RE-InVEST
REBUILDING AN INCLUSIVE, VALUE-BASED EUROPE OF SOLIDARITY AND TRUST THROUGH SOCIAL INVESTMENTS

Towards inclusive service delivery through social investment in Italy

An analysis of five sectors, with particular focus on health care

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Executive summary

This report examines trends in social investment in Italy following the financial crisis of 2007/8.

The first section considers social investment in relation to four policy areas: early childhood education and care, housing, financial services and water.

The second part of the report provides an overview of social investment and disinvestment trends in the healthcare system in Italy since the 1990s.

This section includes a detailed account of service users' and professionals' experiences of the impact of liberalisation and austerity measures on health service delivery drawing on qualitative data collection. Throughout the report we identify policy recommendations to address the effects and impacts of emergent trends towards social disinvestment and liberalisation of public services.

This study is part of the wider pan-European RE-InVEST project to investigate the impact of the EU Social Investment package on marginalised groups since the 2007 crisis

Contents

List of tables

List of figures

Introduction

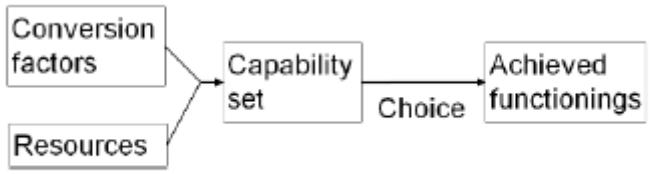
RE-InVEST: Social Investment, Human Rights and Capabilities Framework

Re-InVEST, a H2020 funded project under Euro 3 Europe after the Crisis, involves 19 organisations (universities, research centres and civil society organisations working with vulnerable groups). Re-InVEST aims to investigate the philosophical, institutional and empirical foundations of an inclusive Europe of solidarity and trust. To this end it draws on capability and human rights based participatory approaches to examine how the European Union Social Investment package can be strengthened.

Human rights form a common European basis of values and describe core elements of what constitutes well-being and a good life. Human rights are the basic rights and freedoms that belong to everyone. International law, including treaties, contain the provisions which give human rights legal effect. Specific groups are protected in specific treaties such as women, children, and people with disabilities, minorities, and migrants. Human rights are transformative. For vulnerable groups the usage of a rights-terminology has changed perspectives, by empowering people, by increasing awareness and creating tools to address compromises of these rights.

Capability approach as developed by Sen (1999) and Nussbaum (2011) defines a person's well-being in terms of 'what a person can do' or 'the beings and doings (the functioning's) a person achieves and her capability to choose among different combinations of such 'functionings'. Resources and conversion factors are preconditions or necessary for leading a life one values and has reason to value (Figure 0.1). Resources refer to the material conditions of a person: her income, the goods and services she disposes of. Conversion factors help her to convert resources into 'doing and being well'. Both the achieved functionings as well as the freedom to choose a life one values matters.

Figure 0.1 Resources, conversion factors, capability set and achieved functionings



A human rights and capability framework for Social Investment in Services

Our model builds on human rights1 and capabilities as building blocks for the social inclusion/wellbeing of individuals. (Formal) human rights (e.g. right to work, right to social protection) are values and social norms which do not automatically result in improved wellbeing. For the implementation of such rights (mainly in the field of economic, social and cultural rights), different types of policy measures need to be implemented: legislation, organisation of (public) services, subsidies, social transfers, inspection, judicial enforcement, ... Although some legal measures may establish effective rights (e.g. a guaranteed access to basic services), most policies necessitate additional 'social investment' in individual and collective capabilities through public or subsidised service provision (e.g. ECEC, health care, ...) and the transfer of power and resources - either directly to individuals/households (e.g. social housing), or to companies and civil society organisations (e.g.

subsidies to housing companies, water distribution, ECEC providers). These 'collectives' in turn interact with households and may invest in their capabilities

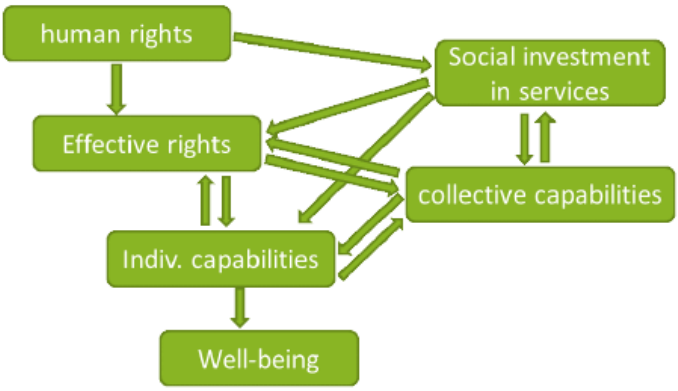
European Commission Social investment Package

In 2013 the Commission issued a communication on social investment for growth and cohesion, *the Social Investment Package*. The Package provides guidance to Member States to help reach the Europe 2020 targets by establishing a link between social policies, the recommended reforms in the European Semester and the use of relevant EU funds. According to the European Social Policy Network, the EU approach to social investment in the package is largely consistent with the scientific debate on the issue, but the Commission puts more emphasis on dimensions such as effectiveness and efficiency, policies to raise the human capital *stock* (e.g. through ECEC, vocational training, education and lifelong learning), *flows* (through policies supporting employment, active labour market policies) and *buffers* protecting people through risky transitions (such as adequate unemployment benefits and minimum income support schemes). Social investment strategies are seen as a package of policy measures in a life course perspective, that are complementary and mutually reinforcing. It is clear that the approach in the SIP covers more policy measures than social services, that form only part of the social investment strategy, but social services play an important role.

RE-InVEST define social investment as investment of resources into people – more precisely, into the sustainable enhancement of individual and collective agency'. The criterion to assess success becomes the sustainable impact on capabilities rather than the source or nature of the investment.

- In Section 1 we first briefly examine how social investment or disinvestment impacts on human rights and capabilities in the national context in four sectors, ECEC, health, financial services and water.
- In Section 2 we focus on the direct research question and focus on the impact of social disinvestment in a national context in a specific sector examining the human rights and capabilities of vulnerable people.

Figure 0.2 From human rights and capabilities to individual wellbeing



1. Social investment in Italy on ECEC, housing, financial services and water

1.1 Italian overview on social investment and economic crisis

When assessing the main policy-making trends in European countries in relation to social investment, three broad clusters of countries can be identified (though the line between the clusters is not a sharp one).[1]

There are some 13 countries (AT, BE, CH, DE, DK, FI, FR, IS, LI, NL, NO, SE, SI) which are maintaining an (often historically) well-established social investment approach to many social policies.

There are nine countries in the second cluster (CY, ES, HU, IE, LU, MT, PL, PT, UK) which, while still o develop an explicit or predominant social investment approach, show some increasing awareness of social investment and have begun to apply elements of a social investment approach in a few specific policy areas.

Finally, there are thirteen countries in the third cluster (BG, CZ, EE, EL, HR, **IT**, LT, LV, MK, RO, RS, SK, TR) where a social investment approach has not so far made many significant inroads into the overall policy agenda though some seem to have started moving slightly in a social investment direction in a few policy areas (e.g. EE, HR, LT, LV, RO).

In Italy, improvements towards a social investment approach were found in schemes related to unemployment benefits, but serious deficiencies characterised other policy areas and a minimum income scheme is yet to be introduced throughout the national territory. As a result, a clear social investment strategy is lacking and Italy does not incorporate the protection of the rights of the people experiencing poverty and social exclusion into its policy pillars.

In Italy, the experts claim that an integrated social investment approach constitutes an ambitious challenge, due to the functionally biased (towards old age) fragmented and corporatist welfare system. This system has historically been characterised by a low degree of universalism (apart from healthcare), limited vertical redistributive capacity, a low degree of selectivity to reach those most in need, a low degree of service provision, meagre enabling and 'activating' measures, significant regional disparities, and overall inequality in income distribution (accompanied by a fragmentary and chaotic tax system).

Several experts report that a key factor in their countries that has limited and in some cases actually lead to a decline in the development of a social investment approach has been the impact of the economic crisis and a policy environment dominated by fiscal consolidation policies whose primary aim is to reduce public budget deficits.

They identify four main ways in which a focus on fiscal consolidation and a failure to apply social impact assessments of policy changes have often led to negative effects for the development of social investment policies. Fiscal consolidation has led to:

1. cuts in budgets for some existing investments in building human and social capital resulting in reductions in availability and/or quality of programmes;
2. a move away from successful universal social investment policies to more targeted and conditional policies towards the most in need that are often less effective in addressing social challenges and lead to increased stigmatisation and inequality;
3. the postponement or cancelling of new policies which invest in human and social capital;

1 Denis Bouget, Hugh Frazer, Eric Marlier, Sebastiano Sabato and Bart Vanhercke (2015). Social Investment in Europe: A study of national policies ESPN 2015.

4. it has resulted in prioritising passive short-term measures to protect people over the introduction of more enabling and active measures.

In Italy there has been a reduction in financial resources for public services, as well as in the general budget assigned to regional and local authorities, i.e. the main providers of services and benefits. This reduction is likely to jeopardise the service delivery capacity of local authorities as demonstrated by a 23.5% general decrease in their investments which occurred between 2008 and 2012.

1.2 Overview of national investment scenario in four of five sectors

1.2.1 Early childhood education and care

In Italy in general, policies for early childhood development are not well integrated. This is the result of fragmented legislation and scarce coordination between institutional levels and between financial funds.[2]

Experts note significant disinvestment in early childhood education and care.[3] In some cases, this is especially for those who are most vulnerable such as children from a migrant or ethnic minority background (especially Roma).

In Italy, the number of children younger than three attending formal ECEC services has declined and a lack of affordable public ECEC services forces families to play the role of first safety net and social services supplier. Moreover, the current economic crisis has strengthened 'compulsory familialism', since households are obliged to ensure mutual aid especially towards children (but also towards the elderly).

Italy belong to a cluster of European counties whose performances have been negatively assessed by the national experts.[4] In the experts' views, these countries show serious shortcomings concerning the availability, affordability and quality of childcare services.

In some cases (e.g. IT), experts clearly detect signs of further retrenchment due to fiscal consolidation measures. In Italy, the National Fund for Childhood and Adolescence, which plays an important role in fostering integrated child well-being projects in large metropolitan areas, has been continuously cut since 2008.

According to Indire,[5] 98% of children go to Italian kindergartens (the average of the other European Union countries is 94%), a very positive result for the country since the goal for the Member States is that at least 95% of 4-year-olds attend pre-primary education (prior to compulsory schooling).

However, the situation of the younger children is different. For the nursery schools we are still at 25%. Only one child out of four attends them. The Lisbon objective (33%) is not satisfied either at national or regional level: if the majority of children in the third year of life have access to an educational service (especially kindergarten), less than 1/5 of the 2-year-olds and less than 1/10 of 1-year-olds attend a nursery school.[6]

Italy, despite a very high rate of participation for children between 4 and 6 years, continues to register a demand that is higher than the offer and offers no guarantee to the families of a place in the framework of education and training facilities. Early childhood care (Indire, 2016).

2 Italy has a split Early Childhood Education and Care (ECEC) system, with different authorities in charge of ECEC: the Ministry of Labour and Social Policies (Ministero del Lavoro e delle Politiche Sociali) and the Department of Family Policies (Dipartimento per le politiche della famiglia) within the Presidency of the Council of Ministers (Presidenza del Consiglio dei Ministri) are responsible for ECEC for children up to the age of three years; the Ministry of Education, University and Research (Ministero dell'istruzione, dell'università e della ricerca) is responsible for children in ECEC between 3 and 6 years.

3 ESPN (2015). Social Investment in Europe.

4 Ibidem.

5 INDIRE- Istituto NazionaleDocumentazione Innovazione Ricerca ed Educazione. (2016). Educazione e cura della prima infanzia in Europa. 1-2016.

6 Bezi e., Chiaf, M. (2017) Innovate early childhood services. Centro Studi Socialis. 10-2014.

Private services, though with average receptivities lower than public ones, represent the main element of system development over the last few years. In addition, the private entities actually manage a substantial number of services with public ownership due to the difficulty of direct management for the Municipalities but also for flexibility and economy often combined with quality

Different territorial distribution of the service offer in the country: - coverage from 26.2% to 28.2% in central/northern Italy; 12.4% in the South. - nurseries and supplementary services are concentrated in central/northern Italy

Early childhood services are insufficient, with difficult and selective access. They are distributed in the territory without criteria of fairness and not accessible for those who would need it. It could be blamed on institutions that have not been able to invest or who have considered non-priority childhood problems. But even the market has done its part, proposing alternative but onerous solutions. The lack of answers for early childhood also discriminates against women, because it makes their employability more difficult.[7]

Family benefits are a crucial part of investing in children as they help to ensure that families have sufficient income to ensure that children do not lack basic necessities and grow up in a secure and healthy environment in which their development can be ensured. Several experts highlight that there have been significant cutbacks or increased conditionality and means-testing attached to family benefits or a failure to uprate benefits in line with living costs in recent years.

In Italy we assist to recent increases in some family benefits even if these do not always make up for devaluation at an earlier stage of the economic crisis. Expenditure devoted to family benefits increased by 53% in 2014 compared to 2010 (6% compared to 2008) and is expected to continue to increase in 2015 and 2016. However, such increase does not represent a clear move towards social investment, since it favours cash benefits (e.g. bonuses and vouchers in case of newborn or adopted children) rather than services (e.g. those supported by a national fund for family policies decreased by 88% between 2008 and 2014).

The extent and types of parenting support services vary very widely: in Italy, parenting services are embedded in childcare services, long-term care services and social services, which are managed by regional and local authorities. Thus, a clear distinction between these services is difficult to make.

A negative trend is highlighted by a number of experts pointing to serious deficiencies in domestic leave schemes or expressing concerns about recent developments linked to the socio-economic situation.[8]
In 2012, Italy introduced (rather short)[9] paid paternal leave measures to support the employment of mothers (vouchers to purchase baby-sitting services or ECEC) and to encourage a more balanced take-up of parental leave (by extending the total duration of the benefit when fathers apply for at least three months). Furthermore, in 2014 the rules regarding maternal leave and the return to work for women employed with fixed-term contracts were harmonised with the rules for women with open-ended contracts.

Impact on vulnerable groups

Recent studies have underlined a strong association between the social position of the family and the main form of care used: families with more educated mothers and fathers in higher occupational positions use more forms of child care other than parental care, and in particular kindergartens[10] . It is however important to highlight how the low-income families with disadvantaged backgrounds are those that can benefit most of these services. For this reason, unequal access and use of services for early childhood can further widen

7 Vecchiato, T. (2013). I servizi per l'infania in futuro saranno ancora così? Studi Zancan 4 – 2013.

8 ESPN (2015). Social Investment in Europe.

9 One day of mandatory, paid leave after the child's birth plus two days optional paid leave within five months.

10 Brilli, Y, Kulic N, Triventi M (2016), Who cares for the children? Family social position and childcare arrangements in Italy, 2002–12 in Blossfeld HP, Kulic N, Skopek J and Triventi M (eds). Childcare, Early Education and Social Inequality, Cheltenham, UK/Northampton, MA, USA: Edward Elgar.
Bennet, J. (2008), Early Childhood Services in the OECD Countries: Review of the Literature and Current Policy in the Early Childhood Field' Innocenti Working Paper 2008-01, Florence, UNICEF Innocenti Research Centre.
Istat (2014). L'offerta comunale di asili nido e altri servizi socio-educativi per la prima infanzia. Anno scolastico 2012/2013'. Istituto Nazionale di Statistica, Roma (Italy).

the socio-economic differences between families, generating long-term repercussions to the disadvantage of the educational and life opportunities of children born in disadvantaged backgrounds.

The data indicate strong socio-economic differences in the use of nurseries in Italy.[11] Unfortunately it is not clear whether this depends on parents' preferences or insufficient income to pay for private services, or on supply-related factors. In general the availability of services has recently grown particularly in the central and northern regions, but mainly due to the increase in the number of private kindergartens which, however, are often difficult to access from disadvantaged groups.[12]

Policy recommendations

A key to the success of policies to support early childhood development is the extent to which they are delivered in an integrated way across different policy areas. One of the key weaknesses that many experts identify is the lack of an integrated approach and the tendency to a piecemeal and ad hoc or fragmented approach to the development of services.[13]

The Italian childcare system is structured in a rather different way for children in the age group 0-3 years and for children in the 3-6 age group. The kindergarten for children 3-6 years is considered an integral part of the first cycle of education and falls within the competence of the Ministry of Education, University and Research, while the provision of services for the early childhood is still rather fragmented and is regulated at the regional level with great inequalities following a North-South divide.[14]

The European target of 33% of children taken in charge in the 0-3 age group still remains far away. On the other hand, Italy has been in line with the 90% target for older children (3-6 years). Therefore, the efforts seem to be concentrated in the development of services and strategies dedicated to the 0-3 year group of users.

Fiscal consolidation has become the dominant theme in national policy making and it has been implemented in a way that has actually led to a reduction or freezing in investment in early childhood development and to the abandonment or curtailing of some previously positive developments. Expenditure devoted to family benefits increased by 53% in 2014 compared to 2010 (6% compared to 2008) and are expected to continue to increase. However, such increase does not represent a clear move towards social investment, since it favours cash benefits (e.g. bonuses and vouchers in case of newborn or adopted children) rather than services (e.g. those supported by a national fund for family policies decreased by 88% between 2008 and 2014).[15]

1.2.2 Housing

In the so-called Mediterranean welfare regime of today, the housing regime of Italy emphasises home-ownership (67.2% of households in 2011; 73% of population in 2015) strongly as it always had, a largely liberalised private rental sector (about 16%; from the 1990s on), a small public rental sector (about 5.5%; and some intermediate tenures, 10%). A tolerance for illegal and informal housing situations is also characteristic of present-day Italy.[16]

The Italian system of housing policies may be characterised as a system in which 'diffusive' policies (mainly addressed to support access to home ownership) have been predominant. State involvement has

11 Istat (2014). L'offerta comunale di asili nido e altri servizi socio-educativi per la prima infanzia. Anno scolastico 2012/2013'. Istituto Nazionale di Statistica, Roma (Italy).

12 Brilli, Y, Kulic N, Triventi M (2016), Who cares for the children? Family social position and childcare arrangements in Italy, 2002–12 in Blossfeld HP, Kulic N, Skopek J and Triventi M (eds). Childcare, Early Education and Social Inequality, Cheltenham, UK/Northampton, MA, USA: Edward Elgar.

13 ESPN (2015). Social Investment in Europe.

14 Bettio, F, and Gentili, E, (2015). Asili nido e sostenibilità finanziaria: una simulazione per l'Italia. Fondazione Brodolini, 10/2015.

15 ESPN (2015). Social Investment in Europe.

16 Di Feliciantonio, C. And Aalbers, M.B. (2017). The pre-histories of neoliberal housing policies in Italy and Spain and their reification in times of crisis. Housing Policy Debate 27;
Baldini, M. (2010). Le politiche abitative in Italia. Il Mulino, 3-2010. 407-415.

been weak, social housing policies have been weak. Until the late 1980s the obvious emphasis of Italian housing policy was to expand production, usually of larger homes, to cope with a growing population. However state support for doing so was both restricted and, at the local scale, poorly organised.

Furthermore housing policies are characterised by a great regional variance of strategies: housing problems are very different according to areas; responsibilities for welfare and for housing are regional, and there is a high discretionary power for municipalities; local welfare system are very different, also for historical reasons, as for the extension of the protection they offer and the effectiveness of their action.[17]

The global financial crisis which impacted on the housing market in 2007, (the series of) central government(s) that took office, took initiatives to support the housing market, which it had mostly left to the regional authorities until then. Government passed the National Housing Plan in 2009. It had two main aims: strengthening social housing and helping individuals to become an owner-occupier.

A social rental or owner-occupied housing program (distinguished from public housing organised by municipalities) was started in 2009.[18] This housing plan was to be realised locally and privately by a new form of partnership between public authorities, private investors and builders and offered with discounts, but they focus on households with a higher income than those with the lowest incomes.[19]

To stimulate homeownership directly after the start of the crisis, the municipal tax on property (ICI) was abolished for principal residents in 2008.[20] In 2012, under tight financial budgets, a new tax was introduced (IMU). The next government abolished it for principal dwellings and introduced a new tax called TASI for principal and secondary homes. The government thereafter confirmed the implementation of TASI in 2014. Tax revenues will increase, and the tax aims to stimulate owners to use their dwellings, sell them or rent them out.

In a situation of tight budgets, Italy, therefore, continues to work largely with indirect measures via the tax system, also for private renting.[21] In European countries, there are two forms of public intervention: cash aid to low-income tenants (often also extended to owners) for the reduction of housing costs, and the direct provision of public-owned or semi-public rental properties. Italy is seriously late on both fronts, but especially on the second one.[22]

Always via the tax system, the landlords are compensated for extending the statutes for the suspension of evictions of private tenants, while awaiting new emergency regulation[23]. To stimulate income tax payment by natural persons and affordable rents for the occupants, a proportional (instead of progressive) tax rate was offered for commercial tenancies and a lower one for so-called 'assisted tenancies'.[24]

Italy also introduced a number of measures to stimulate the recovery of the mortgage loan market in 2013 and help owner-occupiers in financial problems, as repossessions were rapidly increasing between 2008 and 2012.[25] This included the setting up of funds to help families maintain or take out a mortgage loan. Banks also have been setting up initiatives.

Impact on vulnerable people.

Housing policies have been relatively weak from a welfare viewpoint. On the one hand, the supply of social housing has been scarce and, on the other hand, social housing policies have not been sufficiently targeted

17 Tosi, A. & Cremaschi, M. (2001) Housing policies in Italy. Vienna: Interdisciplinary Centre for Comparative Research in the Social Sciences.

18 Bianchi, R. (2014). National Report for Italy. TENLAW: Tenancy Law and Housing Policy in Multi-level Europe.

19 Baldini, M. (2010). Le politiche abitative in Italia. Il Mulino, 3-2010. 407-415.

20 Bianchi, R. (2014). National Report for Italy. TENLAW: Tenancy Law and Housing Policy in Multi-level Europe.

21 Bianchi, R. (2014). ivi

22 Baldini, M. (2010). Le politiche abitative in Italia. Il Mulino, 3-2010. 407-415.

23 Bianchi, R. (2014). National Report for Italy. *TENLAW*: Tenancy Law and Housing Policy in Multi-level Europe.

24 Ivi.

25 Bianchi, R. (2014). National Report for Italy. *TENLAW*: Tenancy Law and Housing Policy in Multi-level Europe.

to the needs of marginalised groups and groups in extreme poverty as well as being poorly integrated with general social welfare programmes.[26]

Today about 3.3 million people live in inadequate housing (unaffordability, quality, etc.), while an estimated 4.9 million dwellings (17% of stock) are not used as principal residents; thus officially are vacant. Housing investment has taken place, but housing problems may largely be regarded as distributional issues, as close to 1 million of the vacant dwellings are estimated to be rented out on the black market (amounting to 20% of dwellings in the private rented sector), while about 3.5 million are estimated to be second (holiday) homes; leaving about 400,000 dwellings actually vacant. Some of these may be public rental dwellings, which are in urgent need of renovation, while funds are not available to the local public authorities. Black market problems predominantly affect students and immigrants.[27]

It seems that, when facing problems related to the housing market, many Italian politicians have still in mind the typical family of the fifties. But today families of this type are less and less frequent. Family ties have become more unstable, the single-parent families and those made up of one person are constantly on the rise, work is increasingly flexible and unpaid and there is often a need to change cities, together with employment. Families with two incomes are able to satisfy by itself its own housing needs, while those with only one income, which was once the most common condition, today they are often at risk of economic poverty.

Many of the measures that have been implemented have not been effective (so far). This applies to a number of tax measures that have been implemented in response to the black market that aim to bring contracts into the legal sphere.[28] Some authors conclude that the new social housing program that was set up in 2009 in response to the crisis had not been effective (as far as these local activities can be tracked down). One of the main problems with the program seems to be the coordination between the partners, which was brought to the constitutional court by the regional and local authorities.[29]

Financial austerity limits actions and choices of the Italian government(s). Funds generally were and still are focused on homeowners mainly. The public rental sector is kept small by maintaining a type of right to buy (with a discount) for occupants. Worries are that the same fate will apply to social rental dwellings.[30] Sales of other public buildings have also given an impulse to homeownership. Furthermore, the increasingly liberal regulation to make investments in private renting attractive has caused more (affordability) problems.[31]

Policy recommendations

The new types of family, made up of young people, single parents or elderly people, separated, mobile workers, need forms of housing that the private market offers in scarce quantities, that is, small or medium-sized houses rented to moderate canons.

A greater offer of rented accommodation would also allow a faster exit of young people from the family, which is happening in Italy very late. The efficiency of the whole economic system would benefit, also favouring a greater mobility of workers towards the cities with more intense economic development.

Social housing programs can play a significant role in helping to solve the problem of relative lack of these types of housing. The supply of public or semi-public-owned houses for rent, much lower than in almost all Central and Northern European countries, should be a priority. Recently we witness various

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26 Tosi, A. & Cremaschi, M. (2011) Housing policies in Italy. Vienna: Interdisciplinary Centre for Comparative Research in the Social Sciences

27 Baldini, M. (2010). Le politiche abitative in Italia. Il Mulino, 3-2010. 407-415.

Bianchi, R. (2014). National Report for Italy. *TENLAW*: Tenancy Law and Housing Policy in Multi-level Europe

28 Bianchi, R. (2014). National Report for Italy. *TENLAW*: Tenancy Law and Housing Policy in Multi-level Europe.

29 Tosi, A. & Cremaschi, M. (2011) Housing policies in Italy. Vienna: Interdisciplinary Centre for Comparative Research in the Social Sciences

30 Bianchi, R. (2014). National Report for Italy. *TENLAW*: Tenancy Law and Housing Policy in Multi-level Europe..

31 Bianchi, R. (2014). Intra-team Comparison Report for Cyprus, Greece, Italy, Technische Universiteit Delft, Tenlaw report (grant agreement no. 290694), http://www.tenlaw.uni-bremen.de/intrateamcom/CY-GR-IT%20comparison%20report%2020150203.pdf

initiatives in this direction, which try to involve a plurality of subjects: regions, municipalities, banking foundations, agencies for the home.[32]

Social housing, however, cannot be the only solution, for many reasons. The main one is that the Italian public budget is in serious difficulty, with no chance of improvement on the short period.

There are also other areas of expenditure, such as social safety or health, on which political pressures are mobilised much stronger than those on home issues. There is no money, but even if they were present they would take other directions.

It is therefore necessary to follow a third policy option to increase the available supply, in addition to social housing and the leasing fund: improving the mechanisms of the private rental market. It should act on the system of rules, offering more guarantees to the owners on the times and ways with which they can return to dispose of property, as well as on the tax system, with a reduction of the tax burden on rental income.[33]

1.2.3 Financial services

General Information

Financial exclusion is defined as lack of access to an affordable range of financial services for the purpose of transactions, savings, borrowing/credit and insurance (for contingencies and retirement). It is not just about *not* having a bank account – i.e. 'un-banked,' but also not having access to the full range of banking product and services – i.e. 'marginally banked.' Financial exclusion should therefore be viewed across a spectrum of access to financial services. The main indicators of financial exclusion are lack of access to bank accounts (to manage payments and save), affordable credit and mortgage, and insurance; and a situation of over-indebtedness.

According to the latest available EU wide data Italy is a country with *a medium - high level* of financial exclusion, where about 16% of adult population lack at least one type of financial product (see Table one for a comparison of Italy with other EU countries). EU (2008a, p. 20) More detailed breakdown of financial exclusion shows that 19% are 'un-banked' (the corresponding figure for the EU-27, is 11.6%, EU2010, Table 1, p. 6.), seven% are 'marginally banked' and 26% have 'no transaction bank account.' (Ibid.) Study of the financially excluded reveal that they are more likely to be unemployed, female, rural resident, less educated, in short at risk of social exclusion.[34]

32 Baldini, M. (2010). Le politiche abitative in Italia. Il Mulino, 3-2010. 407-415.

33 Ivi.

34 EU (2008a, p. 50) Financial Services Provision and Prevention of Financial Exclusion. http://www.ec.europa.eu/social/BlobServlet?docId=5092&langId=en.

Table 1.1 Level of financial exclusion (percentage of adults) by country, EU, 2008

Level of financial exclusion (% of adult population)	Country
Low (less than 3%)	Luxembourg, Belgium, Denmark, Netherlands, France, Sweden
Low – Medium (3 – 8%)	Germany, Austria, the United Kingdom, Finland, Spain, Slovenia
Medium – high (12 – 28%)	**Italy**, Ireland, Portugal, Greece, Estonia, Czech Republic, Cyprus, Malta, Slovakia
High (34% and above)	Hungary, Poland, Lithuania, Latvia

Source Our compilation based on EU (2008a), p. 34.Low level of financial exclusion in the EU is associated with the high level of per capita income or consumption, and low level of inequality. EU (2008a) An observation that does not seem to hold for Italy where its index of per capita consumption level in 2016 was 97 just below an EU-28 average of 100 (EU, 2017a). The EU Barometer Data of 2003 indicate that that there is a weak association between high financial exclusion and high level of income inequality. (EU, 2008a, p. 20) This seems to be the case in Italy where the Gini coefficient of inequality is 0.32 compared with an EU average of 0.30. (EU, 2017b)

As far as access to low cost credit is concerned it was found that 56% of Italian adults had 'no revolving credit', 13% had 'a loan' and 50% had 'no savings'.[35] These figures are very different from the EU-15 averages of 40% ('no revolving credit'), 18% (have 'a loan') and 30% ('no savings').

However, it has to be noted that the spread and use of modern banking services has to be put in the context of a society's tradition in the use of cash and banking services, and the fact that use of modern banking services could expose individuals and firms to official scrutiny. It should also be noted the above figures may well overestimate credit exclusion because they include people who are in principle against borrowing or did not need them.[36]

Moreover, lack of connection to the formal financial sector is not necessarily a sign of financial exclusion, and whether people have made a conscious decision to engage with the financial sector and had a choice over it. These are issues that have to be explored.

The 2008 SILC survey of those without a bank account in Italy revealed that 13% of them had income more than poverty line of 60% of the median income, whilst the figure for the income poor (below 60% of the median income) was 44.8% and for materially poor (those 'deprived of 3 of 9 items') 47%; which are well above the EU averages of 22.5% and 36.2% respectively. The poor in general are therefore less 'banked' than the non-poor. But the vast majority of the un-banked, whether poor and non-poor, declared that the reason was 'no need-prefer dealing in cash'.[37] Some studies also found that people at risk of social exclusion (women, rural residents, unemployed and less educated) had a higher rate of financial exclusion.[38]

As far as access to credit card, over-draft facility and outstanding loads are concerned, higher percentage of the poor than the non-poor reported lack of access -45.3% of the non-poor compared with 70.1% of the income poor and 59.4% of the materially deprived poor.[39] The corresponding figure for the total population was 50%. It is interesting to note that at least half these groups reported that they did not have any need to borrow, whilst between a quarter and a third relied on friends/family for their credit needs. Only 1.3% of the total sample reported that their 'application for loan turned down' or that 'banks refuse credit to people

35 (EU, 2008a, p. 27). Financial Services Provision and Prevention of Financial Exclusion. http://www.ec.europa.eu/social/BlobServlet?docId=5092&langId=en [Accessed 15 Dec. 2016].

36 (EU, 2008a, p. 25.) Financial Services Provision and Prevention of Financial Exclusion. http://www.ec.europa.eu/social/BlobServlet?docId=5092&langId=en [Accessed 15 Dec. 2016].

37 (EU, 2010, Tables 2-3, pp. 8-9).

38 (EU, 2008, p. 50.) Euroactive. 2008b. *Financial inclusion – Ensuring adequate access to basic financial services.* MEMO/08/344 Brussels, 28 May. https://www.euractiv.com/...europe.../accessing-financial-services-difficult-for-europe**.**

39 (EU, 2010, table 6, p. 13.) EU. 2010a. *Financial Exclusion in the EU. New evidence from the EU-SILC social module.* Research Note 3/2010.

like us', reasons that can be deemed as financial exclusion.[40] The response of the income poor were equally low: 3.4%, and the same for the materially poor: 5.5%.[41]

Impact on vulnerable people

The 2008 data collected by the EU provides the evidence on the financial pressure on the poor. In general a larger proportion of the poor are at critical situation with respect to arrears and outstanding debt.

In Italy about 7% of the poor are in 'critical situation' compared with less than 4% of the total population. The poor share the same experience of financial pressure irrespective of the level of affluence of the country. The poor in the affluent UK and Sweden are in the same position as the poor in Greece.

As far as the impact of financial crisis of 2009 is concerned, in the immediate aftermath of the crisis - 2010 - the percentage of people who reported '(great) difficulty to make ends meet' declined by a very small amount, that could well be due to the fact that just under 40% of population who were in difficulty before the financial crisis still could rely on the social security support to make ends meet.

This is also corroborated by data on facing unexpected financial expenses. Between 2013 and 2014 there has been very little change in the percentage of Italians who could not 'face unexpected financial expenses.' But it is useful to put these findings in perspective and note that in the Euro Area or EU-27 the average figure for those who had '(great) difficulty to make ends meet' was half that in Italy whilst the corresponding figure for those who could not 'face unexpected financial expenses' was close to the Italian figures.

Policy recommendations

As noted earlier Italy has a high level of financial exclusion considering that its per capita income is very close to the EU average. Government policies have been centred on both the supply and demand sides of the financial markets. Commercial banks have been encouraged to provide low-cost transaction banking, with very low overdraft facility, under a voluntary agreement (called Patti Chiari) among Italian banks in 2003, that however has not been very effective considering the high level of un-banked Italian in 2008.[42] The post office is offering limited financial services like bill payment facilities without the need for an account.

As for access to credits and interest charges, Italy has enacted a law on 'rules on usury practices' that is backed up by a special fund financed by the treasury to assist people who are at risk of usury practices, but this facility is not open for consumption purposes.[43] The introduction of an interest rate ceiling has been treated with some scepticism in Italy since it could lead to exclusion of the poor and high risk people if the cost of providing credit were to be higher than interests charged, thus pushing the people to high cost informal money lenders.[44]

1.2.4 Water

Water services in Italy are relatively good quality at cheaply priced (the average monthly residential water and sewer bill in Italy is € 20 compared to € 31 in France), however this means water in Italy has been under-priced with high per capita water use for residential uses. There is an uneven distribution with better resourcing in the North than the South, and with extensive leakage, malfunctioning water meters and water theft. Existing water infrastructure is under pressure 9% of the population faces water cuts. Low tariffs are enabled though government subsidies for investments which are increasingly hard to sustain and make it

40 (EU, 2010, table 9, p. 19.) EU. 2010a. *Financial Exclusion in the EU. New evidence from the EU-SILC social module.* Research Note 3/2010.

41 (EU, 2010, tables 10-11, pp. 20-21.) EU. 2010a. *Financial Exclusion in the EU. New evidence from the EU-SILC social module.* Research Note 3/2010.

42 (EU, 2008a, p. 87) Financial Services Provision and Prevention of Financial Exclusion. http://www.ec.europa.eu/social/BlobServlet?docId=5092&langId=en.

43 EU (2008a) ivi.

44 EU (2008a) ivi.

difficult to justify investment in an ageing infrastructure in Southern Italy where water supply is intermittent or naturally contaminated

The 1994 Galli Law consolidated local providers into regional utilities but investment levels and efficiency still remain low, putting service quality at risk. Of 91 regional water areas or 'ATO's, 72 have chosen an operator with 6 served by a private operator, 12 by a 'mixed' (public-private) operator, 13 by operators listed on the stock exchange and 34 publicly-owned operators ('in-house') and 7 by 'other', the remaining 19 ATO's are fragmented and incomplete with multiple operators. On 20 April 2016, the Italian Chamber of Deputies approved a draft bill that removes compulsory public management of municipal water services. The bill forms part of Italy's broader water market restructuring including system consolidation and tariff revision.

A 2011 referendum saw 96% of voters reject a proposal to privatise water supplies. Water rates have increasingly come under the control of semi-privatised giants such as ACEA (Azienda Comunale Energia e Ambiente), 51% controlled by the municipality of Rome, and water rates have become both more standardised and more expensive. Italian affordability issues are usually tackled through a tariff system based on a traditional IBT (both block widths and prices fixed and a fixed charge). This leads to issues of equity and affordability and **c**an be very regressive if: (a) low demand elasticity to income; (b) resulting average tariff is below cost recovery levels and this discourages extension of network, (c) many households sharing the same tap. There is a strong territorial variation in unpaid bills going from 2.4% in the North to 8.6% in the South.

Based on a recent survey carried out for 2015,[45] an average cost of water is calculated of € 0.997 per cubic meter (+6.7% compared to 2014 and +54.1% compared to 2007), followed by the fee for purification and sewerage with € 0.796 per cubic meter (+4.5% compared to 2014 and +66.5% compared to 2007), and from the fixed quota (or former freight rental) that has an average cost of € 30/year (+7.1% compared to 2014 and +76.5% compared to 2007).

Overall, on average, in one year a typical family sustains an expense of € 376 for the integrated water service, with an increase of 5.9% compared to the expenditure incurred in 2014 and 61.4% compared to 2007. The rates vary obviously depending on the territorial area of reference. The central regions are distinguished on average by the higher tariffs applied to the integrated water service with € 511 per year. Comparison with previous years shows that the main increases were in the central area (+9.2% compared to 2014 and +82.5% compared to 2007), followed by the northern area (+5.1% compared to 2014 and +61.9% compared to 2007) and therefore the southern one (+3.2% compared to 2014 and +44.7% compared to 2007).

In the 2011-2017 period, the choice of drinking tap water rose from 70.4% to 75.5%, according to a research by the independent institute Cra Nielsen carried out in collaboration with Aqua Italia, the association that brings together companies for primary water treatment. A choice, to drink water at 'zero kilometer' instead of bottled water, made primarily to save money.

In 2015, 38.2% of the water introduced into the drinking water distribution networks of the provincial capital municipalities was lost (from 35.6% in 2012), thus not reaching the final users.[46] Regional network dispersions show more critical situations in the Islands and in the Centre-South regions. Even with lower levels, also in the northern regions there is a general worsening of the network dispersion.

In 2016, 9.4% of Italian households reported an irregular supply of water, a percentage that decreased compared to 2002 (14.7%), but which still assumes values that vary between 37.5% and 17.9% in the southern regions.[47]

The share of households who declare that they do not trust drinking tap water remains relevant despite the downward trend: from 40.1% in 2002 to 29.9% in 2016. This mistrust is still very high in the Southern regions.

45 Cittadinanzaattiva (2016). Il serviio idrico integrato. 11 indagine a cura dell'Osservatorio prezzi e tariffe di Cittadinanzattiva. 03-2016.

46 ISTAT (2017). Giornata mondiale dell'acqua. Le statistiche Istat. 03-2017.

47 Ivi.

Regarding issues related to the privatisation trends in 2014, the operators of water services operating in Italy were 3,161, of which 83% are municipal administrations.

Impact on vulnerable people

To date, the relatively low cost of water and the overall coverage of the Italian water service seem to overshadow the critical nature of the issue for the most vulnerable people. The dynamics and data described above seem to affect the whole population there are no strong issues that could affect specific vulnerable populations. On the whole, however, the north-south territorial divide that emerges in terms of costs and losses of service certainly does not favour an equitable distribution of the right to water.

Policy Recommendations

Given the large quantity of water lost, serious inefficiencies in terms of water distribution emerge, with a water system based on 30/50 year old infrastructures.

Water services and its management have had a very lively history, characterised by continuous legislative changes that, even after the 2011 referendum, do not help to give stability to a sector that would have desperately needed it.

The number of management is still too high. Despite the aggregations and rationalisation started up in the 1990s with the Galli Law and despite the emergence of solid industrial entities operating in more than one region, over 10.5 million inhabitants have served 2,098 operations in economics. Each management slightly exceeds the 4,700 inhabitants served, with obvious repercussions in terms of economies of scale and capacity for investment and planning.[48.]

48 *Blue book 2017. I dati sul servizio idrico integrato in Italia. Utilitatis.*

2. Italian social investment: health in a rights and capability perspective

2.1 Policies and European policy context on health issues

Healthcare systems within the European Union differ widely, and a great deal of public money is involved in this sector. Therefore, Member States have always watched jealously to keep the competence on healthcare within their national borders. Article 168, 7° of the Treaty on the functioning of the EU states that *'Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care.'*

Despite this, European integration affects national healthcare policies in different ways.

First, the European Single Market rules impact healthcare systems.

It has always been clear that the free movement rules applied to certain segments of the healthcare sector, for instance to ensure the right to free movement of health professionals. Progressively, the EU internal market rules have also been declared applicable to other aspects of publicly funded healthcare systems. This is mainly driven by case law of the Court of Justice of the EU. This application of the EU Single Market rules limits the possibilities for public intervention and regulation in the healthcare sector.

The Court made it clear that a healthcare service, when it is provided for remuneration, is an economic activity to which the Treaty provisions on the free movement of services apply.[49] The free movement rules apply when the health provider wants to provide care on a temporary or permanent basis on the other side of a border or when a patient wants to receive care from a provider established in another Member State. As a consequence, healthcare providers can challenge regulation if it is considered as potentially hindering their free movement.[50] Health authorities can justify their regulation if it is deemed necessary to protect a public interest objective, such as the protection of public health or the financial balance of the social protection system.[51] Justified measures must furthermore be proportional, which means that it has to be demonstrated that there are no other actions possible to reach the same public interest objective that are less hindering to the free movement.

After a lengthy policy process looking for answers to the legal uncertainty created by the Court ruling, a Directive on the application of Patients' Rights in Cross-border Healthcare was adopted in 2011.[52] This Directive aims to clarify the rights and entitlements of patients to reimbursement for healthcare they receive in another EU country. However, it does not address the deregulatory effects that could result from the application of the free movement principles to providers wishing to temporarily or permanently provide health services in another Member State.[53]

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49 The main cases are: CJEU, Case C-120/95 Decker v. Caisse de Maladie des Employés Privés [1998] ECR I-1831; CJEU, Case C-158/96 Kohll v. Union des Caisses de Maladie [1998] ECR I-1931; CJEU, Case C-157/99 Geraets-Smits and Peerbooms [2001] ECR I-5473; CJEU, Case C-385/99 Müller-Fauré and Van Riet [2003] ECR I-4509; CJEU, Case C-372/04 Watts [2006] ECR I-4325; CJEU, Case C-444/05 Stamatelaki [2007] ECR I-3185.

50 Gekiere W., Baeten R. and Palm W. (2010) Free movement of services in the EU and health care, in Mossialos E., Permanand G., Baeten R. and Hervey T. K. (eds.) Health Systems Governance in Europe: the role of European Union law and policy, Cambridge, Cambridge University Press, 461-508.

51 See e.g. Case C-158/96 Kohll [1998] ECR 1931.

52 Directive 2011/24/EU of 9 March 2011 on the application of patients' rights in cross-border healthcare, O.J. L88/45-65, 4 April 2011.

53 Baeten R. and Palm W. (2012) Preserving general interest in healthcare through secondary and soft EU law: the case of the Patients' rights Directive, in Neergaard U. et al. (eds.) Social Services of General Interest in the EU, The Hague, T.M.C. Asser Press, 385-412.

EU competition law comes into play when public intervention is likely to favour certain market actors to the detriment of others. When actors in the healthcare sector have a certain degree of freedom e.g. to negotiate, to fix prices or to allocate their budgets, these practices are likely to be subject to competition law[54]. This means that, if public authorities decide to give more (financial) responsibilities to actors, introduce market elements and 'regulated' competition, in an attempt to control public spending, then competition law might apply. The application of competition law in turn limits the possibilities for public intervention and regulation of the activities of these actors.

Public funding to healthcare providers and purchasers also has to be compatible with the Treaty rules on state aid and public procurement. Funding of healthcare services is justified if it is a compensation for the mission of general interest the providers carry out and provided that this mission has been entrusted to them by an official act.[55]

Whilst healthcare regulation aims to ensure universal access to healthcare; to redress the important market imperfections in this sector and to guarantee that the limited available budgets are used in the most cost-effective way, the application of the EU Single Market rules challenge healthcare regulation. Commercial providers and purchasers can make use thereof to enter new markets, which can lead to more diversity in healthcare provision and more fragmented healthcare systems. Moreover, increased choice for patients and providers might undermine public support for the equity and solidarity principles underpinning European healthcare systems.

Second, healthcare policies are also addressed in voluntary EU level governance mechanisms. Since 2005, healthcare has been part of the open method of coordination for social protection and social inclusion (Social OMC). Through this, the EU provides a framework for national strategy development on social protection and social investment, as well as for coordinating policies between EU countries. The OMC objectives include access to high quality healthcare services, along with the financial sustainability of systems. Other voluntary co-operation mechanisms have also been set up on specific issues such as e-health and health technology assessment.

Third, the European sovereign debt crisis provoked a radical change in the way the EU engages in national health system reforms. EU institutions acquired unprecedented powers - especially in the Eurozone countries - to supervise national budgetary and economic policies. Within this context, healthcare systems are a particular target. Whereas, traditionally, EU involvement in this policy area was limited to supporting voluntary cooperation between member states, henceforth EU institutions are calling for major healthcare reforms as a means of consolidating public expenditure. Not only have the countries in receipt of financial assistance been required to implement the detailed list of reforms stipulated in their respective Memorandums of Understanding (MoUs); other Member States too have been encouraged to undertake reforms to their national healthcare systems and the EU has continuously strengthened its tools to enforce compliance.[56]

Under the European Semester for Economic Policy Coordination, an important number of Country-Specific Recommendations (CSRs) on healthcare have been issued and have grown in scope and detail. The focus of CSRs is mainly, but not exclusively, on fiscal consolidation; the call is for long-term structural reforms aimed at improving cost-effectiveness. The reforms stipulated under the MoUs, on the other hand, were not exclusively aimed at a more cost-effective use of financial resources but also include measures designed simply to decrease costs in the short term, thus shifting costs from the public system to patients and workers.

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54 Lear, J. and E. Mossialos (2010) 'EU competition law and health policy' in E. Mossialos, G. Permanand, R. Baeten and T. Hervey (eds.) Health Systems Governance in Europe: the Role of EU Law and Policy, Cambridge, Cambridge University Press.

55 Commission Decision of 20 December on the application of Article 106(2) of the Treaty on the Functioning of the European Union to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest, Communication from the Commission, European Union framework for State aid in the form of public service compensation (2011)

56 Baeten, R. and Vanhercke, B. (2016) Inside the black box: The EU's economic surveillance of national healthcare systems, Comparative European Politics, advance online publication 21 March 2016; doi: 10.1057/cep.2016.10

2.2 Methodology

Health issues in reference to the most vulnerable sections of the population - theme that constitutes the area of investigation of the present study - was analysed according to an alternative survey methodology with respect to the procedures of classical empirical research. The methodological system followed, in fact, was inspired by the canons of participation and active involvement of the target population in the co-construction of knowledge on the most salient health issues affecting the country today.

2.2.1 Participatory Action Human Rights and Capability Approach

RE-InVEST makes the links between rights and capabilities, with capabilities or resources and conversion factors understood as essential to turn abstract rights into real entitlements, 'to have the capability to make rights real and live a life one values'. Central to such concepts are key human rights principles including agency, participation, and voice which can be realised at an individual and collective level. This theoretical framework translates into our choice to work, to much as possible, within a transformative and participative methodology paradigm to answer core research questions, conduct our analysis and formulate potential solutions. This qualitative, participatory research is not suitable as a means to 'validate' or 'prove' hypotheses and we make no such positivist claim. Rather we combine qualitative research with quantitative data to deepen understanding of precisely how social investment in services and social policies relate to rights and capability.

As participative research the validity of our methodology lies in the co-construction of knowledge by a mixed group of researchers: academic researchers, NGO's and people experiencing poverty working through an iterative and ongoing process of action, knowledge creation and reflection. This practical utilisation of a capability approach in research methodology is a core outcome of the project. It is not just instrumental in facilitating a more grounded empirical answer to research questions but permeates our whole project. NGO's or civil society organisations and the representatives of vulnerable groups participating in the process enhance not only validity but our collective capacity to transform social environments, as such they are a core and valued part of our approach.

Participatory action research views participants as co-researchers who have special knowledge about their own situation. Hence they are not only 'interviewed' but take part in research by engaging in, examining, interpreting, and reflecting on their own social world, shaping their sense of identity. Crucial for this kind of knowledge generation is the 'merging' or 'crossing of knowledge' that comes from three parts: scientific knowledge as gained by researchers; knowledge which the poor and excluded have, from their first-hand experience, of the twin realities of poverty and the surrounding world which imposes it on them; and the knowledge of those who work among and with these victims in places of poverty and social exclusion (Figure 2.1).

Figure 2.1 Merging of knowledge

While flexible, PAHRCA entails a process of seven steps (Murphy and Hearne 2016) including commitments to action and outcomes, to ensure PAHRCA engagement is significantly deeper than data extraction. This participatory approach commits to not only document specific problems but to actively work toward change using the empowerment principles associated with PAR. This approach is adapted to engage with specific research questions, examining different areas of policy relevant to enhancing social investment, human rights, individual capability and collective agency.

2.2.2 Case study

The research was conducted by the researcher of CNCA, working in the area of mental illness and substance abuse services, an involved two types of stakeholders: a) medical specialist in the field of health policies and director of an health service for pathological addiction in the city of Alba (Piedmont, north-western Italy) and b) a group of our women aged between 25 and 52 years living in the area of Alba and characterised by different psycho-social vulnerability factors. Core to the methodology is a merging of knowledge between these stakeholders.

The qualitative approach included the following phases:

1. We worked with 4 out of 8 women already involved in RE-InVEST WP3 (cf. Rovere, 2016). We decided to continue the work already started within WP3 with the same group of vulnerable women to stimulate participation as much as possible, as well to foster their involvement in a sort of 'participative journey'.
2. We engaged in qualitative interviews with a key policy expert (with knowledge of policy formation, design implementation and evaluation of the health services especially those related to drug users and mental health).
3. On July 18, 2017 in the offices of Cooperativa Alice we facilitated action research and a dialogical merging of knowledge where policy expert, NGO representatives and vulnerable women came together to create new forms of understanding and dialogue and ultimately new knowledge about Italian health system, its problems and ways of functioning and current dynamics.

2.2.3 Overview of Italian health policy context

The Italian National Health System was born in the 1978 to substitute a previous Social Health Care Insurance Model.

While the 1980's represented a period when governments tried to implement the new institutional design, the 1990's were already a time of changes and attempts were made to shift to a more private-like system. The reforms had to follow a difficult path between cost containment (given the huge of public debt) and innovation.[57]

The 1990's

In this period we assist a shift of power and responsibilities from the national level to subnational (regional) governments. Following the rescaling/regionalisation reforms of the 1990's a large part of the regulatory public power in health care was shifted from National State to Regions. In this period the role of Regions changed due to the market process of strong political devolution definable as 'health care federalism'.[58] Since then two phases can be traced. The first starting in 1992 (with two bills n.502/1992 and 517/1993 respectively named, 'Riordino della disciplina in materia sanitaria' and 'Modificazioni al decreto legislativo 30 dicembre 1992, n. 502, recante riordino della disciplina in materia sanitaria') ended in 2001 (amendment to Art. 117 of Italian Constitution) and marked a shift in the balance of power between State and Regions

57 Pavolini, E. & Vicarelli, G. (2013). Italy: A strange NHS with its paradoxes. In Pavoli & Guillen (2013). Health care systems in Europe under austerity. Palgravi-McMillan, Pp.81-101.

58 Ibidem.

in favour of the latter: inside a relatively loose national institutional setting, regions were able to develop their Health care Systems with different choices in terms of provision organisation. The State essentially maintained two tasks (a substantial part of financing and setting 'homogeneous standards of health care provision' over the country), the Regions received all other tasks (from planning to managing health care provision).

In the same years and chiefly through the same laws and similar process, strong attempts were made to modernise the NHS administration following a new management approach: local health care authorities (Unità Sanitaria Locale USL) were transformed into health care agencies (Azienda Sanitaria Locale - ASL) and Hospital Trust (Aziende Ospedaliere). In connection to managerialisation the 1990's also witnessed the introduction of competition and a broader use of private providers within the NHS.

The 2000's

The 2000s were a time when no relevant policy reform was implemented: cost-containment policies in traditional 'State corporatist' WS fields coupled by no real 'functional' recalibration towards new social risks has meant that an overall retrenchment process took place in the country.

At the beginning of 2000' the central government attempted to find better ways of controlling regional health expenditure imposing tougher budget constraints (with Plans to cut health care deficits). Decentralisation made it more difficult to control expenditure, given the implementation of a regionalised and fragmented policy-making structure (Mosca, 2006).

In the 2001-2010 period, regions generated over € 38 billion of cumulative deficit, approximately 4.2% of the total expenditure over the period. This deficit has been highly concentrated in the Lazio, Campania and Sicily regions, which together account for 69% of the total cumulative deficit.

Given the fact that out of 21 Regional Health System, seven had significant deficits, these Regions in particular experienced more of a 'return' of Central Government in running their health care: the seven regions in difficulty are in such dire financial straits that they have been prepared to accept severe limitations of their freedom of action. This exercise of central spending power represents a dramatic break with the period pre-2001 when state financing was granted virtually unconditionally' (France, 2008: 18).

In terms of rescaling, the second part of the last decade witnessed a new (hidden) form of recentralisation of powers: the 'Piani di rientro' was a strong and effective tool through which National Governments could impose decisions to Regions with deficits (the closure of hospitals, the hiring freeze of new professionals, different drugs policies, etc.). Managers in the NHS have not seen any formal change in their status nor have new models of governance been introduced for local health care authorities. However year after year, Regional top administrators (Presidents, Health Councillors, heads of the Health Care departments, etc.) have gained an increasing amount of power over General Director.

Discussing privatisation we might refer to two different phenomena: the privatisation of expenditure (reduced state financing) and privatisation of providers (the State mantains its level of expenditure but it contracts out the delivery of health care services to private providers).

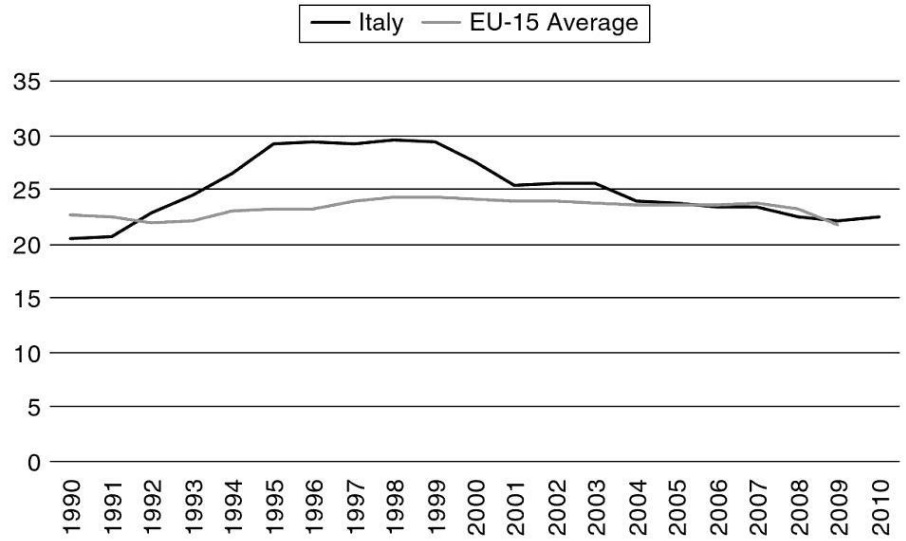
Comparing the data between 1990's and 2010's it seems that the second type of privatisation took place, whereas the privatisation of expenditure was more prominent in the 1990's than in the last decade.[59]

The incidence of private health expenditure in Italy in the period 1990-2010 followed a bell curve path. In the first part of the 1990s there was a dramatic increase in the share of private health expenditure on total health care expenditure: from 20.5% in 1990 to 29.4% in 1996. Then, at the beginning of the following decade (2000-2010), the situation changed and the distance between Italy and EU-15 narrowed down and no distance was visible from 2004 to 2010.[60]

59 OECD (2013). Health at a glance. Paris: OECD.

60 Pavolini, E. & Vicarelli, G. (2013). Italy: A strange NHS with its paradoxes. In Pavoli & Guillen (2013). Health care systems in Europe under austerity. Palgravi-McMillan, pp. 81-101.

Figure 2.2 Incidence of private expenditure on total health care expenditure



Source OECD, 2013

If a clear and explicit trend towards expenditure privatisation did not take place, some scholars argue that it took two other forms: reduction in the access to health care services and the partial transformation in the composition of private expenditure.[61] If an increase in the privatisation of expenditure took place mainly in the 1990s, then perhaps it assumed a more 'hidden' form whilst a more straightforward process could be detected in terms of privatisation of health care provision. At the beginning of the 1990s around 23% of total hospital beds in Italy were private. Two decades later they reached around 32%.[62]

The 2010's

Since 2010 no relevant explicit reform took place in healthcare. However the same cannot be said for the level of public expenditure. From 2010 cost-containment in the Italian NHS became the primary goal for Italian Government and from 2014 the Law introduced a freezing on new hiring and a robust new set of co-payments on health-care services.[63] In expenditure terms the distance in respect of the EU-15 has grown: Italian per capita expenditure in 2000 was 85.5% of the EU-15 average, in 2011 it dropped down to 77%.[64]

In more recent years, changes might strongly affect the functioning of the Italian NHS. The economic and financial crisis did not have a short-term impact on the public health care system. Until 2010 no relevant changes (cuts) were put in place, even if Italy maintained a relatively lower level of public expenditure: the public per capita expenditure in 2009 was equal to $ 3,137 (PPT) in Italy, and almost $ 4,000 in the EU-15.[65] Due to the huge public debt (around 120% of the national GDP) and the persisting financial crisis, 2011 was the first year which saw the Government intervene decisively in the NHS in terms of co-payments and public expenditure.

The 2011 'Finance Law', the main national law regulating the amount of resources given yearly to the public sector, marked a very important turning point for the Italian NHS: for the years 2013-2014, it introduced an amount of expenditure cuts equal to around € 8 billion (the overall NHS financing from the State in 2012 was around € 106 billion). Among the measures that the Law introduced there were the substantial

61 CEIS (2010).

62 Pavolini, E. & Vicarelli, G. (2013). Italy: A strange NHS with its paradoxes. In Pavoli & Guillen (2013). Health care systems in Europe under austerity. Palgravi-McMillan, Pp.81-101;
OECD (2013). Health at a glance. Paris: OECD.

63 (Jessoula and Pavolini, 2012).

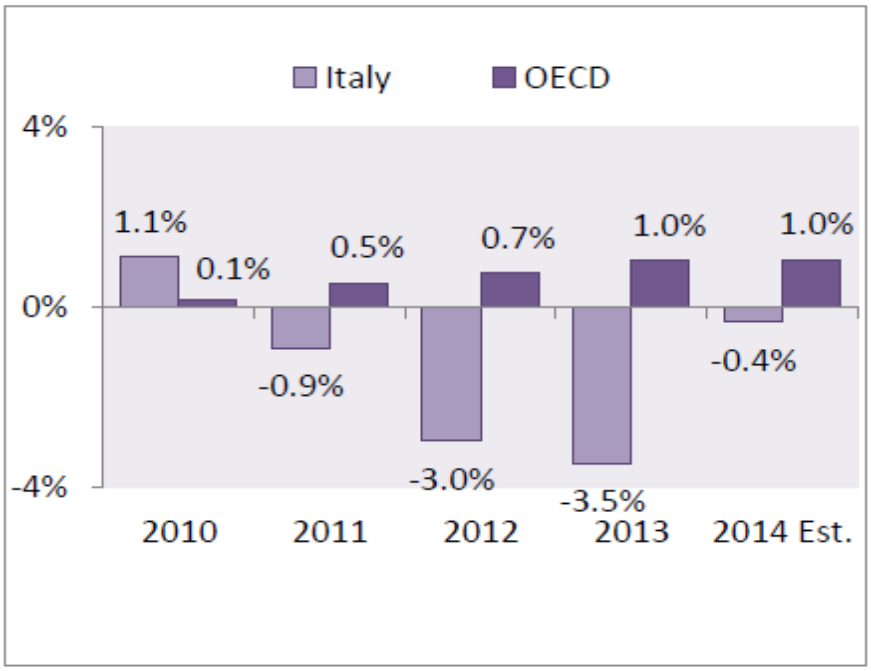
64 (Eurostat 2012-2014).

65 (OECD, 2012).

hiring freeze of new health care workers in the NHS; from 2014 there are new 'nationally set' co-payments on pharmaceutical goods and health care services, for an amount equalling € 2 billion.

Health spending in Italy continues to contract in 2013, per capita health spending in Italy dropped by 3.5% in real terms - the third year in succession that health expenditure has fallen in real terms.

Figure 2.3 Annual health spending growth 2010-2014

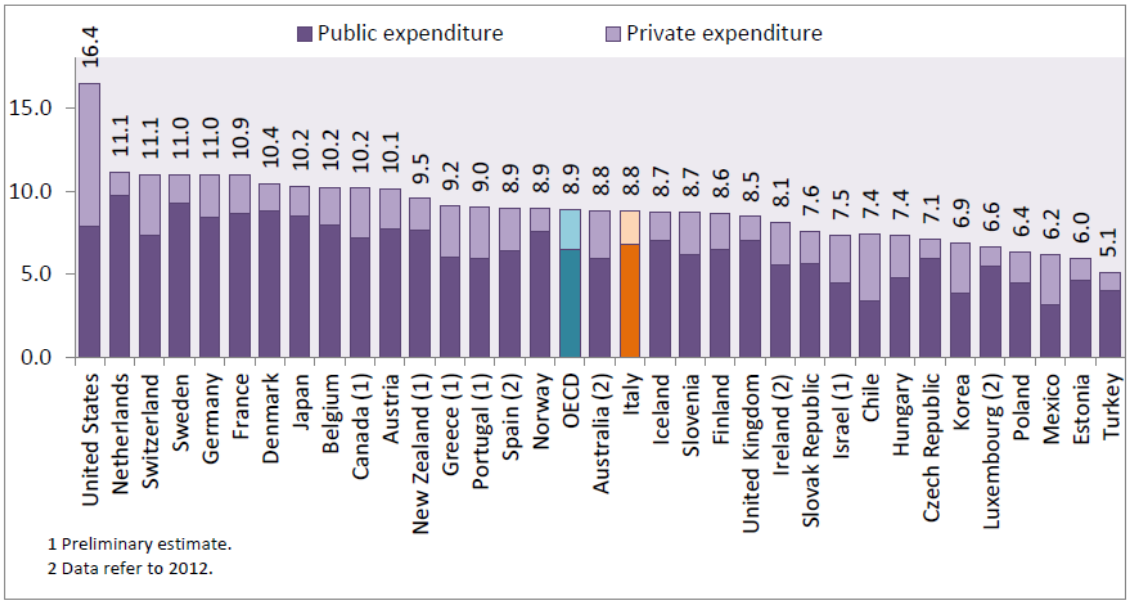


Source OECD Health Statistics, 2015)

Both public and private health spending have shown continuous falls since 2011. As a result, per capita spending on health in Italy remains at a level below that prior to the economic crisis. A number of cost-containment measures have been taken in the wake of the economic crisis to reduce public spending on health. Cuts in pharmaceutical spending, which were already targeted prior to the crisis, have contributed to the overall fall. The share of the generic market has increased, although it remains relatively low in Italy. In 2010: a 12.5% reduction in the retail price of generic drugs was brought in while the following year saw maximum reimbursement prices for generics established in line with prices in Germany, UK, France and Spain.

Health spending as a share of GDP in Italy remains just below the OECD average. Health spending in Italy (excluding investment expenditure in the health sector) was 8.8% of GDP in 2013 (Figure 2.4), slightly below the OECD average of 8.9%.

Figure 2.4 Health spending as share of GDP 2013



Source OECD Health Statistics, 2015

This has increased by one percentage point since 2003, mainly because of slow growth in GDP over this ten-year period. The share of the economy allocated to health spending is similar to Spain, Portugal and Greece, but well below the levels of France and Germany (10.9% and 11.0% respectively).

The share of government spending in Italy as a share of total spending on health has remained relatively constant over the last decade at around 77%. This is slightly above the OECD average of 73%. Among OECD countries, only the United States and Chile report public spending on health below 50%.

Although out-of-pocket spending at 22% of health spending has not increased in recent years, it remains relatively high compared with other western European countries such as France (7%), Germany (14%) and United Kingdom (10%), although still well below some other southern European countries such as Greece (31%) and Portugal (28%).

Figure 2.5 Trend: public health spending/GDP

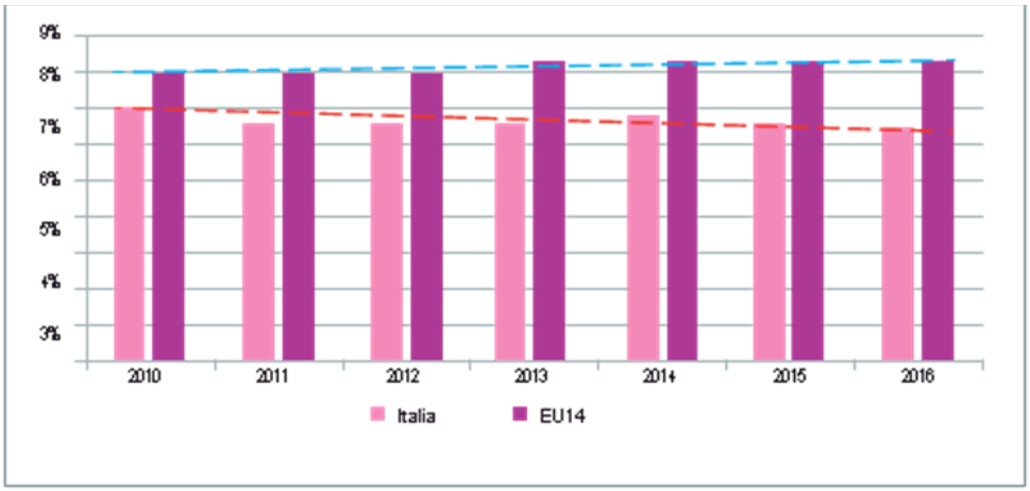
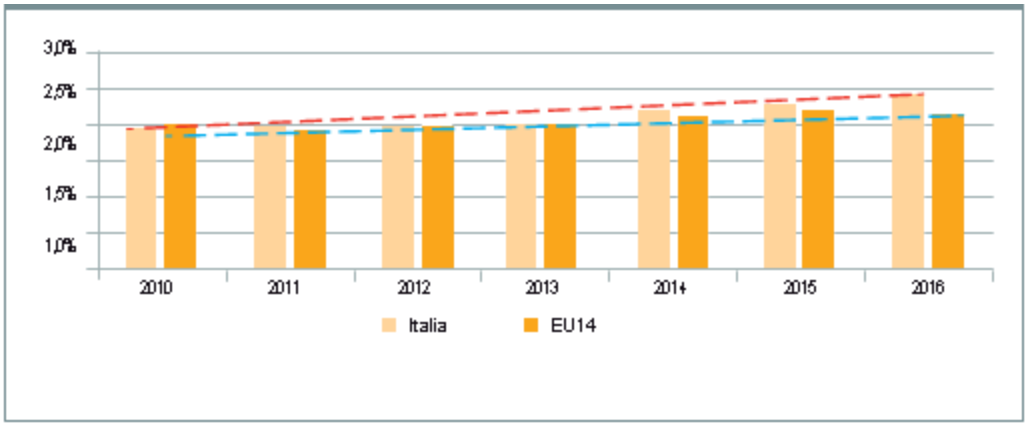


Figure 2.6 Trend: private health spending/GDP



The recent developments make one wonder for how long it will be possible to preserve universal access to health care and how much will the quality of such services be affected in the medium term. What seems to be at work is a potential 'policy drift' or gradual transformation. Formally no explicit reforms dismantling universalism has been promoted but severe cuts in public expenditure, changing in the rules concerning co-payments and hiring professional personnel can undermine the universalistic functioning.[66]

2.3 Health in a Human rights perspective: access, affordability, quality.

During the focus group and individual interviews we investigated participants' perceptions and evaluations about the Italian health services, analysing their experiences from the perspective of human rights and capability approach.

We report the main qualitative results in the following section through some quotations extrapolated directly from the discussion.

2.3.1 Quality and access

In 2000 Italy's healthcare system was regarded, by a World Health Organisation's ranking, as one of the best in the world[67]; since then, the performance has constantly decreased mainly because of the austerity policy[68]. This austerity policy is not justified by the Official OECD data which show that Italian Health Care expenditures are below the average in OECD Countries.

Our interviewed framed the quality of Italian health system as follows:

'I had a long time experience with the doctors and the healthcare system but to date I still have strong feeling of exclusion and many contradictions with doctors. I feel I criticise the over-specialist approach that goes today but leads to a fragmentary and somewhat delusional care'. M. FG.

'If I think about quality in the broader sense, it is difficult to make a net judgment, at times it has happened to me to be fulfilled, others are not. The problem is that everything seems somewhat uncertain... even when you ask others or seek for advice ... in short it is as if you could not have an assurance in terms of quality 'C.FG.

There seems to be a certain level of dissatisfaction beside feelings of uncertainty and restlessness.

66 Pavolini, E., Leon, M, Guillen, A., Ascoli, U. (2015). From austerity to permanent strain? The EU and welfare state reform in Italy and Spain. Comparative European Politics, 3, 1, 5676.

67 World Health Organisation (2000). Health system: Improving performance. World Health Report.

68 Petrazzuoli, (2016). Italian Primary Care System: an overview. Family Medicine & Primary Care Review 2016; 18, 2: 163–167.

Regarding the issue of involvement and participation as a form of patients' empowerment is an important aspect of a right-based approach. Patient empowerment and patient rights today are not specified by a single law but are present in several pieces of legislation, starting with the Italian Constitution and the founding law of the national health system. Despite the lack of systematic programmes or initiatives, the NHS reforms of the last 20 years have progressively recognised these principles and provided a number of tools for their implementation at several levels but no systematic strategy exists and implementation varies across the country, as does the satisfaction of citizens with the quality of health care.[69]

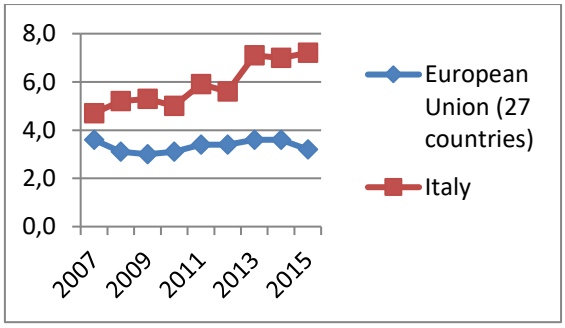
Today the health service quality erosion seems to involve the public and contractual component. Most Italians across the country and social groups are in line with the opinions we collected from our respondents, and in general people think that the health service of their region has worsened in the last two years and in the southern regions this worsening concerns structures and services that were already considered inadequate to local health needs. Today 45.1% of Italians think that the NHS has worsened in the last two years, + 2.4% compared to 2015.[70]

Considering the area of prevention as an indicator of quality of NHS, besides the perceived quality of citizen or the one based on outcome and health indicators, may be useful to note that the debate on sustainability of NHS since 2012 has been oriented almost exclusively to seek solutions to finance an expenditure that will continue to grow and not, instead, to look for solutions to prevent it from continuing to grow. The area of prevention is a strategic one where investments should lead (tomorrow) to a reduction in the number of people to be treated. Unfortunately, according to OECD data which indicate that spending or prevention has increased in the period 2005-2009 while has then decreased on average by 0.3% per year between 2009-2013, the area o prevention is one of the sectors that has suffered more cost-containment policies.[71]

Regarding the issue of access, actually the NHS provides universal coverage largely free of charge at the point of delivery.

However if we analyse the trend of people self-reported unmet needs for medical examination we can see a marked increase in the period 2012-2013, even more pronounced if we consider the weakest income groups (Figure 2.7 and 2.8).

Figure 2.7 Self-reported unmet needs for medical examination by main reason declared (too expensive or too far to travel or waiting list)

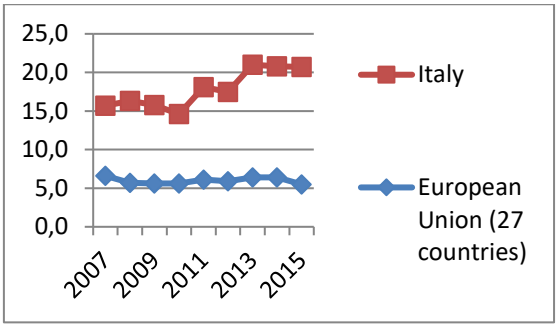


69 Ferré F, de Belvis AG, Valerio L, Longhi S, Lazzari A, Fattore G, Ricciardi W, Maresso A. (2014). Italy: Health System Review. Health Systems in Transition, 2014, 16(4):1–168.

70 RBM Censis, 2017; VII Rapporto sulla sanità pubblica, privata, intermediata.

71 Rapporto Osservasalute 2015. Osservatorio Nazionale sulla Salute nelle Regioni Italiane.

Figure 2.8 Self-reported unmet needs for medical examination by main reason declared (too expensive or too far to travel or waiting list) and income 1 quintile



Health-care delivery to vulnerable or excluded groups has undergone a recent change in policy. After several years without specific regulations, legislation has now been defined to guarantee that immigrants (both legal and temporarily undocumented) are eligible to receive the same public health-care services that are available to Italian citizens. However considering the important economic and demographic impact of immigrants[72] and their status of potentially vulnerable people, integration policies for foreign residents are still inefficient and sub-optimal.[73]

Other vulnerable groups are exempted from paying tickets for certain situations. This is the case for unemployed people, but this benefit declines as soon as income increases.

'It's true that there are unemployment exemptions but be sure that If you just earn something then you have no exemptions. And, among other things, to be certified as a condition is always a mess ... I do not know what is better or worse in the end ...' M. FG.

2.3.2 Private expenditure

The relative role and weight of healthcare spending increases for citizens, especially in the private component. This fact is particularly critical and disadvantageous for our interviewed, often affected by economic and working difficulties:

'With my monthly € 175 I have to be careful ... because if I buy too much on one side then I cannot buy the medicines I need.' M. FG.

'... And after paying all the expenses you need to move on, you still try to save a few euros because if you get sick at least you see a private doctor before you die in waiting list.' C. FG.

Less public health, more private health and even less health and hence less health for those who have economic difficulties or still cannot pay out of their pockets.

There are 10.2 million Italians who think as our women and who in recent years have resorted more to the private health services.[74] And it is a much more important issue, given that these are years of deep redefinition of family budgets, with costs decoupling.[75]From one side the crises reduces disposable income and thus privately paid demand; on the other side patient may be forced, because of cost containment

72 Immigrants represent approximately 7.5% of the national population (compared to a European average of 6.6%, contributing to 12% of GDP growth and doubling the country's fertility rate.

73 Associazione di Iniziativa Parlamentare Legislativa per la Salute e Prevenzione, 2013; European Observatory on Health Systems and Policies, 2014.

74 RBM-Censis, 2017 VII Rapporto sulla sanità pubblica, privata, intermediate.

75 The boom in private health spending, in 2015 rose to 34.5 billion euros, with a real increase of + 3.2% compared to 2013, almost twice the total spending on consumption. The increase in private health spending is more impressive given the deflating dynamics that, in the case of some health products and services, is significant (RBM Censis, 2017; VII Rapporto sulla sanità pubblica, privata, intermediata).

policies in the public sector, to pay higher co-payments or to go fully private. In this respect it is interesting to note the emergence of low-cost initiatives in the private sector, especially for dental care[76].

'My son was treated and we put dental support in a private dentist cabinet, a new one which works at advantageous prices and were you can pay in tranches. This is the only place I know where with € 30 people can access dental hygiene and a free visit. With them I saved € 600 for my son's treatment, compared to other places…and all costs were included ... I will finish paying in 8 months and then I will be a free woman (she laughs). I will not have that burden anymore ... if I had done this when he was younger I might have spent less.' C. FG

'I did it to the dentist for my son, to ask for a loan. But you know I could not sleep at night with the worry of funding ... anxiety!' C. FG.

It is the universe of denied public health that even tends to dilate and to develop a new geography of health system made of high barriers and new borders in access to the public services.

'I try to cope with the time of waiting lists by pushing on my own resources ... I clench the teeth and I think 'it will pass.' C. FG.

2.3.3 Waiting lists

The growth of private use seems to be due to a fundamental reason that prevails over the rest: the length of waiting lists.

'It happened with the ophthalmologist for my daughter. Within NHS we should have waited two or three months. On the other hand, by paying a private facility, we could have been visited the next day ... 'M. FG.

'... and this means attacking the right to health ...' C2. FG.

This is why citizens are turning to a private facility, followed by comfort reasons linked to long hours or weekend opening or the contraction of the performance offered in the public health service[77].

A recent survey compared the frequency of recourse to private care, paid out of pocket, for services that were also available free-of-charge from the NHS in Italy. This practice appeared to be common in Italy, mainly because of waiting times in public facilities.[78]

The 54% of Italians indicate the reduction of waiting lists as a priority of the National Health Service (62.6% of 29-44-year-olds, 59.1% of residents in the South). There are 31.6 million Italians who have urgently

76 In Italy inpatient care and primary care are free at the point of treatment. However, co-payments are required for diagnostic procedures, specialists, and prescription drugs. The size of such co-payments has crept steadily upward over the past decade and now runs as high as 30 percent for some services. The following services are offered to all residents: pharmaceuticals, inpatient care, preventive medicine, ambulatory care, home care, primary care. Cosmetic surgery is not offered for free and there are services which are only partially covered: orthodontics and laser eye surgery. Only a limited number of drugs are reimbursed (partially or totally). Many drugs which are reimbursed in most European Countries are not free in Italy: for example benzodiazepines, all drugs for venous disease except low molecular weight heparin, antispasmodics in tables (antispasmodics in injection are reimbursed), cough medicines, paracetamol, aspirin, many painkillers et cetera. The rules for this are established by the Italian agency for drugs AIFA with the assumption that only drugs with type A evidence in the Evidence Based Medicine can be offered for free by the public system, but there also other reasons mainly linked to the austerity policy [7]. Dental health care is included in the essential level of care for specific populations such as children (0–16 years old), vulnerable people (disabled people, people with HIV, people with rare diseases), and individuals who need dental health care in some urgent/emergency cases. For the rest of the population, dental care is generally not covered and is an 'expensive' out of pocket expenditure.
Exemptions from co-payment are applied to people aged over 65 or children less than 6 who live in households with a gross income below a nationally defined threshold (approximately € 36,000); people with social or minimum pension, unemployed people, people with severe disabilities, are also exempted from any cost-sharing. People with chronic or rare diseases, people who are HIV-positive, and pregnant women are exempted from cost sharing but only for the treatment related to their condition. Petrazzuoli, F. (2016). Italian Primary Care System: an overview. Family Medicine & Primary Care Review 2016; 18, 2: 163–167.

77 RBM-Censis, 2017 VII Rapporto sulla sanità pubblica, privata, intermediata.

78 (Domenighetti et al., 2010); European Observatory on Health Systems and Policies, 2014.

needed at least a health service and because of too long waiting lists in the public facilities have turned to the private. It is important to note, however, that the waiting list phenomenon also shows a consolidated growing trend. In fact, between 2014-2017 for the majority of the health services analysed there was a constant lengthening of waiting lists. [79].

Always waiting lists explain the use of *intra-moenia* doctors[80] by a lot of Italians. If the key reason is the length of the waiting lists and therefore the desire to access the benefits faster, however, sometimes the doctor directly suggests the use of paid healthcare within public facilities.

In some case there is a generalised experience of public ticket for a single healthcare performance equal or just above to the full rate charged in private facilities.[81] On the other hand, it is quite high the share of population who have perceived the reduction of prices in private facilities.
Ultimately, it can be said that the nightmare of waiting lists is too long and is the explanatory spine of the Italian healthcare behaviour of these years.

Citizens have to wait a long time to have public performance, and when they have access, they will have to face costs that are not always far from those with whom they can access the private: here is the new framework in which the Italian health choices are placed.

2.4 Impact on individual capabilities

In general, there is a situation where the average citizen has to wait longer to receive healthcare services and the share of private healthcare spending is increased. With these premises, those who can often opt to resort to paid health-care.

In this context, available financial resources is therefore a decisive factor in scanning choices and opportunities in health.

The problem with respect to the economic factor as a criterion that can guide choices and opportunities is, however, that the most vulnerable are often not in the condition to resort to private health or, if they can do so, this has for them of very high costs.

Vulnerable women taking part in the research reported a reduction of protection and opportunities in the health services that can be seen as a critical factor threatening the capabilities to live a full human life of normal length and to enjoy bodily health.

'Then I think that in a few years we will do as they do in the US, where you need to have insurance or a credit card to face your health needs ... but who does not have these options what will he do? What will happen to vulnerable people? M. FG.

The economic crisis penalises women in terms of health: the interviewees in fact seem to give up taking care of themselves to dedicate expenses to the family.[82]

79 RBM-Censis, 2017 VII Rapporto sulla sanità pubblica, privata, intermediata.

80 Intra-moenia doctors are health workers who exercise their private activity in the intra-moenia regime, within the public healthcare hospitals where they are already employed operating within the National Health Service.
RRBM-Censis, 2017. Rapporto sulla sanità pubblica, privata, intermediata.

82 According to some recent data presented by the Ministry of Health, women have a greater frequency of access to health services, generally take more drugs and manage family health problems. According to ISTAT data, 8.3% of Italian women report a poor state of health against 5.3% of men. Disability is also more common among women (6.1% compared to 3.3% of men). They live more, but not well, therefore. Access to health services (58% of outpatient accesses) is not only due to their role as family care-giver, but also due to the fact that they get sick more; moreover, they often go to the consultors, they regularly worry about their prevention (Pap test) and because of the use of continuous drugs like the contraceptive pill they have more regular contact with the general practitioners. The most frequent reasons for consultation include upper respiratory tract diseases, urinary tract infections (and in particular cystitis), gastrointestinal disorders, depression, anxiety and, last but not least, female-related reasons such as menopause, pregnancy and prescription of contraceptive or substitutive estrogen-progestin therapy (cf. Ministero della Salute (2016). Il genere come determinante di salute. Lo sviluppo della medicina di genere per garantire equità e appropriatezza della cura. Quaderni del Ministero della Salute. 26, 4, 2016. ISSN 2038-5293.

'To keep my diabetes under control, the doctor prescribed a series of medical tests ... and counting the ticket for each prescription I would have spent more than € 100 ... at the end I had to wait a couple of months ... I already had to pay for my son's school books.' C2. FG.

Obviously this trend can favour the general increase in the incidence of the main gender pathologies - from mental disorders, to tumours, to cardiovascular diseases.[83]

Also, regardless of a gender reading of the phenomenon, recently, more stringent cost-containment measures have been introduced, including the reduction of hospital beds, promoting lower hospital admissions (by increasing the use of appropriateness criteria to avoid unnecessary admissions) and also reducing the average length of stay.

'Well in general what we have seen now, for example in hospitals, is the reduction in the number of beds (or the aggregation of some departments), the tendency to act on the criteria of hospitalisation with a number of economic strategies as well as to minimise the duration of hospitalisation MD. Individual interview.

In addition, in response to the financial crisis and the stricter public budget imperatives of the European Commission and the European Central Bank, the national government cut central transfers to regions and local governments for services dedicated to disability, childhood, migrants and other welfare policies, beside healthcare.[84]

The lack of investment strategies in the NHS emerges also if we assume the standing point of health workers:

'We witness the erosion of working hours (retirees are not being replaced) and turn-over block of staff; aging health-workers and indirectly negative outcomes on users.' MD, Individual interview.

2.5 Impact on 'collective capabilities'

What scenario emerges of the NHS in terms of the collective capabilities of groups and organisations?

From the standpoint of belonging to particular social groups, the words of our interviewees seems to describe a fragmented health services system that is likely to erode the social-relational tissue of the community:

'It is not a question of being racist but I wonder if giving health care to all the immigrants arriving as well as the citizens who pay 40 years' fees is the right thing to do.' M. FG.

Analysing the dynamics that characterises the NHS today from the point of view of organisations, an overall logistical and economic rationalisation strategy is inspired by national cost containment policies. This strategy however runs the risk of being intricate, adversely affecting health services and citizens.

'Today administrative procedures governing spending are undergoing a strong slowdown; the timing of the procedures is expanding strongly ... the attempt to make procurement more transparent and fair is admirable ... but so the risk is blocking a system, losing resources and this obviously has implications for service and users.' MD, Individual interview.

Since January 2016, a common trend has been the establishment of larger healthcare organisations, namely among Local Health Authorities (LHAs). This re-sizing of LHAs derives from the rationalisations begun in 2012 as a result of the national spending review which aimed to address unprecedented fiscal pressures.[85]

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83 For an Italian woman out of four, prevention and treatment are neglected because of the crisis. ONDA (2012). La salute della donna. Analisi e strategie di intervento. FrancoAngeli.
Ministero della Salute (2016). Il genere come determinante di salute. Lo sviluppo della medicina di genere per garantire equità e appropriatezza della cura. Quaderni del Ministero della Salute. 26, 4, 2016. ISSN 2038-5293.

84 European Observatory on Health Systems and Policies, 2014 Vol. 16 No. 4

85 OASI (2016) Chapter 3 'Strutture e attività SSN'. Rapporto OASI, Cergas Università Bocconi, Available at: https://www.unibocconi.it/wps/wcm/connect/Cdr/Centro_CERGASit/Home/Area+download+Rapporto+OASI+e+Mecosan/

'The aim of mergers and centralising processes is to achieve efficiency gains and improve quality of care through organisational integration ... However, their effect will be clear only after implementation. Indeed, organisations currently are dealing with managerial and governance issues to make them work.' MD, Individual interview.

Always from 2016, and by promoting the new Code of Conduct and Concessions on Procurement[86] National Government should streamline some procedures, make them more transparent and strengthen the control by the National Anti-Corruption Association (ANAC), also governing for the first time (!) the public-private partnership institute (PPP).

'The new procurement management legislation is a pretty strong change. It's good to have more control over the procedures so that scams and waste are avoided, but today it is very laborious and there is a risk that some resources and funding to ensure the provision of services will be lost... or that we strive for balance with actors from the third sector with whom we have been working well for years ... in some cases the calls for applications require the participation of a number of candidates who maybe are not even in the territory there! Or maybe they can come from outside with cheap bargain deals ... and ultimately the risk is compromising the quality of the service we offer.' MD. Individual interview.

A recent taxonomy of waste in Italian healthcare assigns the first two places respectively to the overuse of ineffective, inappropriate and low-value services and health services (at all levels of care and by all health professions and specialised disciplines; 30% of total waste) and the vast fraud network which constantly erodes valuable resources to public health (20% of total waste).[87] Undoubtedly, for some categories of waste, the institutions are going in the right direction, at least at the regulatory level: national anti-corruption plan, selection criteria for general managers, centralisation of purchases, the digital health pact. Other actions still remain a mirage, including the integrated reorganisation between hospital and primary care (strongly linked to regional policies) and above all the contribution of professionals in defining health services and services from which to disinvest.

Connected to the organisational dynamics affecting Local Health Authorities, it seems to emerge a second set of collective issues regarding NHS, this time in the geographic sense and territorial affiliation. Because of regional differences in policies and financing, a large *vertical fragmentation* exists in the extent and the quality of health strategies between regions or ASLs of excellence, which are mainly found in the northern part of the country, and other areas. Health quality outcomes almost show a clear North-South divide in almost all health care sectors. Disparities can be found in almost any area of health care provision, in health policy making, health care expenditure, quality of health care, public satisfaction and health care services organisation.[88]

'Unfortunately I came from a period when I had to attend my father at the hospital. He was in Rome and he was hospitalised down there ... I'm sure there's a big difference in how things work out here ... maybe it's due to the big city but I assure you it's a delusional ...' C. FG.

In addition, *horizontal fragmentation* undermines the continuity of care for some diseases but also the construction of mixed partnership and projects, as integration between actors of health care (ASLs), social care (municipalities) and others varies across the country and is mostly incomplete. We can find examples of this fragmentation in the division between the prevention and rehabilitation areas of treatment (usually managed by different structures) or the division between outpatient and specialist/inpatient care, not to mention the tiring relationship between social care and health care services.

86 Legge Delega del 28 gennaio 2016 n.11. Deleghe al Governo per l'attuazione delle direttive 2014/23/UE, 2014/24/UE e 2014/25/UE del Parlamento europeo e del Consiglio, del 26 febbraio 2014, sull'aggiudicazione dei contratti di concessione, sugli appalti pubblici e sulle procedure d'appalto degli enti erogatori nei settori dell'acqua, dell'energia, dei trasporti e dei servizi postali, nonche' per il riordino della disciplina vigente in materia di contratti pubblici relativi a lavori, servizi e forniture. (16G00013).

87 OECD, (2017). Tackling Wasteful Spending on Health.

88 Petrazzuoli (2016). Italian Primary Care System: an overview. Family Medicine & Primary Care Review 2016; 18, 2: 163–167.

'Some time ago we developed a video-making-based prevention project thanks to the active engagement of schools, which set the hours-work of their students' curricula. It was a project with very low economic impact but very high content. And I think these are the kind of strategies to promote, among the actors of the system ... in this case health and education/training.' MD. FG.

Today Central Government, using financing power as leverage, is regaining a more central role within NHS an RHS. This however applies to Regions with higher deficits whilst other Regions still enjoy a high degree of freedom. These last years of spending cut experience in the weaker Regions have undoubtedly led to a positive result in achieving budget balance, but the focus has been mainly on economic factors. The consequence was a further gap in the delivery of essential level of care between the virtuous and the returning regions, with the risk of deteriorating the quality of the care provided, even in the virtuous regions due to strategies mainly inspired by cost-containment objectives.

3. Conclusion: policy recommendations to counter social disinvestment

To summarise the recent developments of the NHS in Italy, one could say that great attention has been posed to the 'rebalancing of the accounts' and little to 'upgrading' the system. 'Cutting' and 'cost containment' rather than 'investing' strategies seemed to be implemented in a more or less explicit way.

In the last five years the NHS has been targeted by a number of policies aimed at containing or even reducing health expenditure without reducing the provision of health services to patients. To a certain extent, these policies have been effective as expenditure is now under strict control and industrial relations within the NHS have not worsened. However, citizens' perception of the quality of services has declined slightly. Overall, the NHS is clearly strained due to the long period of cost cutbacks and there are clear signals that the economic crisis has worsened some health outcome indicators and increased demand for a variety of services. With some very specific exceptions the crisis has generated a double burden for the health-care system: it has increased demand for health care and at the same time has reduced available resources due to fiscal constraints.

Given current financial constraints, waiting times are on the rise and continuity of care and intermediate care for chronic diseases is increasingly difficult to ensure. While so far the SSN has been able to cope with the crisis, it is unlikely that it can keep on offering the present level of services if resources are reduced further. While efficiency improvements are always possible, it is unlikely that further cuts can be made without reducing the quantity and quality of care provided to patients.

No relevant explicit reform took place in the healthcare sector in Italy. However the same cannot be said for the level of public expenditure. The Government intervened decisively in the NHS in terms of co-payments and public expenditure which respectively continued to expand and contract since 2011.

After the recent cuts to 'unnecessary' benefits, the government goes on with a de facto 'privatisation' of the national health system. And for citizens caring will become more expensive. The most evident sign is the decline in Italian healthcare spending, which has reached the lowest level in the last ten years (6.6% of GDP), relegating Italy to the third-last place among the OECD countries. The contraction of public spending inevitably pushes patients into the arms of private health care system. If the public service does not work or is slow, the citizen who needs treatment can end up paying his own money. The proof of a progressive 'silent privatisation' of health manifests itself with the progressive contraction of the role of the public in the name of public spending review.

Some recommendations

- Promoting the use of equivalent medicines at all levels of NHS (suppliers, doctors, patients).[89] According to the NHS Sustainability Observatory, the use of equivalent drugs (and the corresponding over-use of brand-name drugs) is a major priority, because the shift from brand vs equivalents is a concrete strategy to increase the return in terms of health of money invested in healthcare (value for money).
- Investing (or at least reducing cuts) in the area of prevention.[90] The recent debate that has animated the discussions on sustainability of NHS since 2012 has been oriented almost exclusively to seek solutions to finance an expenditure that will continue to grow and not, instead, to look for solutions to prevent it from

89 Cartabellotta, Iacono (2016). Il sotto-utilizzo dei farmaci equivalenti in Italia. Evidence, 8, 10. Pp.

90 Italy spends in prevention just 0.5% of total health spending , against an EU average of 2.9, over which countries such as Germany (3.2), Sweden (3.6), the Netherlands (4.8) and Romania (6.2). OECD (2012). Health at a glance: Europe 2012.

continuing to grow or at least grow at rates minors. The adoption (today) of measures aimed at increasing investments in prevention should lead (tomorrow) to a reduction in the number of people to be treated. Adopting such an approach would therefore also mean looking at health spending more in terms of spending on investments and study and implement strategies that will not necessarily be limited to interventions in the health sector.

- Promoting e-health tools.[91] In the perspective of the Europe 2020 Strategy, the process of digitisation of Italian health still appears to lag behind the majority of EU countries. The process of digitisation of NHS is counted among the priority actions, as a fundamental step to improve the cost-effectiveness of health services, to limit waste and inefficiencies, to reduce differences between territories as well as to innovate front-end relationships and to improve perceived quality from the citizen.
- Reducing contracting fraud,[92] actions in this direction have already been initiated by promoting the new Code of Conduct and Concessions[93] that should streamline some procedures, make them more transparent and strengthen the control by the National Anti-Corruption Association (NAC) and governed for the first time (!) the public-private partnership institute (PPP).
- Reducing waste of health money. Today about 20% of health spending is wasted.[94] A recent taxonomy of waste in Italian healthcare assigns the first place to the overuse of ineffective, inappropriate and low-value services (followed by the vast fraud network). Undoubtedly, for some categories of waste, the institutions are going in the right direction, at least at the regulatory level (national anti-corruption plan, selection criteria for general managers, centralisation of purchases, the digital health pact). Other actions still remain a mirage, including the integrated reorganisation between hospital and primary care and the contribution of professionals in defining health services and services from which to disinvest.
- Promoting empowerment strategies at all levels of NHS[95] and especially of patients with chronic diseases.[96] Empowerment processes in health are a useful tool to facilitate the provision of effective and appropriate treatment from a clinical and ethical point of view and, at the same time, guarantee the highest possible level of equity in the use of resources.
- Consider the interaction between policy areas of investment (work-health-house etc, ...).[97] Policies of social investment should be integrated to be fully effective. These strategies should be thought of as a 'package' of policy measures to be implemented in a consistent and coherent manner. Policy interventions should be conceived in a life course perspective, i.e. they should represent a continuum of actions accompanying people throughout the key stages of their lives: childhood, working-age and parenthood, and old age. On the other hand, measures related to the various policy areas should be complementary and mutually reinforcing. In other words, the development of institutional complementarities is a necessary condition for the implementation of successful social investment strategies.

91 Censis, (2016). Le condizioni per lo sviluppo della Sanità Digitale: scenari Italia-UE a confronto.
OECD (2010). Improving Health Sector Efficiency: The Role of Information and Communication Technologies.

92 Del Monte (2014). Buone pratiche e strumenti anti-corruzione per il settore sanitario. Rapporto Transparency International Italia.

93 Legge Delega del 28 gennaio 2016 n.11.

94 OECD, (2017). Tackling Wasteful Spending on Health.

95 Agenas (2010). Il Sistema sanitario e l'empowerment. I Quaderni di monitor. Elementi di analisi e osservazione del sistema salute, 25, 2010.

96 Today 38% of the population has at least one chronic disease, up 74.8% in the population aged 65-74 and over 85% in over 75. (Meridiano Sanità, Rapporto 2016).

97 ESPN (2015). Social investment in Europe.

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RE-InVEST - Rebuilding an Inclusive, Value-based Europe of Solidarity and Trust through Social Investments

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