2.1.

[31] In 2019 the G20 summit in Osaka defined population ageing a "global risk", urging specific structural policies. The UN estimates that the older population is expected to reach 994 million by 2030 and 1.6 billion by 2050 (United Nations 2022, 7).

[32] In fact, in 2009 elderly were almost 12 million (20.3% of the population), but they grew from 4.6 million in 1960 (9.3% of the population) to 10.3 million in 2000 (18.1%) (Istat 2020, 11).

[33] It is no coincidence that the value generated by the so-called *Silver Economy* is estimated, at a global level, at 15.6 trillion dollars. Italy is in fifth place in this ranking, and the propensity to consume seems inevitably destined to grow, given that in 2050 as many as 34% of the population will be over 65-years-old (Istat 2022a). The Italian over-65-years-old is – on average – a person who lives in a house he or she owns; with enough money to help family members financially; with a rich social life; who plays a sport, goes to vacation, and often volunteers. The total value of spending by the over-65s is about 200 billion euros (about one-fifth of the entire amount of resident household consumption) (Confindustria 2020).

[34] Global life expectancy at birth reached 72.8 years in 2019 – an improvement of nearly 9 years since 1990. According to current projections, further improvements in survival are expected to result in an average global life span of about 77.2 years in 2050 (United Nations 2022, 16).

[35] According to Istat (2021), the condition of over-75 in Italy before the pandemic was improving. Despite this, there are many over-65s with chronic diseases: in 2019, about 7 million over-65s have multimorbidity, reporting at least three chronic diseases. Among the over-85s, the share reaches two-thirds, with a higher percentage among women (69% versus 60%). Ageing leads to chronicisation of conditions, non-self-sufficiency, sensory and cognitive disabilities.

In the country there are 3.8 million non-self-sufficient elderly people, but only 6.3% live in a residential facility (and 0.6% in a semi-residential one).[36] While 21.5% benefit from home care services – but only for an average of 15 hours per year –, another 1 million (26%) have a caregiver (60% of whom are partially or totally irregular). The remaining 45% does not receive professional help[37] and usually it is assisted by family members (De Vita and Corasaniti 2022) – in 71% of cases a woman[38] (Gori 2023).

Until now, the Italian non-self-sufficiency protection system provide for three kinds of intervention:

- Home care assistance, both sociomedical (as integrated home care-ADI) and purely social (as a home care service-SAD).
- Residential care assistance, both in the form of socio-medical and care facilities for the elderly and in post-acute hospital settings: RSAs, nursing homes, etc.
- Welfare monetary transfers provided in the form of accompaniment allowances for civil invalidity or in the form of care allowances, vouchers or other transfers provided by municipalities.

What is urgent now is strengthening active ageing programmes, defined by the World Health Organisation (WHO) as "the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age" (WHO 2002), and which has been on the agenda in Europe for several years.[39]

In this direction goes an ambitious initiative launched in Italy in 2019. More than fifty organisations[40] (associations, trade unions, professional orders, etc.) together with Ministries, Regions and Autonomous Provinces have set up a multilevel participatory coordination of policies on active ageing,[41] drawing up and signing the Pact for a New Welfare on Non-self-sufficiency. The aim is to introduce in Italy a National Care System

[36] Moreover, home care facilities for non-self-sufficient people were severely tested during the pandemic (Macchioni and Prandini 2022).

[37] If "the share of persons with high care needs receiving assistance is slightly higher in Italy than the European average (28% compared to 22%)", at the same time the "intensity of such support, in terms of frequency and number of hours, however, is much lower in Italy", and "the coverage rate of care must be increased for residential and semi-residential services" (Lamura and Rosina 2023).

[38] If in the past it was seen an obligation determined by female subordination, today care work and the ethics of care are often claimed as a specific characteristic of the female world. Moreover, care is no longer considered as a residual and low-productivity activity, but as a *skill* that characterises and enhances the female world (Casalini and Cini 2012), and a virtue, and also an investment of energy that stems from a personal motivation and an inner involvement (Palazzani 2017).

[39] For example, the Madrid International Plan of Action on Ageing (MIPAA) adopted in 2002; the creation of the European Innovation Partnership on Active and Healthy Ageing (EIPAHA) in 2011; the designation of 2012 as the European Year of Active Ageing and Solidarity between Generations, and the launch in the same year of the Active Ageing Index (AAI). The latter is a tool – introduced by the European Commission and the United Nations Economic Commission for Europe (UNECE) – which detect the untapped potential of older people for active and healthy ageing health at the national and subnational levels.

[40] Among them: Acli, Caritas, trade unions, the Order of Social Workers, the National Association of Retired Persons (Associazione Nazionale Pensionati), Third Sector Forum (Forum del Terzo Settore), and various medical associations fighting against degenerative diseases.

[41] It was realised via a collaboration of the Department for Family Policies at the Presidency of the Council, the National Institute of Health and Science on Ageing (INRCA IRCCS), and the National Institute for the Analysis of Public Policies (INAPP). See: Dipartimento per le politiche della famiglia 2019.

for the Elderly[42] inspired by the most recent international recommendations on active ageing policies.[43]

Ultimately, the Italian case shows that not only traditional social protection, but also what the dominant liberalist ideology conceives as non-returnable cost activities, could represent an important source of employment and welfare both for those who provide them and for those who benefit from them.[44]

7. Health between legal system, political system and economy: Right and/or business

Over the last century, in the West health and welfare have been legitimised as *values* through national constitutions and international treaties. Then they became enforceable (fundamental and human) *rights* and political objectives of the Welfare State. Even their relevance as *themes of communication* has grown so much. Today the limits of what governments and supranational institutions can concretely do are evident, primarily for economic reasons. However, if the Welfare State crisis showed the limits of public health systems, this does not mean that political systems (politics in the strict sense and administration) and legal systems can ignore the growing claims of citizens. What is being claimed is access to medicines, care, therapies, assistance, but also to prevention and prophylaxis measures. At the same time, compensation claims in court make the so-called *judicialisation of health* (Corsi and Martini 2018b) a major problem for the public spending in some countries. All this depend on the so-called "*claim inflation*" (Luhmann 1984/2015): the individuals and social systems expectations – which help to orient them in the world's contingency – are increasingly legitimised by the Welfare State, characterised by "generalised political inclusion" (Luhmann 1983, 60): then they generate *claims*. Once satisfied, they are subject to judgement (one can consider him/herself fully satisfied or not), and this generates corresponding feelings and subsequent adaptations (with respect to personal behaviour, systems reactions, but also to further claims).

On the individual level, the legitimisation of expectations is a result of modernity: there are no more predetermined affiliations (family, class, census, etc.) of traditional societies; then, an individual is encouraged to make his/her own individuality a claim in itself. Hence the rallying cry is: "be yourself", that is, an original and "authentic" individual who makes "personal" choices. Moreover, one should do everything is possible for personal well-being. It is no coincidence that the WHO itself defines health as a

[42] The Pact for non-self-sufficient people (see: https://www.pattononautosufficienza.it/) has three goals: to create the "National System for the non-self-sufficient elderly population" which should provides health, social services and monetary transfers and should achieve the integration of health and social services at the local level; the definition of adequate intervention and evaluation models (through the "Universal service for non-self-sufficiency", the definition of specific essential levels and a new home care model); the overall extension of the offer. For an overview of the reports summarising these activities, see: https://famiglia.governo.it/it/politiche-e-attivita/invecchiamento-attivo/progetto-di-coordinamento-nazionale/pubblicazioni-e-documenti/in-primo-piano/

[43] In this regard, one of the main issues is the identification of goals to be pursued by each different level of government (Lucantoni *et al.* 2022).

[44] In fact, through the recognition of the social value of care activities, it is possible to achieve two objectives: lightening the burdens of care traditionally managed by women of the family and stimulating their greater participation in the labour market (Presidenza del Consiglio dei Ministri 2021, 203).

potentially unlimited state of psychophysical well-being.[45] Thus health represents an absolute value, indisputable, beyond any ideological controversy (Luhmann 1984/2015, 62).

Consequently, normative and cognitive expectations related to health (e.g. to be adequately informed and to give personal consent for treatments) and even affective expectations (receiving attention, be listened, and understood in the name of empathy) are growing (Baraldi 1999, 2015). At the same time the risk of these expectations not being fulfilled is growing too. The lack of limits to claims in the sphere of health results, on the one hand, in the fact that the regulation of claims themselves is left to individuals (Luhmann 1984/2015, 66); on the other hand, in the emergence of a semantics of unlimited and incremental well-being. This marks an epochal shift in the history of the medical system, which traditionally operates starting from the distinction between *health* and *illness*. But now it is no longer sufficient to consider the negative side of the distinction (illness), which guides the work of physicians (Luhmann 1990):[46] today – due to structural changes in society and the progress of medical and techno-scientific knowledge – health can be given different, subjective, meanings. Moreover, one knows that he/she is always potentially ill. Then, when treated he/she is a *patients*, but is also a *user* (or even a *client*) who wants to prevent or improve his/her own body (*human enhancement*) and health in general. It is not by chance that risk management strategies are being developed more and more in healthcare: patients/users can (must?) choose in whom and what to put their trust (diets, therapies, lifestyles, etc.), while simultaneously in the economic, political and legal spheres, are made available, respectively, products and solutions, policies (such as those of prevention), norms and rights (Zamorano Farías 2019, 58).

Last but not least, the individualisation of claims in healthcare tends to blur the very distinction between *right* and *interest*, with problematic consequences regarding the relationship between law and medicine (*judicialisation*). The fact that it is always possible to intervene (or at least to try it) means that there are no limits to the continuous growth of the system, not least because universal values such as health are difficult to be limited (Corsi 2015, 24). Only the scarcity of economic resources constitutes an effective limitation to health claims (Luhmann 1984/2015, 67). Unfortunately, precisely because of this, the call for economic resources and public expenditure does not end: on the contrary, claims grow and cannot be limited: not on medical, nor on legal and on political grounds (Corsi and Martini 2018a, 72).[47]

[45] A "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1948). Analogously, article 12 of International Covenant on Economic, Social and Cultural Rights (1966) defines right to health as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".

[46] In the Western tradition, the sick person (*infirmus*) was considered impure and similar to the poor person (*pauper*), and could only be assisted with charity. Between the XI and XII centuries, in monasteries, a clearer distinction began to emerge between *infirmitas* and *pauperitas* and between salvation of the soul (*salus animae*) and health of the body (*salutis corporis*) (Corsi 2019).

[47] Precisely because of this, one must ask to what extent the inclusion of values such as health in constitutions is legally and politically sustainable (Corsi and Martini 2018b, 40).

As we have seen, the inability to cope with growing demands is not in itself an economic problem, nor a political, legal, scientific[48] or healthcare one. It is instead a characteristic of the modern society, which preaches the generalised inclusion of individuals in the various spheres of society (economy, education, law, and so on), each one with specific criteria for inclusion and exclusion. Welfare State serves exactly to help persons in a disadvantaged position, through minimum guarantees for inclusion (Luhmann 1983). But again: the distribution of resources for welfare (and health) policies is not an economic issue, but a political decision – even deciding not to invest in rare diseases! This is why in the healthcare system the increasing appeal to financial sustainability is difficult to accept. Whereas the private sector decides to do only what pays off economically, public health systems are organisations structured on the basis of political decisions and ideological visions (and it is hard to see how it could be otherwise). Any reform – radical or not – that would not be based on a clear political vision (whatever the direction would be: favouring the public or the private sector?; local care or centres of excellence?; treatment or prevention?) would be nothing more than the umpteenth attempt to make adjustments, that is, partial and unresolving changes. However, principles have to be translated into concrete actions (through ponderation and hierarchisation) compatible with the formal architecture of the State (the different entities, their autonomies and prerogatives), and according to a clear and transparent design.

Constitution should always be the landmark for reforms. Facing the challenge mentioned here would imply to decide: to what extent the access to healthcare is an individual right (that individuals could claim); when the interest of the community should prevail over individual freedoms; who "poors" are in practice; which meaning have today the "inalienable duties of political, economic and social solidarity". Resolving these questions would mean to establish clear boundaries between legitimate (but irreducibly different) conceptions of health; the limits of the right to health; the difference between individual and public interest; the space reserved to consumption and market.

8. Final considerations

For many, COVID-19 pandemic should have triggered a sort of revolution, drawing attention on malfunctions and problems of Western society (like the low importance of public health and prevention in favour of individual interest and market; lack of solidarity in favour of individualism and selfishness; marginalisation of poor and less educated people in favour of the privileges of *élites*; and so on). However, these expectations vanished quickly, because the effects and the consequences of pandemic are not intrinsic to the event itself (the biological diffusion of a virus), but depend on the reaction of society, its social spheres and organisations. Then, after pandemic, the previous problems of healthcare systems just became more evident.

In Italy, even if radical reforms are not on the horizon, the National Recovery and Resilience Plan (NRRP) could represent a quite significant reaction to pandemic, making the system more resilient to future risks. However, money is not enough: facilities could

[48] Science (therapies, pharmaceutical sector, technology, but also organisational knowledge) just provides inputs, which the political system could take into account.

be built, technologies and digital structures could be improved and modernised; but without sufficient and adequately trained personnel, better arrangements and also active involvement of stakeholders and citizens, the SSN cannot become more solid and efficient.

The analysis of the historical contradictions in public policies and healthcare underlines the structural factors which are leading to a progressive shift in the conception of health itself: from a perspective centred on the role of the State and the protection of the public interest, to one where the role of the private sector and the idea of individual interest are stronger and stronger, with consequent changes in the balance between economics, legal and political system. At the same time, the challenges of population ageing could represent an opportunity to develop new forms of services and promoting a conception of public health where the Welfare State is not limited to a specific set of social policies, but it is conceived as a regular State intervention in economic production and redistribution, in order to reallocate life opportunities among individuals and social classes (Saraceno 2021, 17).

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