

The Italian health system and the COVID-19 challenge

Italy is facing a massive burden from the coronavirus disease 2019 (COVID-19) pandemic. Since Feb 21, 2020, when the first case of COVID-19 was recorded in Italy, the National Healthcare Service, which offers universal access to health care, has faced increasing pressure, with 41 035 total cases of COVID-19 and 3405 deaths as of March 19, 2020.¹ In the most affected regions, the National Healthcare Service is close to collapse—the results of years of fragmentation and decades of finance cuts, privatisation, and deprivation of human and technical resources.

The National Healthcare Service is regionally based, with local authorities responsible for the organisation and delivery of health services, leaving the Italian Government with a weak strategic leadership. Over the period 2010–19, the National Healthcare Service suffered financial cuts of more than €37 billion, a progressive privatisation of health-care services. Public health expenditure as a proportion of gross domestic product was 6.6% for the years 2018–20 and is forecast to fall to 6.4% in 2022.²

The Lombardy region has the heaviest burden of the COVID-19 pandemic, with (as of March 19, 2020) 19 884 total cases of the disease, 2168 deaths, and 1006 patients requiring advanced respiratory support. At its standard operational level, Lombardy has a capacity of 724 intensive care beds.³ To tackle the medical equipment shortage, Italian Civil Protection undertook a fast-track public procurement to secure 3800 respiratory ventilators, an additional 30 million protective masks, and 67 000 severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) tests.⁴ To avert the shortage of health workers produced by decades of inadequate recruitment practices,

the Italian Government authorised regions to recruit 20 000 health workers, allocating €660 million for the purpose.⁵

There are lessons to be learned from the current COVID-19 pandemic. First, the Italian decentralisation and fragmentation of health services seems to have restricted timely interventions and effectiveness, and stronger national coordination should be in place. Second, health-care systems capacity and financing need to be more flexible to take into account exceptional emergencies. Third, in response to emergencies, solid partnerships between the private and public sector should be institutionalised. Finally, recruitment of human resources must be planned and financed with a long-term vision. Consistent management choices and a strong political commitment are needed to create a more sustainable system for the long run.

We declare no competing interests.

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