Department of Political Science

Chair: Analysis and Evaluation of Public Policies

HEALTH INEQUALITY AND HEALTH POVERTY: AN ANALYSIS OF THE SITUATION AND POLICIES IN THE ITALIAN SCENARIO

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Introduction

How much is health worth to us? Italian people – or at least the 80% of them – regard it as the highest value in their life, together with family, with a growth of 61% since 2011[1]. As the old sayings go, “health always comes first”[2] and “health is the true wealth”[3]; however, there is something that has eluded folk wisdom, that is, the fact that wealth is becoming increasingly more relevant – or, better, essential – in order to enjoy good health. Indeed, a low socio-economic status is the main risk factor for our health, for a series of reasons that will be developed throughout this thesis.

The Italian healthcare system, thoroughly reformed in 1978, is founded on the idea of health as an inviolable human right and revolves around two main concepts: equity and universalism. These two values are, indeed, more than coherent with the Italian Constitution, and contribute with the establishment of one of the best healthcare systems in the whole Europe – being Italy the country with the highest longevity. Healthcare is freely distributed on a non-discriminatory basis, comprising emergency care, general medical services, hospitalization, and a good share of pharmaceuticals. Despite this, considering the fact that not all services are freely provided, Italy is not exempt from socio-economic disparities that often cause difficulties for individuals and families in accessing what is necessary for them.

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[1] “Salute. È il valore più importante per l’80% degli Italiani, ma il 36% non fa prevenzione”, Quotidiano Sanità, http://www.quotidianosanita.it/studi-e-analisi/articolo.php?articolo_id=19829#:~:text=20%20FEB%20%2D%20Negli%20ultimi%202,rispetto%20al%2061%25%20del%202011

[2] “La salute prima di tutto”

[3] “La salute è la vera ricchezza”

For this, the main object of this dissertation is health inequality and health poverty as its direct consequence. As a matter of fact, these two issues are gaining increased importance in the Italian social dialogue, considering the impact that they are directly having on our country. In fact, inequality and poverty have been exacerbated from the moment of the financial crisis that hit Italy since 2009. Another element that has boosted these phenomena was the need of contractions in the healthcare expenses in a series of reformation of the SSN coming from the necessity of improving economic efficiency. The analysis of health inequality and poverty will be developed across different levels, beginning with a series of general definitions until reaching the core of the thesis, that is, the situation that Italy is currently facing with regards to inequalities and poverty in the healthcare sector. In particular, the thesis is divided into four chapters, with a progressive focus on the actual situation in Italy and Europe.

The first chapter is organized in a way to offer the definitions of the concepts that will be treated in the thesis itself, like health, inequality and poverty: it is important to have clear in mind all the meanings of these terms to better understand the rest of the work. Indeed, all three of them are not straightforward terms: health is not an easy concept to define, and inequality and different types of both poverty and equality (and, consequently, inequality) do exist. In addition, the chapter also explains the ways in which they have been historically addressed through international policies and provisions or in different scholars' works.

After a more international vision, the second chapter starts to concentrate on Italy, the main focus of this work. It provides a general overview of the history of the Italian SSN, and the reforms that it has undergone since its establishment in 1978, presenting the main principles on which it was created and the way in which it operates nowadays.

Here, great relevance is given to the system through which the SSN is financed, in order to better frame what is covered by the State and the Regions and what are the expenditures borne by the citizens. Furthermore, the last section of the chapter is dedicated to data and statistics about the Italian population demography, state of health, and the performance indicators of its healthcare system.

As previously briefly mentioned, these first two chapters are more descriptive and serve as steppingstone for the development of the most important part of the thesis, in which the main aspects will be investigated. To be more precise, they will be instrumental to better understand what is happening nowadays and what could potentially be the future in Italy. Once provided the instruments to understand situation in Italy, we start with the second and more analytical part of the thesis, the third and the fourth chapters.

The third chapter is a window on the Italian society and, specifically, on how it is affected by the issues of health inequality and health poverty. In building this chapter, a lot of space is given to data: their aim is to demonstrate how huge the analyzed phenomena are becoming year after year. There is also an attempt to understand how they may have gained foothold in a country like Italy and what may “justify” them.

To conclude, the fourth and final chapter issues the fact that there seems to be no public commitment towards health inequality and poverty, and analyzes the existing attempts coming from diverse actors. For instance, there is the recognition that the third sector is playing an essential role in contrasting poverty, as the operate of the Onlus *Banco Farmaceutico* involved in the collection and redistribution of medicines; this is not enough, though, to tackle those ever-growing phenomena. Therefore, some other examples of attempts of policies are made.

This work is built around two main questions: the first one is the attempt of understanding whether the evolution of inequalities may have consequences on inequality and poverty in the healthcare sector. In other words, what this thesis is trying to understand is whether health inequalities – and poverty – are directly, or at least in part, caused by the way in which Italian society is constructed and its SSN structured. On the other hand, the second and most relevant hypothesis concerns the idea that health inequality and poverty – although increasingly alarming – still are struggling to enter the institutional agenda, and there are no effective policy response coming from the public sector. There is awareness about the fact that inequality within the Italian scenario is becoming an impelling problem; however, despite this, no targeted measures to tackle this issue are designed.

In order to construct this dissertation, both qualitative and quantitative researches have been conducted. It has been essential to study data and statistics kept from databases provided by reliable first-hand sources such as Istat, OECD, or the European Union. In this way, it is possible to get scientific insights on the matters, to be elaborated in a coherent and unitary discourse. At the same time, qualitative research has been of equal importance: in particular, reading about other scholars' works – with already coded information – is a certainly useful starting point for conducting personal analysis.

Chapter I

Health Inequality: Definitions and Applications

CONTENTS: 1.1 RIGHT TO HEALTH: REALITY OR UTOPIA? – 1.2 CONCEPTS AND DISCUSSION: 1.2.1 INEQUALITY AND POVERTY – 1.2.2 SUSTAINABLE DEVELOPMENT GOALS – 1.2.3 INEQUITY IN HEALTHCARE – 1.3 EXAMPLES OF PUBLIC POLICY RESPONSES: HEALTH FOR ALL (1980) AND HEALTH 2020 (2020) – 1.4 HEALTH INEQUALITY IN EUROPEAN COUNTRIES: DATA AND FIGURES

1.1 Right to Health: Reality or Utopia?

One of the most famous definitions of health is provided by the WHO. In the first article of its Constitution of 1946, it is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[4]. Thereafter, the constitutional text continues by underlying the essentiality of the health as a human right: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition"[5]. Moreover, the right to health is something stressed also in the *Universal Declaration of Human Rights* of the United Nations: "Everyone has

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[4] WHO, "Constitution of the World Health Organization", 1, https://www.who.int/governance/eb/who_constitution_en.pdf

[5] Ibid.

the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”[6].

Starting with these quite basic assumptions and considering the way in which we personally value health in our everyday lives, we may easily understand how it should be vital for anyone to be assured a certain level of health status. However – despite the universal formal recognition of the fundamentality of a good-health status – the pursuing of health is strongly dependent by variables cited in the Constitution itself of the WHO, that is, the economic, social, and cultural situation of the individual. Every person in the world is defined by a huge range of endless differentials that may influence his/her life experience. For this reason, the fact that health should belong – in equal measure – to anybody – cannot take into account the existing inequalities among countries, regions, social strata, and even families.

“The right to health complements the concept of equity in health by implying that the reference for measuring and comparing equity should be the group in a society that has the optimal conditions for health. Health equity research and analysis are crucial for providing content to the concept of the right to health and for guiding the implementation of state obligations.”[7] The industrialization and economic development of the Western countries have done nothing but exacerbate differences between the rich and the poor or, even better, the less rich since, how we will see, it is not just an issue concerning poor people: “This social gradient runs right through society in a graded fashion. Groups at

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[6] UN, “Universal Declaration of Human Rights” https://www.un.org/en/universal-declaration-human-rights/

[7] WHO, *Health 2020 – A European policy framework and strategy for the 21st century* , 42 https://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf

particular risk are e.g. children to single parents with limited education and low incomes, lonely elderly, migrant workers, long terms unemployed and those working in high risk occupations from a physical and/or psycho-social point of view”[8]. Not to consider, at this point, Eastern countries, which suffer an enormous gap between their health conditions and those of the West. This is exactly what we are going to analyze in the chapters of this dissertation, that is, the different conditions of individuals that unavoidably may influence the quality and quantity of health received: in this case, we talk about health inequalities.

1.2 Concepts and Discussion

1.2.1 Inequality and Poverty

Before starting a detailed analysis on health inequality, it would be relevant to begin from a broader context of what inequality actually is and the ways in which it may influence one’s status of health. From a definition offered by the UN, we read that inequality is “the state of not being equal, especially in status, rights, and opportunities”[9]. Inequality, however, is a concept that cannot be defined in a single way. It is too broad and presents many facets: for instance, we may talk about economic inequality if strictly related with the monetary conditions of individuals, or social inequality when other aspects have a role in this status – and the discussion in this thesis will deal with both of

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[8] Dahlgren, Whitehead, “Policies and strategies to promote social equity in health”, 5

[9] UN, “Concepts of Inequality”, 1
https://www.un.org/en/development/desa/policy/wess/wess_dev_issues/dsp_policy_01.pdf

them. Then, we can also distinguish two kinds of economic inequality: inequality of outcomes and inequality of opportunity.

A scholar that dedicated much of his life to the study and definition of inequality – also associated with the concept of poverty – is the English economist Anthony Barnes Atkinson. Through the years, he made a great contribution to the analysis and the development of these two concepts: he completely revolutionized the way of valuing these two variables thanks to the elaboration of measurements of both global poverty and inequality [10].

He studied poverty and inequality both from a theoretical – based on calculations – and an empirical point of view. According to him, in particular, poverty is a direct consequence of a growing inequality: while during the 1960s income inequality was around 25%, since 1980s it rose and reached 35% [11] starting to become an issue of deep interest. About inequality and its potential resolution, he thought that: “we are not at the mercy of forces outside our control. […] If we want to reduce inequality then there are concrete steps we can take”. He suggested a multilevel approach to tackle inequality not just from an economic point of view but with a strong social component. Citing his words, he specifically affirms that it is quite useless a “tripartite representation from employers, trade unions and the government. Rather, I would see a wider body with representation from NGOs, from groups such as CPAG[12] and Save the Children, from bodies such as RSA, and from consumers such as workers and employers […] These are all subjects on which we need a national conversation, not decisions behind closed

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[10] It is renowned his Atkinson index, used to calculate income inequality

[11] “Sir Tony Atkinson on Inequality”, posted June 2, 2015, https://www.youtube.com/watch?time_continue=347&v=BEpcQEfmOQI&feature=emb_logo

[12] Child Poverty Action Group

doors"[13] . He had quite an optimistic vision about inequality, but the steps that should be followed are very clear and, though, not so easy to pursue.

Likewise, the concept of poverty is almost impossible to define rapidly. As we read in "Statement of Commitment for Action to Eradicate Poverty" published in 1998 by the United Nations,

> Fundamentally, poverty is a denial of choices and opportunities, it is a violation of human dignity. It means lack of basic capacity to participate effectively in society. It means not having enough to feed and clothe a family, not having a school or a clinic to go to, not having the land on which to grow one's food or a job to earn one's living, nor having access to credit. It means insecurity, powerlessness and exclusion of individuals, households and communities. It means susceptibility to violence and it often implies living on marginal and fragile environments, not having access to clean water and sanitation[14].

As for inequality, the concept of poverty may be fractured within more specific definitions that make it be better understood.

First of all, we may distinguish poverty through a classification provided by Benjamin Seebohm Rowntree; he talked about primary and secondary poverty. The first one refers to the condition in which an individual does not have the means to be able to provide for himself/herself a series of standard needs as food, water, clothing, housing, and other essential services. The latter belongs, on the other hand, to individuals who

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[13] "Sir Tony Atkinson on Inequality", posted June 2, 2015, https://www.youtube.com/watch?time_continue=347&v=BEpcQEfmOQI&feature=emb_logo

[14] UN, "Statement on commitment for Action to eradicate poverty adopted by administrative committee on coordination", https://www.un.org/press/en/1998/19980520.eco5759.html

would have the money to satisfy those basic needs, though they decide to spend it in other ways – continuing therefore to live in poverty conditions[15].

While this is a way of classification that does not consider the relationship of the individual with the surrounding world and society, we have another – surely more used – way of defining poverty, that is, the distinction between absolute and relative poverty. Absolute poverty is really similar to the just mentioned definition: it is the state of living of an individual who cannot satisfy his/her and his/her family's bare necessities. As Rowntree's definitions, this does not take into consideration the society a person lives in. However, this is an important datum to consider and, indeed, when we need to measure one's life status compared with the context, we use the concept of relative poverty: "Relative poverty is when households receive 50% less than average household incomes […] This type of poverty is changeable depending on the economic growth of the country"[16]. Relative poors, in other words, do not necessarily live in conditions of complete deprivation: what is underlined here is that they also have to be compared with the standards of life of other citizens of a State.

1.2.2 Sustainable Development Goals

Atkinson's works both about poverty and inequality have inspired a really actual approach promoted by the United Nations, that is, the *Sustainable Development Goals* – also referred to as *2030 Agenda*. The program was signed in 2015 by 193 Member States

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[15] Rowntree, *Poverty: a study of Town Life*

[16] "Relative vs Absolute Poverty", https://www.habitatforhumanity.org.uk/blog/2018/09/relative-absolute-poverty/

from the UN: all those States agreed upon a series of goals – 17 to be more precise – to be realized over a period of 15 years. We clearly see how the same multilevel approach Atkinson talked about is comprehended in the idea of Sustainable Development Goals for tackling these extreme world challenges. As declared in the introduction:

> On behalf of the people we serve, we have adopted a historic decision on a comprehensive, far-reaching and people-centered set of universal and transformative Goals and targets […] We recognize that eradicating poverty in all its forms and dimensions, including extreme poverty, is the greatest global challenge and an indispensable requirement for sustainable development. We are committed to achieving sustainable development in its three dimensions – economic, social and environmental – in a balanced and integrated manner […] We resolve, between now and 2030, to end poverty and hunger everywhere; to combat inequalities within and among countries; to build peaceful, just and inclusive societies; […] We resolve also to create conditions for sustainable, inclusive and sustained economic growth, shared prosperity and decent work for all, taking into account different levels of national development capacities [17].

In addition, these are universal objectives, in the sense that the targets are not only the poor and developing countries, but the entire world: it is an approach whose targets may be delivered differently, but with a unique common objective. Indeed, there is the recognition by the Member States that peoples are undergoing a period of challenges from economic, social, and environmental points of view. People are living a world

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[17] UN, Transforming our World: the 2030 Agenda for Sustainable Development, 6, https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf

increasingly oppressed by the contradiction between progress and extreme poverty, which does nothing but boost inequality.

We have already cited the objectives regarding poverty and inequality – the two themes largely tackled by Atkinson himself, respectively the Goal 1 and the Goal 10. We already know how interconnected these themes are and the repercussions that they both have on people's lives and health.

Many people are currently living disastrous situations: in particular, it is still too large the share of population surviving with less than $1.25 per day[18] - the threshold used to measure extreme poverty. The target imposed by the United Nations is to "reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions"[19] by the year 2030. To do this, it is essential for all the Member States to boost cooperation between them working united for a common goal: different levels of governance have to work together and in a harmonized way for the development and the safety of less fortunate areas.

Simultaneously, the Goal 10 addresses the issue of inequality both within the countries themselves and among them, since inequality is highly present in every kind of country, even in the developed ones. In this case, we talk about the promotion of inclusion without distinction of any nature; it is impossible to talk just about the economic status of individuals, but what has to be achieved is equality in all of its forms. Developing countries need to have both the material and immaterial means to reach a good quality of life: not only do they need to receive financial stability to conduct decent livings, but also

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[18] Ibid., 6

[19] Ibid.

it is essential to build strong communities of equal people. Among other measures, the signatory countries of the Sustainable Development Goals are striving to:

> Achieve and sustain income growth of the bottom 40 per cent of the population at a rate higher than the national average […]; ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard; […]; ensure enhanced representation and voice for developing countries in decision-making in global international economic and financial institutions [20].

All these elements obviously have repercussions on one's state of health, as will be deeply developed through the whole dissertation. In the Sustainable Development Goals, the issue of inequality causing difficulties in health delivering is not actually really developed. There is a goal regarding the promotion of health in all its forms[21], but without paying particular attention to inequality as a major cause.

1.2.3 Inequity/Inequality in Healthcare

Before starting our analysis of health inequities, it is important to make a preliminary remark: while in Italian we would use the term *disuguaglianze*, English is one of those languages in which inequities and inequalities may have diverse meanings. This could create some confusion, being the terms overlapping for some aspects: to avoid

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[20] Ibid, p. 25

[21] Goal 3, "Ensure healthy lives and promote well-being for all ages"

misunderstandings – as specified by works and analyses published by the WHO itself – in this section we will use the term “inequities”; however, the term “inequality” in this paper should be intended in the same way, and finding both of them does not have to create confusion.

In the last years, the issue of inequities in healthcare has been widely discussed and treated, considering the high levels of differences existing all across the world. It is possible to categorize the causes within two different groups: we can state that there are individuals resulting to be more disadvantaged in health than others for factors linked to the context and to the individuals themselves[22]. The first category refers to the structure of the healthcare system in which people live (the extent to which the access is free, the services that are offered, the resources that are provided); the second one falls into the ways of being of the individuals themselves and, recently we have started to consider as more important factors linked to the social identity of the person: they can be of biological nature and, more importantly, of socio-economical nature the level of instruction, of the job that they perform, or even of the district they live in.

As just affirmed, it is proved that factors that apparently do not fall into the healthcare category have a great influence on one’s state of health. As a matter of fact, the definition provided by the WHO is the following one:

> Health inequities are systematic differences in the health status of different population groups. These inequities have significant social and economic costs both to individuals and societies. […] In all countries – whether low-, middle- or high-income – there are wide disparities in the health status of different social

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[22] Osservatorio Nazionale sulla salute nelle regioni italiane, “Le disuguaglianze di salute in Italia”, 1

> groups. The lower an individual’s socio-economic position, the higher their risk of poor health.[23]

In other words, another important element of this concern is that health inequality is not just a Third-World countries issue: even the most developed states face this challenge, even though obviously to different extents – as will be illustrated later in details. Living conditions may influence a lot people’s lives, if we consider factors as life expectancy and quality of life:

> For example, a child born to professional parents in the United Kingdom, can expect to live over five years more than a child born into an unskilled manual household. In France, the life expectancy of a 35-year-old university lecturer is nine years more than that of an unskilled labourer of the same age. In Hungary, the Budapest Mortality Study found that males living in the most depressed neighbourhoods had a life expectancy of about four years less than the national average, and of five and a half years less than those living in the most fashionable residential district.[24]

Furthermore, there is evidence that these huge differences regard not only diverse social groups within the same country, but they are also a matter of geography within a same country: “For example, infant mortality rates in the USSR in 1987 were over 21/1000 live births in urban areas, compared with over 31/1000 live births in rural areas”[25]. These are instances regarding chances of survival; on the other hand, inequities have a role even

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[23] WHO, “10 facts on health inequities and their causes”, https://www.who.int/features/factfiles/health_inequities/en/#:~:text=Health%20inequities%20are%20differences%20in,right%20mix%20of%20government%20policies.

[24] Whitehead, “The Concepts and Principles of Equity and Health”, 3

[25] Ibid, 4

in the quality of life itself: “In many countries unemployed people have poorer mental health and their children are found to be of shorter stature than children of employed fathers. Differences commonly show up in dental health, too: in Norway, 44% of the lowest income group had their own teeth, compared with 86% of the highest income group”[26].

Taking a step back, we may state that, at least in the last decades, there has been an increasing commitment to the support of the cause of equality in health – despite the controversiality of the concept of equity:

> All the 32 Member States in the World Health Organization European Region adopted a common health policy in 1980, followed by unanimous agreement on 38 regional targets in 1984. The first of these targets is concerned with equity: By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups.[27]

This is something that will be deeply developed in the next pages of this chapter: the beginning of what will be a common policy against inequities in healthcare.

As it may appear in this figure, there are numerous factors that might influence inequality in health between one person and another: being more specific, we may refer to them as the major “determinants of health”. It is possible to observe that there are 4 strata, one above the other as concentric circles: for the way in which they are represented, the more they are on the outside (and, therefore, far from the sketched individuals), the more generic they are in relation with people.

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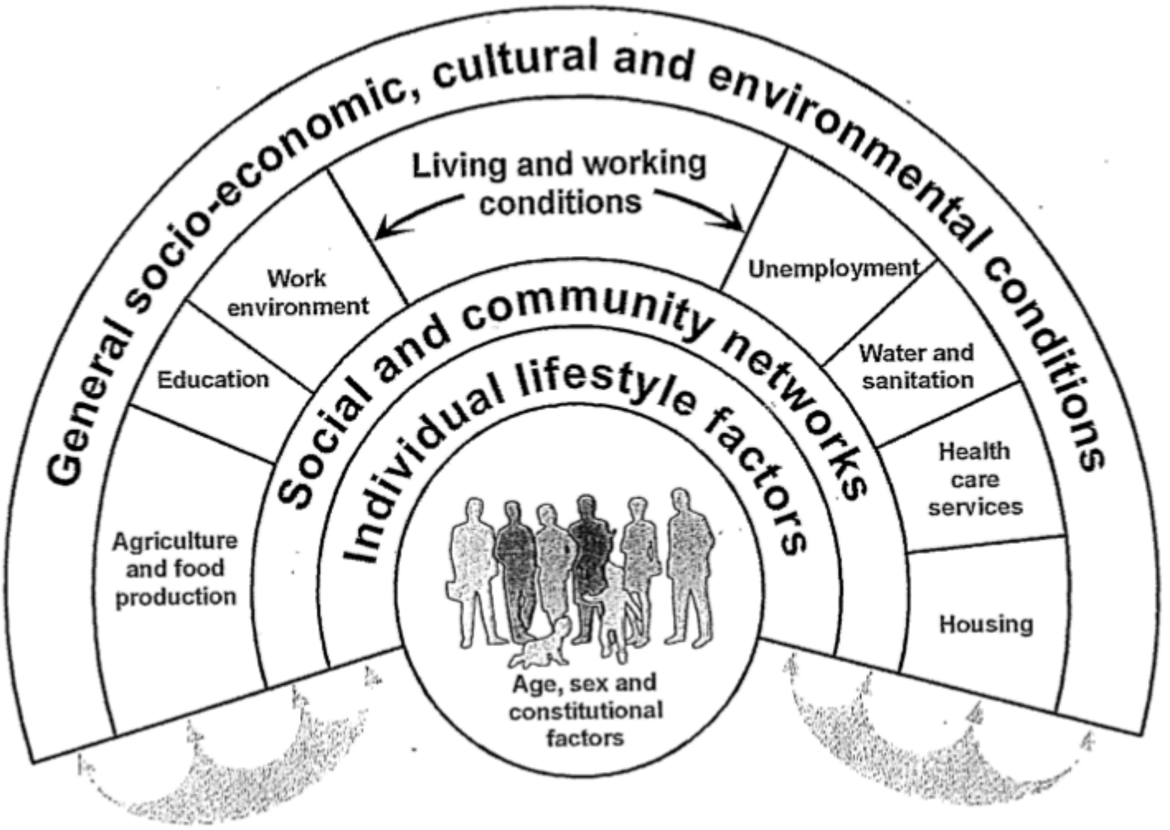
[26] Ibid., 4

[27] Ibid., 3

The main determinants of health



Source: Dahlgren, Whitehead, “Policies and strategies to promote social equity in health”, 11

Another way of classification of this kind of differential – similar to the one mentioned before – comes from an analysis conducted by the WHO. There, it has emerged that there are two broad categories of differentiations among people: inevitable differences and unacceptable differences. Among a list of seven determinants of differentials in health, four of them have been categorized as bearers of inequities in health. Namely, they are: “health-damaging behavior where the degree of choice of lifestyle is severely restricted, exposure to unhealthy and stressful living and working conditions, inadequate access to essential health and other public services, natural selection or health-related social mobility involving the tendency for sick people to move down the social scale”[28]. These factors have to be considered unnecessary or unfair, in the sense that they are not a choice of the single individual nor something natural, as others may be. For instance, some unavoidable elements could be a natural differentiation between an individual and another, or some personal choices that could unavoidably influence one’s health: in this case, we can use the example of bad habits or lifestyles as a smoking habit or not conducting a healthy and fit lifestyle. As it may appear clear, these examples just enounced cannot be considered causes of health inequity, since they do not depend upon society or demography: “the very heart of an equity oriented health policy must be to facilitate for less privileged groups to avoid avoidable health hazards and make the healthy choice as easy for them as it already is among more privileged groups”[29]. Surely, there could be actions taken by the States to raise awareness on good habits for good health: this could absolutely be a way of preventing problems coming from something avoidable, especially for disadvantaged people for whom properly heal themselves could be difficult. However, this is the maximum that can be done. Moreover, there is nothing one could do to avoid differences naturally arising among individuals, whose biological traits and peculiarities are written in their DNAs themselves. As a matter of fact, these are not the factors that we are going to consider when talking about inequities and poverty in health.

On the other hand, it is also true that differences in biological traits are not the main cause of inequities among individuals, but there is much more to be investigated and better developed at this point. As already stressed out, we are referring to all those

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[28] Whitehead, “The Concepts and Principles of Equity and Health”, 5

[29] Dahlgren, Whitehead, “Policies and strategies to promote social equity in health”, 7

situations – out of the personal choice – that influence one's level of health. If a family lacks basic economic resources, it is way easier for its components to live in dangerous situations for both their mental and physical health. In other words, not only will they be disadvantaged for living in bad conditions (as they could be, for instance, overcrowded quarters or polluted environments), but they also may not have means to provide for their care – considering the heavy needs that they could have. Moreover, one could imagine that this is an issue regarding only really poor people, living in slums or without running water. However, socio-economic differences influencing one's state of health may regard even middle-income or mediumly educated people: suffice to say how many people cannot afford – or are not cultured enough to – particular behaviors to improve their health. For instance, how many families would need to go to the seaside for health reasons but cannot afford it? If we consider all these just enounced elements, it is easy to understand that what they could enter is a vicious circle from which it is almost impossible to escape, and that has as only solution the exasperation of inequities.

Another question that WHO has tried to answer is about the criteria to be used when we consider something to be unfair or not. According to the documents, the less choice an individual has, the more we find ourselves in a situation of inequity:

> A person's particular way of life is shaped by patterns of interpersonal interaction and social learning that interrelate with and depend upon the social environment. Thus, lifestyles, shaped by experience and environmental factors, are not simply individual decisions to avoid or accept certain health risks. There are limits to the choices open to individuals – limits imposed by their physical, social and cultural environment and by their financial means[30].

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[30] WHO, *Targets for Health for All*, 53

Indeed, to use the official definition according to this criterion, "Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided […] Equity is […] concerned with creating equal opportunities for health and with bringing health differentials down to the lowest level possible"[31]. Now that we have clear in mind what equity is, it should be easier to understand what it is not and, therefore, the meaning of inequity.

1.3 Examples of Public Policy Responses – Health for All (1980) and Health 2020 (2020)

As anticipated at the beginning of this chapter, equity has been an issue of increasing interest among WHO Member States. This section will focus on the attempts that have been made throughout the years and the practical responses to the problem. In particular, we will offer an analysis of two particular projects: the first one was published during the 1980s for the period up to 2000, and the second one – published in 2012 – regards the following 8 years up until 2020.

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[31] Whitehead, "The Concept and Principles of Equity and Health", 7

1.3.1 Health for All

In 1980, the 32 members of the WHO European Region decided to follow a common path for health, adopting all the same common health policy. Even though in the European area is not so common that people die for scarcity of care due to impossibility to pay it, yet there was and there is a large share of inequity that prevents people to an equal distribution of services: "problems of poverty, inadequate nutrition, bad housing, functional illiteracy, poor sanitation and poorly developed primary healthcare are also to be found in countries with a high per capita income"[32]. Moreover, it has to be considered the situation of extreme poverty in which the Eastern countries of the area were.

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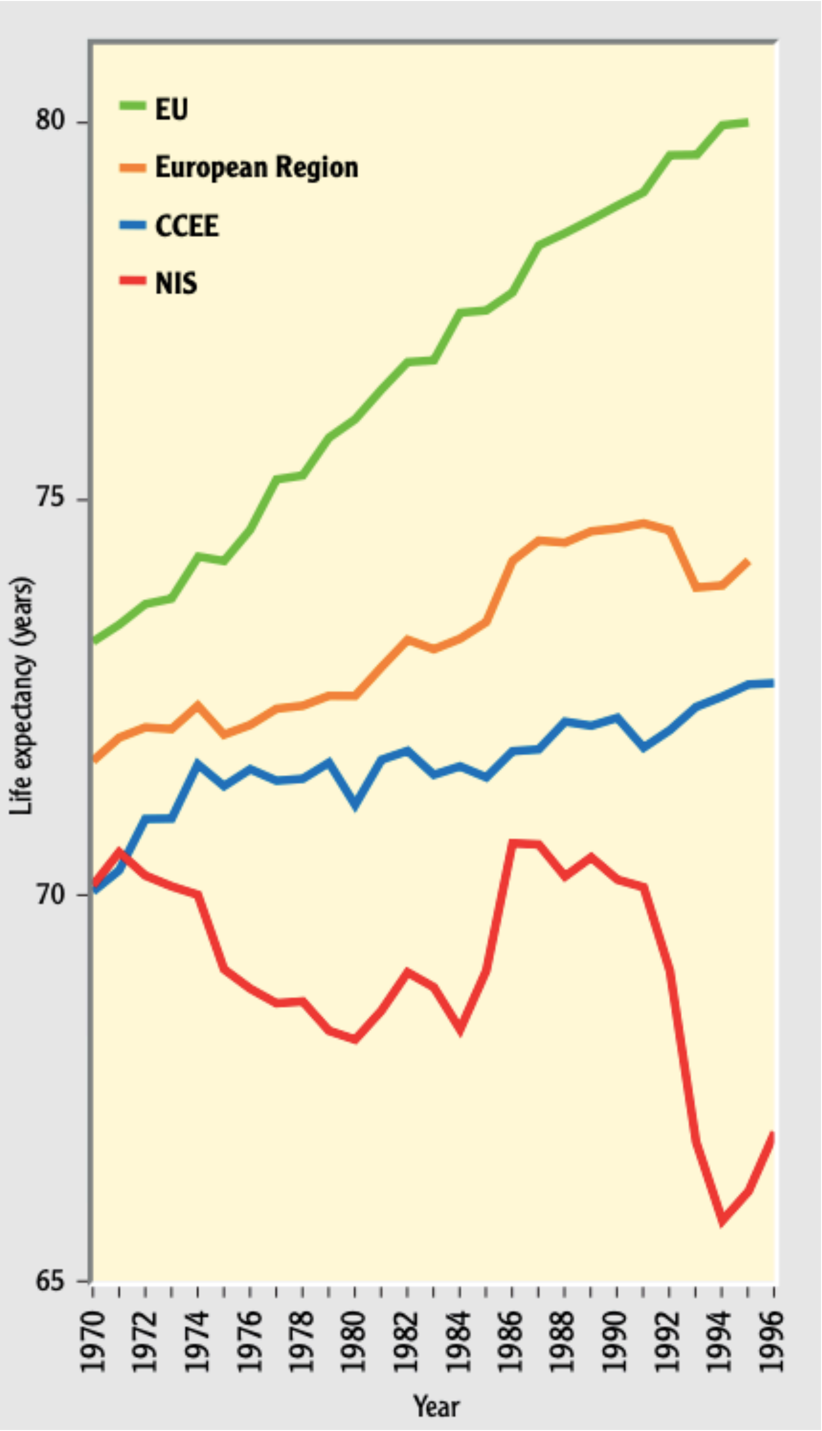
[32] WHO, *Targets for Health for All*

Life expectancy at birth in subregional groups of countries in the European Region, 1970-1996



Source: WHO, "Health 21- health for all in the 21 century", 6

As we can see in the graph, life expectancy is inversely proportional to the levels of economic and social poverty. As a matter of fact, some years later, in 1984, those countries approved a number of regional targets concerning – among the others – the issue of equity in health. Four aims are enounced within the document: "The first aim is to ensure equity in health between and within countries, initially by reducing differences in health levels between countries and between different population groups within countries by at least 25% by the year 2000"[33].

These targets are part of a book published in 1985, "Health for All": its main aim is very clear since the beginning and is the following one:

> […] To set out the fundamental requirements for people to be healthy, to define the improvements in health that can be achieved by the year 2000 for the peoples of the European Region of WHO, and to propose action to secure those improvements. […] The main social target of governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 a level of health that will permit them to lead a socially and economically productive life[34]"[35].

At the basis of this project there is the idea that all the European countries – being them more developed and industrialized – have a major responsibility in setting an example for the rest of the world, where there are even more issues related to healthcare. It is an ambitious plan, therefore, not only for them, but also for those who are watching and that are called, through the years, to take action. In order to attain this common policy, a multisectoral approach was deemed essential: "not merely the health services but all

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[34] From the Resolution WHA30.43, the Thirtieth World Health Assembly

[35] WHO, *Targets for Health for All*, 1

sectors with an impact on health should take positive steps to maintain and improve it […], much more stress should be laid on the role that individuals, families and communities can play in health development"[36]. That of cross-sectoral cooperation is a relevant concept that will be often reaffirmed throughout the chapters of this thesis: we will understand how the promotion of policies from institutions as schools or the active participation and awareness of individuals, for instance, may be of vital importance.

Since the beginning of the document it is easily perceived that there is the need of a bilateral effort to reduce the problem of inequity: on one hand, people have to be assured equal opportunities and, on the other, their health has to be improved through injecting into citizens a sense of responsibility towards their health status – among other things. In this way, not only is a common ground of equal means and resources is created, but also the value of health itself has a major role in preventing diseases and situations of need. It is essential that these two paths are simultaneously followed, since one appears to be the consequence of the other, in a virtuous circle that cannot be broken.

At this point, a section with an analysis of a selection of the most coherent targets with our discussion on equity will follow. In particular, we will consider the targets 1, 2, 27, and 28.

The first target of this ambitious project, precisely named "equity in health", can be considered the core of it. It has already been cited at the beginning of this chapter and regards the reduction of socioeconomic differences among people by 25%: the diminishing of inequities is not just something to be applied to poor countries, but to the rich and developed ones, too. To gain this result, the way should be that of enhancing health of the less fortunate groups. Here, it is stressed the "need for willingness in

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[36] Ibid., 2

recognizing the problem, for initiative in actively seeking information on the real extent of the phenomenon, and for political will in designing social policies that go to the roots of social group formation, in terms of guaranteed minimum income, assurance of the right to work, active outreach services to assist the groups in need, etc.”[37]. For measuring the inequities, the used indicator is linked to mortality, more than health status: certainly, it is a more objective and rational measurement and says a lot about the possibility that one has to take care of herself/himself. As a matter of fact, it is important, for the good functioning of this target, to reduce the differences of mortality between less fortunate and more fortunate individuals. It is proved how, in different socioeconomic situations, the levels of life expectancy are extremely diverse.

The second target – “adding life to years” – regards the fact that anyone, indistinctly, should have to exercise his/her right to health in order to have a healthy lifestyle from an economic and a social point of view. In the vision of this target, good health is perceived as a springboard for people to live their lives in a proper way. Health, here as in the entire WHO vision, is not seen just as lack of disabilities but as the total functioning of one’s capabilities to experience the best the life that he/she has chosen to live: in order to do it, it is essential that everybody can be free to choose, and to choose it is essential to be able to do it without restrictions:

> Health for all requires the creation of mechanisms that promote the health capabilities of all people and the removal of any barriers that may prevent use of the available potential. It also requires the enhancement of people’s awareness of

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[37] Ibid., 26

> health as an important resource for leading satisfying lives and the development of attitudes and skills to enable them to make full use of their health capabilities, whether whole or residual, to cope with life. [38]

For instance, something proposed within the document is the promotion and the raising of awareness on themes that would lead to healthy lifestyles; here, again, there is the necessity of actions made by sectors outside the healthcare one. Social policies, for instance, should play a fundamental role, for example towards old or disabled people, but also for particular strata of the population like single mothers, who obviously face huge difficulties in simultaneously taking care of themselves and their children, too. Undoubtedly it is an arduous mission, considering the difficulty to delineate health or perceived health, since everyone has a different way of perceiving this value; however, it seems to be a good indicator: "measurements of perceived health status have been shown to predict health outcomes, including mortality, more accurately than many other indicators of health status". It is the duty of the states, at this point, to proceed with collection of useful data and keep the situation monitored.

At this point, it follows a series of targets aimed at the entire population but that would be useful especially for those in need. It is a matter of preventing all those situations that poor and disadvantaged individuals would find difficult to face under the impediment of the barriers that are inevitably present. The targets concern the elimination of certain types of diseases or avoidable mortality and the reduction of disability, accompanied by issues such as accidents or suicide cases; there is also a large section about the promotion of health through the creation of healthy environments and the raise

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[38] Ibid., 27

of awareness also at family or school level, which makes the reader understand how strictly related wellbeing and the socioeconomic environment of a person are.

Thereafter, we can move to the target number 27, *Rational and preferential distribution of resources*. At the core, there is the idea that equity in health care should be characterized by an equal distribution of resources truly following people's necessities and making them accessible to anyone in need. The issue of inequities arises both for different organizational frameworks between a country and another and for flaws in the system of territorial distribution of resources. All this is accompanied by socioeconomic barriers that prevent certain kinds of citizens to have access to the system. What is suggested in this target is a reorganization and redistribution of primary healthcare: "Much can be done in many countries in trying to define a more rational organization of the hospital system […]. Practice has shown that, in many countries, a systematic review of the situation […] can release substantial resources. Such institutional resources can often be reallocated to primary healthcare, reducing the overall cost of the healthcare system compared with what otherwise would have been the case"[39]. In other words, working within a more efficient system would not only help distributing resources in the fairest way possible, but also contribute to a decisive cost cutting. Finally, another reading key of this target implies the consideration of situations in which resources are allocated on instruments of high technology used to heal only a limited number of cases and not accessible to everyone (because of their high costs), while there is little space for those very basic services that would cover a larger share of population but on which reluctantly is invested.

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[39] Ibid., 105

The same concept is reiterated in the target 28, which encourages a strong set of policies created country by country, especially underlining the necessities of those "high-risk, vulnerable and underserved individuals and groups"[40]. There has to be a shift towards a more patient-centered healthcare system, able to understand the needs of one single person to provide him/her with the correct and fair quantity and quality of care he/she deserves and avoiding wastes of resources. The idea is that anyone should receive exactly what is needed in that determinate situation.

Within the "Health for All" strategy, large space is given to the role that public policies have in influencing this scenario and making things more favorable for those weak strata of the population: it is an important recognition of the enormous responsibility that public policies have in this field. The project fixes the aim for all the States to promoting healthful lifestyles through the consolidation or even the creation of a strong administrative and legislative framework at the level of the government itself; it is interesting to point out how these policies may work in these cases and the tasks that every country should perform even if these programs are not strictly related to the reduction of inequities among countries and citizens. Just to give some examples of the mentioned fields of intervention, we can cite cuts to the subsidizing of industrial products that can be damaging for health, the recasting of tax policies in order to nudge citizens not to buy specific kinds of goods , and the reorganization of urban spaces in a way that favors healthy lifestyles.

To conclude the analysis on "Health for All", it may be relevant to sketch and more clearly reaffirm the essential beliefs and core points of this 1980-2000 project. We have seen, especially in target 1, what equity in healthcare matters actually means: it is

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[40] Ibid., 106

not just about providing everyone the same amount of care or the same amount of health, but it is something much more subtle and deep than this. Equity means that, for the same needs, different people have to receive the same level of care and, on the other hand, anyone should be granted the possibility to equally have access to the same structures, technologies, medicines, and – in general – care. We also have seen how much importance has been given to collaboration of different levels of services and institutions: the health sector alone can barely do something resolutive.

1.4.2. Health 2020

Has "Health for All" worked at the end of the fixed terms? Surely, through the decades, the levels of health are higher than before. However, it seems that – among all of the targets of the project – the ones that have not produced the expected results and in which no progress has been made are those concerning equity in health. There is still too much difference both between developed and developing countries in the European area and within the single States themselves. Despite this, in the last decades the interest towards the issue is growing, and inequity is becoming an ever-increasing field of discussion both in the public and in the political agenda. As we will see now, other projects have been thought and put into practice by the European Area of the WHO: "Health 21" and, finally, "Health 2020". In this dissertation, it has been made the choice to analyze the last one, being it more distant from the very first attempt and more recent with respect to the period we are living. Many of the concepts of this document have already been deeply treated and, therefore, they will not be repeated. However, it is important to offer a limited spectrum on this relatively new approach for an old issue.

"Health 2020" has been signed by the then 53 States of the area at the end of 2012. The aims are those that had already characterized the previously analyzed project, that is, the strengthening of health with a strong stress on equality in healthcare. It takes into consideration the new challenges that this decades are undergoing, such as the irrepressible boost of globalization and the recovery from the global crisis, with all the consequences these events have brought.

Also in this project, and probably even more than the previous ones, health as a precious value for the good of the community as a whole is strongly recognized by the signatory Member States:

> Good health benefits all sectors and the whole of society – making it a valuable resource. Good health is essential for economic and social development and a vital concern to the lives of every single person, all families and communities. Poor health wastes potential, causes despair and drains resources across all sectors. Enabling people to have control over their health and its determinants strengthens communities and improves lives. […] Health contributes to increased productivity, a more efficient workforce, healthier ageing, and less expenditure on sickness and social benefits and fewer lost tax revenues [41].

A specific aim of the governments is the joint undertaking of particular measures in order to grant it to all their citizens; on the other hand, the pursuing of a good and equitable health has to become the goal of the society, too, which has the role to collaborate and be proactive for what can be considered both a private and a common good: one of the objectives is, indeed, the creation of a pool of active citizenship for the development of a collaborative governance. Furthermore, it has been found that having healthy people

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[41] WHO, "A European policy framework and strategy for the 21st century", 11, https://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf

is now explicitly considered as a positive externality for the economy in the most pragmatic sense possible: just to make some instances, health brings – among citizens – happiness, productivity, the creation of strong human capital and the basis for sustainable development, and gives prestige to the State in question, too.

An element that was already present in "Health for All" and that is even more stressed in this new version is the need for a multisectoral approach:

> This approach advocates moving health up the policy agenda, strengthening policy dialogue on health and its determinants, and building accountability for health outcomes. Health impact assessment and economic evaluation are valuable tools in assessing the potential effects of policies and can also be used to assess how policies affect equity. Qualitative and quantitative health data can be gathered and validated to assess impact on health.

More specifically, a considerable importance is given to the sector of education and the fact that there is a positive correlation between a good level of instruction and a good level of health, since well-educated people not only will have more profitable jobs, but they also will be more inclined to take care of their own health. Moreover, there is this strong belief that there should be sensibilization since the very first years of primary schools towards the importance of healthy behaviors, in order to create generations of aware young adults.

As said before, one of the targets of "Health 2020" is the reduction of health inequities, in addition to the reduction of premature mortality, the increasing of life expectancy and of the well-being of the population, and the boost of the vision of the right to health as a value deserving universal coverage[42]. The Commission in charge of

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[42] Ibid., 61

dealing with the target of inequity, had decided to proceed by "improving the conditions of daily life […], tackling the inequitable distribution of power, money and resources […] and measuring the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health and raise public awareness about the social determinants of health"[43]. Welfare policies are one of the main vehicles for these goals: measures of social protection have to be implemented to the whole society by all the governments of the Member States in order to create minimum standards for all. In this way, everybody should be provided with a series of fundamental rights, as a basic level of instruction and a dignified work, awareness on the importance of empowerment. All these elements, put together at the disposal of every individual, should grant them the ultimate goal of the project, that is, a good level of sanitation.

As an innovative element in this project, differently from the previous one, a lot of attention is paid to the most vulnerable groups that have been emerging in these very last years: in particular, the elderly and the migrants. As specified at the beginning of this section, "Health 2020" is structured in a way that gives much space to the issues that are arising nowadays: is the case of the aging populations and the migration flows coming to Europe. These groups face many difficulties especially considering their health, and the programme is set in a way that its policies should favour their categories as a whole. The governments should actively deal with the issues that these groups face every day: respectively, need for care and assistance and need for healthcare regulation and for jobs. The project expressly refers to policies to be implemented both nationally but also locally and represents great work and responsibility for the Member States.

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[43] Ibid., 62

Finally, for what concerns the gain of a successful outcome, the importance of a good base of knowledge is stressed in this document, too – just like in "Health for All". As a matter of fact, there is among the signatory States that, especially for health policies, the phase of the gathering information from which to formulate policies is essential:

> Policymakers need trustworthy, up-to-date information on health and well-being status, on health needs and on health system goals and outcomes. Health information is a policy resource that is vital to health planning, implementation and evaluation. Health-related information generated by research is needed on health needs and health system functioning, effectiveness, efficiency and outcomes. Developing and evaluating policy depends fundamentally on aligning and combining both health and health-related information[44].

There are, for these scopes, continuously up-to-date databases run by the WHO and specific for the European Area: these contain wide information easily accessible and available on their website itself on, for instance, levels of life expectancy and mortality, of education and employment, and so on: all indicators able to provide an all-inclusive framework about the health status of a population.

1.4 Health Inequality in European Countries – Data and Figures

The health situation within the European Union – considering the health status of its citizens – has certainly improved in the last years. However, as one may expect

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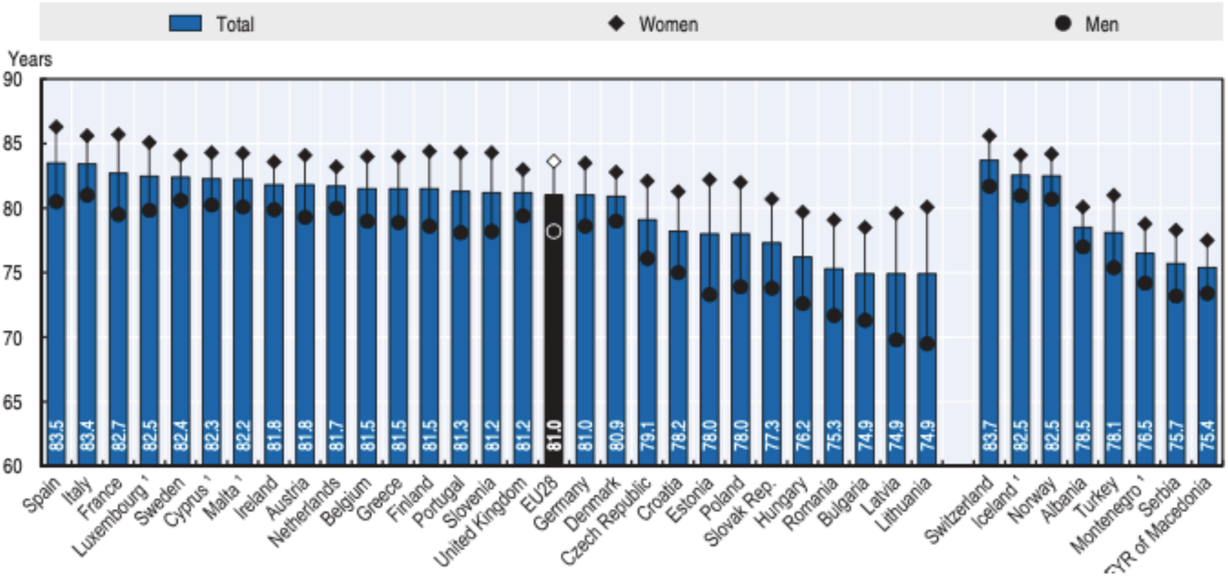
[44] Ibid p. 151

considering factors as an extreme development and the financial crisis, socio-economic differences both among the States and inside the single countries themselves are increasing. Obviously, this leads to an exacerbation of discrepancies in healthcare matters between the most and least privileged groups [45]. This section will provide a practical overview of the current situation regarding health inequality.

As it has already been pointed out before, life expectancy is one of the best and most objective indicators to measure the health status of a people and, consequently, health inequalities. This indicator has increased in the last decades, starting to decrease only in these few years.

Life expectancy at birth, by gender, 2016



Source: Health at a Glance, Europe 2018

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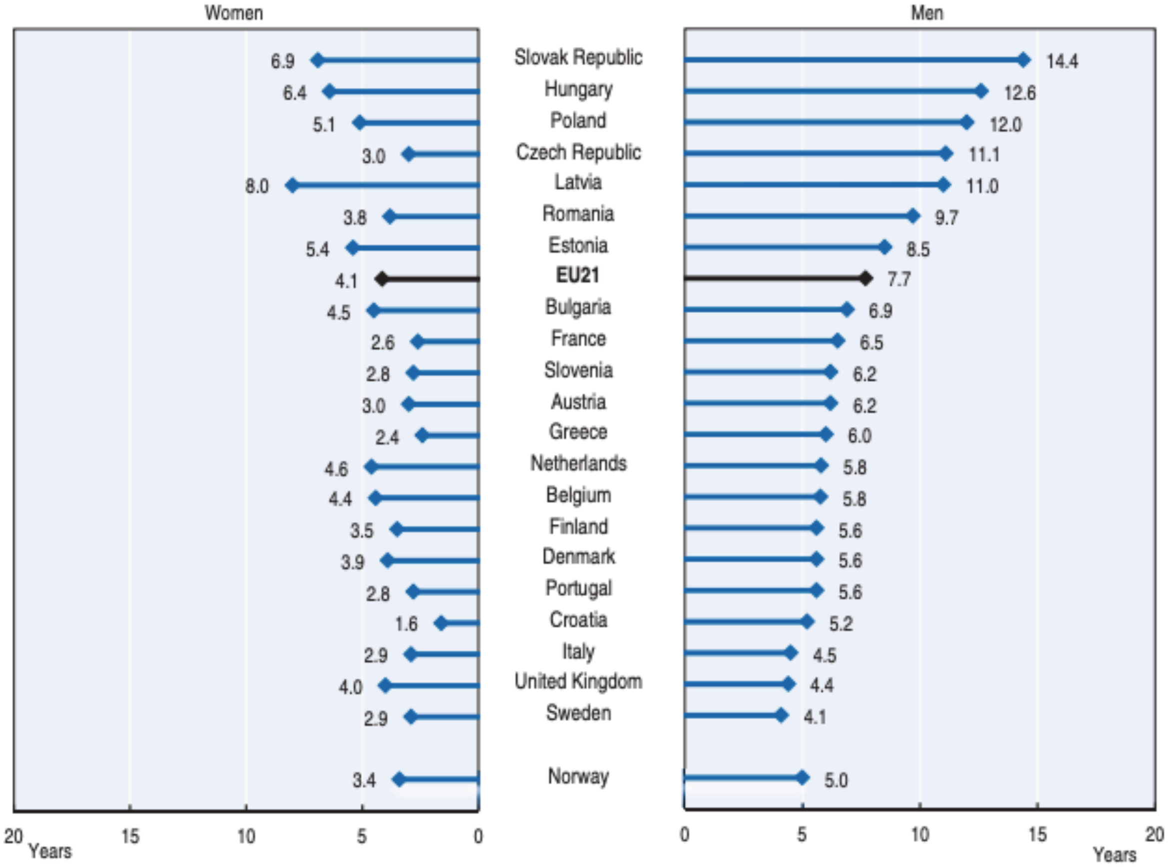
[45] Commissione delle Comunità Europee, "Comunicazione della Commissione al Parlamento Europeo, al Consiglio, al Comitato Economico e Sociale Europeo e al Comitato Delle Regioni - Solidaritietà in Materia di Salute: Riduzione delle Disuguaglianze Sanitarie Nell'UE"

As observable in the graph, the longest-running countries are Spain and Italy (more than 83 years), with a couple of years above the EU average of 81 years. On the other hand, the lowest-rate countries are the Eastern ones, with a difference of around 7 years, which is quite significant. This differential says a lot about health inequality, considering the fact that those underdeveloped countries have the lowest average.

As a matter of fact, it is possible to affirm that socioeconomic status – as we have already said – is a crucial discriminating factor for what concerns inequality. In particular, a useful indicator is that of education: we may say that mortality rate is higher for less-educated people.

3.3. Gap in life expectancy at age 30 between people with the lowest and highest level of education, 2016 (or nearest year)



Source: Health at a Glance, Europe 2018

> On average across EU countries, 30-year-old men with less than upper secondary education can expect to live about 8 years less than those with a tertiary education (a university degree or the equivalent). The education gap among women is smaller, at about 4 years. In the Slovak Republic, Hungary, Poland, the Czech Republic and Latvia, 30-year-old men with a low level of education can expect to live more than 10 years less than those with a high level of education [46].

As we may observe, indeed, people with a lower education – and that consequently may have lower wages and lower propensity and openness towards healthcare – are more likely to have diseases that cause a bad health status and mortality.

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[46] OECD/European Union, *Health at a Glance: Europe 2018: State of Health in the EU Cycle*, https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_rep_en.pdf

Chapter II

Healthcare System and Health Status in Italy

2.1 How Healthcare System Works in Italy: SSN and its reforms

After having offered a general background about the concepts of equity and – on the other hand – inequity and the ways in which the issues should be addressed, also considering the attempts of policy made by the European Area of the WHO, in these following sections a focus on the situation in Italy will be offered.

In order to understand the way in which we can frame the issues of health inequity and poverty in Italy, it is important to make a regression on the way in which health and healthcare are perceived by the State and the peculiarities of the Italian National Health Service. After having investigated this, we will be able to understand whether there are flaws in the system that may represent or not an accentuation of these issues. In other words, we will provide an analysis of the main elements of our SSN and see if they can be – even in part – responsible of the problem for the way in which they are structured. This will be exactly the question that we will be attempting to answer throughout the development of the body of this dissertation: which peculiarities of the Italian SSN – if any – are in any ways boosting health inequities in the Italian peninsula?

Let us proceed with some historical background. First of all, also here, it is the Italian State itself that recognizes health as a fundamental right. The importance of the protection of health is strongly stressed in the art. 32 of the Italian Constitution: "The Republic safeguards health as a fundamental right of the individual and as a collective interest and guarantees free medical care to the indigent"[47]. According to the founding fathers of the Constitution, health is not only a fundamental right – or an enforceable right with a self-determination component – but it also can be seen as a common good, which has to be intended as an interest of the community as a whole. The vision of health in this manner comes from the art. 2 of the Constitution itself: "The Republic recognises and guarantees the inviolable rights of the person, both as an individual and in the social groups where human personality is expressed. The Republic expects that the fundamental duties of political, economic and social solidarity be fulfilled."[48] The State is committed to grant a number of rights within a community that, in turn, has to give back duties to it according to a solidarity scheme.

Furthermore, the same right to health has been revived years later in 1978 in the law 833/1978 [49], which takes inspiration from the Constitution itself. There, it is specified that the protection of the health of the collectivity has to be carried out through the Italian NHS, established in that law itself: as a matter of fact, the just-cited law is called

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[47] *Constitution of the Italian Republic* , https://www.senato.it/documenti/repository/istituzione/costituzione_inglese.pdf, 11

[48] Ibid., 5

[49] Law 833/1978, http://www.comune.jesi.an.it/MV/leggi/l833-78.htm

"Establishment of the National Health Service". December 24th of that year represents the birth of a universalistic healthcare system, with the replacement of a previous mutualistic one. We can say that 1978 is the birth of the SSN as we know it today, more or less, effective since 1980. Indeed, before 1978, it worked very differently. The biggest differentiation is that, in the past, it was not universal, meaning that the system did not guarantee a free care for the population. However, this point will be better explained in the following section.

As a matter of fact, before 1978, in Italy there was a mutual system, that is, a so-defined Bismarck model[50] made of numerous mutual societies[51]: different categories of workers were signed to a different society and could, in that way, use the insurance provided by that entity, through the fruition of the medical cares that were financed by the contributions paid by the workers themselves. In other words, the right to health was then linked only to the status of worker of an individual and his/her family. When in need, one had to turn to his/her local doctor[52] if covered by the system of insurance. Otherwise, one had to pay it out of his/her own pocket. The same thing used to happen if there was also the need of surgery, while today these kinds of provisions are almost free, as we will see later in the chapters.

During the 1960s, this system was shocked by a deep crisis because of the confusion caused by the enormous number of societies and a sharp extension of the healthcare expenditure due to an excessive increase of services not covered by the

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[50] With Bismarck model, we use to refer to an insurance-based system financed by the workers. It is called in this way since it was established by the German chancellor Otto von Bismarck in 1883

[51] The so-called *casse mutue* in Italian

[52] In Italian, we use to refer to him as *medico della mutua*

insurance funding[53]. All these elements, together, will bring to the birth of the new sanitary system in 1978: from a Bismarck model, we will have a Beveridge one[54].

Since the establishment of the SSN, it became clear that the concept itself of health had to change starting from the flaws that used to characterize the previous model. Three principles – around which health was developed – became evident: universality, equality, and equity[55].

The first value, universality, means that health is not anymore just an individual value – as before; rather, it starts to belong to the collectivity as a whole, which has to be promoted by the SSN as a resource in the entire Italian territory. For this reason, free health services are to be guaranteed by the State to all the population through the guaranteeing of the LEAs[56] - which will be better explained later.

The concept of equality expresses the fact that no distinction has to be applied for citizens in need of care. Poorer people usually get a free share of services – and we will see in which ways later through the various chapters of this dissertation – while normally a ticket has to be paid, depending on the type of service that is requested.

Finally, equity: while this concept may be easily confused with the previous one, it is important to remember that equality and equity are not the same, especially in the

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[53] Di Novi, “Modello Bismarck vs Modello Beveridge”, http://www.coripe.unito.it/Portals/0/EeS/41_LpV_BevVSBism.pdf

[54] Funded by the English William Beveridge, it refers to a universal sanitary system where the responsibility of healthcare is in the hands of the government. The services are financed by income taxes of citizens

[55] Italian Ministrry of Health, “I principi del Servizio sanitario nazionale”, http://www.salute.gov.it/portale/lea/dettaglioContenutiLea.jsp?lingua=italiano&id=5073&area=Lea&menu=vuoto

[56] *Livelli Essenziali di Assistenza*

Italian language as we have specified in the previous chapter. In general terms, while the first one refers to allowing anyone to have the same thing, the second means that anyone has the same opportunity to gain that thing; in this sense, equity is more about the choice that policymakers have to do in order to give anyone those instruments. This explanation may be applied in every field, even in the healthcare one. As stated in this principle of the SSN, "every citizen has to be granted parity of access in relation to equal health needs. This is the fundamental principle that aims to overcome citizens' differences of access to medical services"[57]. In more practical terms, this is translated in two particular necessities: first, to grant "quality, efficiency, appropriateness, and transparency" in the services that are to be delivered to all the patients in need and, second, the provision of an adequate communication between the medical personnel and the patients – about their medical status or the care that they will be granted according to their level of instruction or social status (basically, doctors and nurses have to be able to make themselves comprehensible by anyone).

In addition to these, which are the fundamental principles at the basis of which the SSN lays, there are also the so defined "organizational principles". Among these, the most important – also mentioned in the website of the Ministry of Health itself – are the following ones: centrality of the person, public responsibility for the protection of the right to health, collaboration between the levels of government of the SSN, valorization of the professionality of the healthcare professionals, and socio-medical integration[58]. These principles are at the basis of the building of the sanitary system, as a sort of foundation thanks to which the SSN is held together. We have an individual-based

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[57] Ibid.

[58] Ibid.

system, in the sense that the needs of the person are considered the priority of the job made within it. The person, who becomes a patient to take care of and not anymore a client – as he/she was considered before the establishment of the SSN – has a series of rights that have to be respected, as the freedom to choose where to be healed, the rights to be informed about his/her illness and, in the meanwhile, the right to privacy. Moreover, it is stated that the SSN is programmed in a way that gives priority to all these elements that do what is right for the person. In doing this, the three levels of the system[59] (as we will see later on) have to collaborate in a harmonious, balanced and coherent way in order to assure appropriate, adequate and fair care to citizens. Those who choose to work for the SSN – doctors, nurses, and so on – have to be aware that what they do according to their technical knowledge has to be accompanied by something that goes beyond objective capabilities: they have to be able to grant their patients and their co-workers values as empathy, compassion, and cooperation in order to provide the best service possible to those in need, and be able to organize themselves in teams.

Coming back to the law establishing the Italian NHS, it is defined in art. 1 as "constituted by the set of the functions, of the structures, of the services, and of the activities bound to the promotion, the maintaining, and the restoration of the physical and mental health of the entire population, without distinction of individual and social conditions and according to the modalities able to grant the equality of citizens towards the service"[60]. In short, the Italian SSN is a regional-based national system, providing to its citizens a universal and free service. Fundamentally, it is possible to define it as a

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[59] State, Regions, and local authorities

[60] Law 833/1978, http://www.comune.jesi.an.it/MV/leggi/l833-78.htm

"multi-level system", in the sense that it is developed and organized along three levels: the national, the regional, and the local ones. To be more specific, at the national level we have the State – represented by the Ministry of Health and flanked by the expertise of several entities and agencies – coordinating the system and giving general directives to be followed. Secondly, the Regions have to follow these directives, but they have the majority of powers and are the main responsible of the functioning of the system. And, finally, at the local level we have the figures of the so called ASL (*Aziende Sanitarie Locali*), or LHAs (Local Health Authorities) which are in charge – in practical terms – of delivering all the health services that people need. However, the distinction and the interplay and separation of competences between these three levels will be made clearer and better developed later in this chapter, as well as the role of the ASLs and the way in which they worked at the very beginning of the SSN. Indeed, the law 833/1978 established territorial units at the base of the service, the so-called USL[61] – or, in English, LHAs[62]. Everything was managed at the municipal level: cities were the ones that had the responsibility to deliver services and resources to their citizens.

Another important point has to be made here. In order to understand the Italian NHS, it is vital to specify that it does not have to be imagined as a fixed and static system: indeed, it has undergone a series of changes brought by reform packages through the years, probably more than any other institution in the Italian policies scenario. The SSN in its original version – that of its birth in 1978 – presented several problems linked to its very nature, especially due to social and political instability accompanied by an increasingly limited number of resources, financial boundaries, and difficulties in

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[61] *Unità Sanitarie Locali*

[62] Local Health Authorities

satisfying healthcare demand[63]; moreover, a strong link between the management of the system and the political parties existed. This brought to a necessity to reform the system, operating with the aim of rationalizing public expenses through cost

making the system more and more efficient, with also an attempt to give a major extent of autonomy to the system.

We will see how these elements will appear clear in the reform packages applied throughout the years, using the outline of the four more important steps of the evolution of the Italian NHS.

The first attempt of change happened between the years 1992 and 1993: the aim of this first reform was to improve the economic efficiency – considering the strong constraints imposed in the European context in the Maastricht Treaty. It was important, therefore, to proceed with a rationalization of the health expenditure, while keeping the same universalistic principles that have always been at the core of the Italian NHS. In this reformation, we had the birth of what we commonly know now as ASLs[64], which are nothing more than an evolution of what we used to identify as USLs. The substantial difference is that, while with the USLs the municipalities were entrusted of the management of services and resources, with the ASLs there is a partial shift of responsibilities in the hands of the Regions: to sum up, the Region purchases, and the ASL provides.

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[63] Burioni, "Sistema Sanitario Nazionale: com'è cambiato dal 1978 a oggi" https://www.medicalfacts.it/2020/03/12/sistema-sanitario-nazionale-dal-1978-oggi/

[64] *Aziende Sanitarie Locali*

A second step was realized in 1999: the process of devolution continued to deepen some years later with this piece of reform, the d.lgs. 229/1999[65]. The Regions are always more responsible for the healthcare sector. Another important element that constitutes the SSN was born, that is, the so defined LEAs ("livelli essenziale di assistenza"). The concept of LEAs will be better illustrated later in this chapter; for now, all we need to know about them is that they are a list of benefit packages having the aim of improving efficiency of the health expenditure. What may seem quite straightforward is that, also in this package of reformation, the aim is the attempt to gain an efficient functioning of the system itself: as a matter of fact, the identification of the financial resources is a focal point in the relatively new order of the SSN.

Two years later, the foundations of the SSN in the most similar form as it is today have been placed. At the beginning of the new millennium, more specifically in 2001, the previously existing relationship between the State and the Regions changed, giving to the Regions a way greater role than what they used to have. What happened was a revision of a part of the Constitution, the Title V "The new Article 117 of the Constitution, adopted in 2001, made it explicit that health protection is a matter of concurring legislation, with the clarification that in such matters the State, which maintains exclusive powers with regard to the determination of the basic level of benefits relating to civil and social entitlements, is given the role to lay down only the fundamental principles"[66]. Moreover, all the Regions have now the obligation to provide the same extent of quality of services and the same extent of benefit packages. In other words, in this case the Regions are the collectors of the resources in a scenario that may be perfectly

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[65] Semplici, "The right to health-care and the regionalization of the health-care system", https://ijponline.biomedcentral.com/track/pdf/10.1186/1824-7288-40-S1-A88

[66] Ibid.

defined as fiscal federalism. However, what happens in reality is that this system does not work how it should because of the many discrepancies existing across Regions: there are major variations considering economic growth, levels of tax revenue and – mainly – the quotas of healthcare expenditures that any Region may be able to pay through the taxation it collects. As a matter of fact, the risk of this reform is the creation of a wide gap between richer and poorer zones in Italy: "The major risks that deserve a special attention are those concerning the possibility of a too deep fault of inequality as to what is offered in different regions beyond the threshold of what is established as essential at the national level and a too broad discretion in defining standards, procedures, guidelines, not to mention the burning issues of costs and quality"[67]. We will see later how this may have serious consequences regarding healthcare and the state of health of the Italian population in general.

To conclude, the last important reform happened in 2012, during Mario Monti's government and, therefore, a crucial phase for Italy, in the middle of the financial crisis and in a compelling need for waste reduction. As a matter of fact, the d.lgs. 158/2012 provides for an enhancement of a number of contractions in the healthcare expenses, accompanied by an increasing level – as we have seen in the previous reforms – of rationalization of the healthcare system machine. Moreover, we may also find new role of the territory, which takes on even more significance than before: the idea of fiscal federalism is always more present and tangible[68].

Since the changings that the Italian NHS has undergone may be confusing, it would be good to repeat the little scheme cited at the beginning, representing the levels

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[67] Ibid.

[68] Morana, "I decreti del 2012 tra le riforme della Riforma sanitaria ", http://www.cortisupremeesalute.it/wp-content/uploads/2019/06/10_I-decreti-del-2012-1.pdf

of responsibilities of any institution. Therefore, to sum up, we have said that – as of today – the SSN is based and distributed around three levels: national, regional, and local. Every level has its own aims and duties, distributed in a way that should help the pursuing of the values at the basis of our healthcare system.

But in practice, what do the Italians do to receive care when in need? In other words, how is care provided? First of all, we may say that at the basis of the health care sector there is primary care. Basically, this kind of support is provided by GPs (general practitioners)[69] or independent physicians: people have to be registered to their personal lists to be able to receive care, and they are paid according to the number of patients they have. Once visited by the GP, if the situation is clear and the patient does not need any other treatment, he/she can go home; otherwise, the doctor may prescribe other visits or other kinds of care. The prescription is obtained through the CUP (Central booking point)[70], a service collecting all the bookings and organizing them in a relatively rapid way. After having waited the required time, the patient is accepted to an outpatient specialist care, that is, the examination of a specialist operating in the medical field required: indeed, while the GP is a general doctor, the specialist is an expert in that branch of medicine the patient needs. This kind of care "is generally provided by local health units or by public and private accredited hospitals under contract with them. […] Outpatient specialist visits are generally provided by self-employed specialists working under contract with the SSN. […] Outpatient specialists seeing public patients cannot bill above the fee schedule, but can see private patients without any limitations"[71].

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[69] In Italian language, *medici di famiglia*

[70] *Centro Unico di Prenotazione*

Another turning point for the person happens here: if the patient is good with what the specialist doctor has said or prescribed, the path to be followed is over; if not, he/she has to be admitted for receiving what is called secondary care or, in a more common language, hospitalization. The person may choose in which kind of hospitals to receive the care among public hospitals, private accredited hospitals, and private hospitals (the cost of this last choice is entirely borne by the person). Moreover, according to the rights enumerated before, the patients have the possibility and the freedom to choose to be hospitalized in any Italian region they prefer for any reason. Once nothing more can be done for a patient in the hospital, he/she is dismissed and can come back home or, if he/she needs other care for particular necessities, there is the possibility to be transferred in structures for long-term care or rehabilitation, whose expenses are also covered by the SSN.

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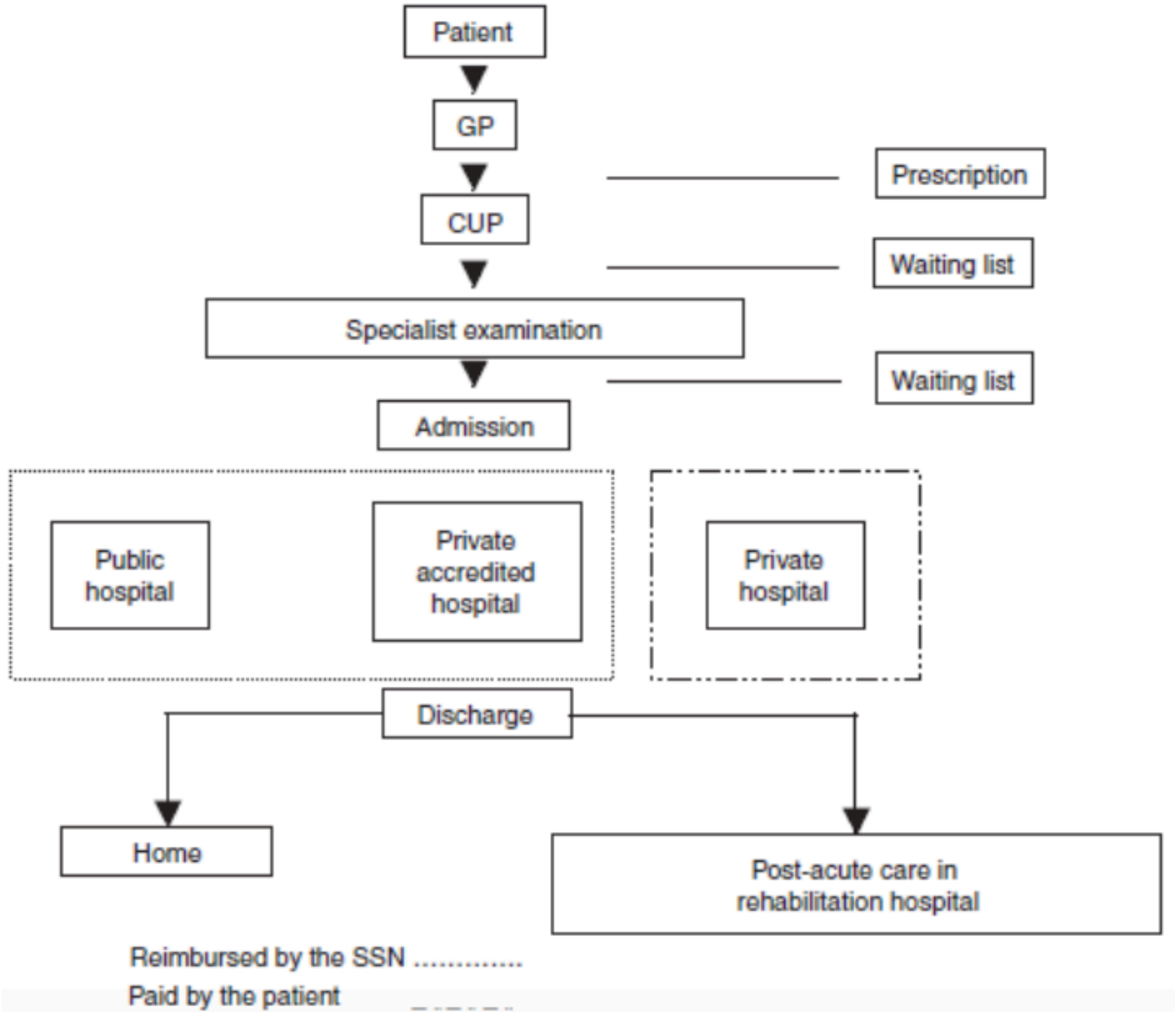
[71] The Commonwealth Fund, "International Health care system profiles – Italy", https://www.commonwealthfund.org/international-health-policy-center/countries/italy

Patient Pathway



Source: Mascia, "The Italian NHS". Lecture, Rome, Italy, 2019

2.2 LEAs – What They Are and How They Work

As specified before in this chapter, even if we say that the Italian SSN is organized on a regional basis, the State has its tools for controlling the operate and the good functioning of the system. In particular, we know that the central government organizes part of the general tax revenues to be injected in the SSN, it has a role of general administration and management and, finally, it defines a package of healthcare treatments. These are the so-called LEAs[72] – standard or minimum healthcare provision. It is an important concept to explore, since it is necessary in order to understand how the system is financed – mechanisms that will be developed in the next section of this chapter.

Being introduced in the reform of 1999 and defined for the first time in January 12th 2001 DPCM[73], they are all those benefits and services that the Italian SSN is obliged to freely provide to all the citizens; sometimes, there is the payment of a participation fee – the so-called ticket[74]. Basically, these services are financed with general taxation that the public periodically pays. The list of the LEAs that have to be yearly provided is defined by the central government and constantly changes according to the needs of the Italian population.

In 2017, another DPCM replaced that of 2001, completely redefining LEAs in a joint commission between the central government, the Regions, and the scientific communities. Briefly summarizing the content of this new DPCM, we may say that it integrates new diseases entitled to exemption of payments to the already mentioned ones, better defines what the State provides for its citizens (in terms of services, activities and benefits), and, lastly, describes in a clearer way what the State was already providing for

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[72] *Livelli Essenziali di Assistenza*

[73] *Decreto del Presidente del Consiglio dei Ministri*

[74] Italian Ministry of Health, "Cosa sono i LEA", http://www.salute.gov.it/portale/lea/dettaglioContenutiLea.jsp?lingua=italiano&id=1300&area=Lea&menu=leaEssn

its citizens within the already existing LEAs[75]. Also, it is specified that also the Regions – apart from the job of the State – may grant benefits and services using their own fiscal and material resources. Moreover, LEAs are continuously updated, even today: as a matter of fact, a commission[76] has been instituted with these aims. It constantly tries to keep pace with the changing sanitary needs of the Italian population. A major focus is on changing technologies and innovative services that could lead to a more efficient allocation of resources.

At this point, it is the moment to see in practice and in a more detailed manner how this mechanism actually works. The most relevant thing is that the Regions are not automatically eligible for receiving benefits, but they have to satisfy some previously agreed objective criteria (since 2005), and they are constantly monitored for this scope. This does not mean that a Region that does not satisfy them, does not receive any provision by the central government, but it is important to keep in mind that those who comply the most have the right to largest "prizes", aside those basic benefits that are provided anyways. Regions are constantly subjected to monitoring by a committee[77] which has to value appropriateness and efficiency in the ways in which services are delivered[78]. The most important thing that they want to reach is the uniform provision of

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[75] D.Lgs 502/1992

[76] *Commissione Nazionale per l'Aggiornamento dei LEA*

[77] *Comitato LEA*

[78] Italian Ministry of Health, "Monitoraggio Livelli essenziali di assistenza, i punteggi di tutte le Regioni in base alla Griglia LEA 2017, "http://www.salute.gov.it/portale/news/p3_2_1_1_1.jsp?lingua=italiano&menu=notizie&p=dalministero&id=3582

services and resources all over the Italian territory, so that there should not be inequities among one Region and another. The method is very objective, since a series of indicators to be respected are established[79] and points are assigned for any of these through a real assessment. At the end of every year, the performance of every Region is published, reporting if it did better or worse with respect to the previous year.

To better understand the theory, we will show practical examples taken from the assessment of the year 2017.

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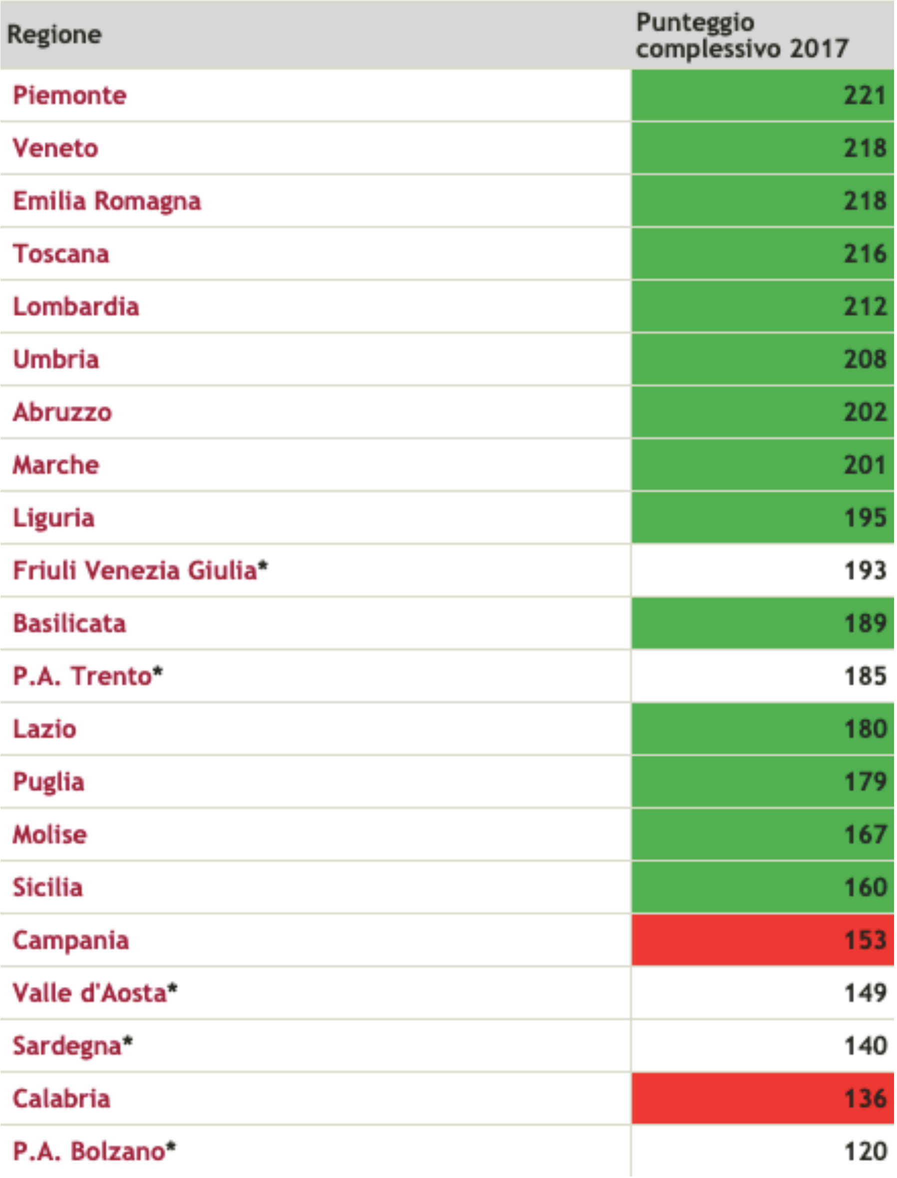
[79] According to the so called *Griglia Lea*

Evaluation and points of Regions according to Griglia LEA 2017



Regione	Punteggio complessivo 2017
Piemonte	🟩 221
Veneto	🟩 218
Emilia Romagna	🟩 218
Toscana	🟩 216
Lombardia	🟩 212
Umbria	🟩 208
Abruzzo	🟩 202
Marche	🟩 201
Liguria	🟩 195
Friuli Venezia Giulia*	193
Basilicata	🟩 189
P.A. Trento*	185
Lazio	🟩 180
Puglia	🟩 179
Molise	🟩 167
Sicilia	🟩 160
Campania	🟥 153
Valle d'Aosta*	149
Sardegna*	140
Calabria	🟥 136
P.A. Bolzano*	120

Source: Ibid.

As we can see in the table, there is a list of all the Regions with points next to them, and the colors green or red are assigned to each of them. How it could be easily understandable, the green Regions are the good performers, while the red ones are the bad performers. To be more specific, to obtain the green color the points have to be ≥ 160 or a number ranging from 140 and 160 with no critical indicator, while the red represents a score < 140 or ranging from 140 and 160 but with at least one critical indicator. The white ones, on the other hand, are those with special status that are not subject to monitoring[80]. Observing the data, we can notice that a great number of Regions – 16 – have been positively evaluated. Among them, there are 8 Regions with a very high score: they are mainly of Northern Italy and no Southern Regions appear in this list. Of the remaining ones – if we do not consider those with special status – we have only two very low scores: Campania and Calabria.

Another interesting point of view may be the comparison of the scores that the Regions got throughout the years. In this way it is easier and more objective to evaluate an eventual progress or regression. In particular, in the table reported below, there is the assessment of the years 2015, 2016, and 2017.

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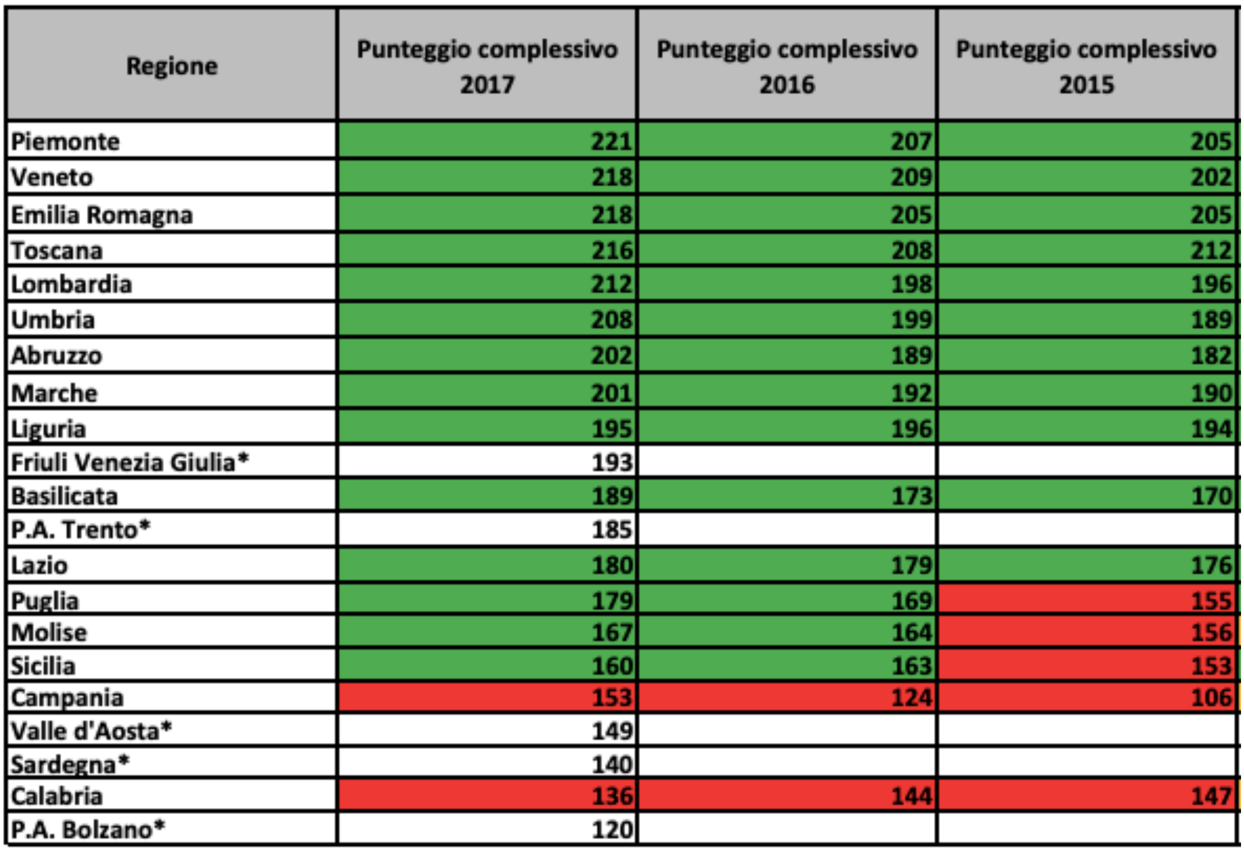
[80] Italian Ministry of Health, "Monitoraggio Livelli essenziali di assistenza, i punteggi di tutte le Regioni in base alla Griglia LEA 2017, "http://www.salute.gov.it/portale/news/p3_2_1_1_1.jsp?lingua=italiano&menu=notizie&p=dalministero&id=3582

Results Griglia LEA 2017-2012



Regione	Punteggio complessivo 2017	Punteggio complessivo 2016	Punteggio complessivo 2015
Piemonte	221	207	205
Veneto	218	209	202
Emilia Romagna	218	205	205
Toscana	216	208	212
Lombardia	212	198	196
Umbria	208	199	189
Abruzzo	202	189	182
Marche	201	192	190
Liguria	195	196	194
Friuli Venezia Giulia*	193		
Basilicata	189	173	170
P.A. Trento*	185		
Lazio	180	179	176
Puglia	179	169	155
Molise	167	164	156
Sicilia	160	163	153
Campania	153	124	106
Valle d'Aosta*	149		
Sardegna*	140		
Calabria	136	144	147
P.A. Bolzano*	120		

Source: Italian Ministry of Health

First of all, we can see that there is no much variation between 2016 and 2017: Campania performed better in one year, but Calabria did even worse. They had different results even though they both had been entrusted to a commissioner[81]. Moreover, a really positive datum is given by the fact that in 2015 five Regions were given the red and negative score, meaning that three Regions (Latium, Apulia and Molise) have been able to make important improvements and go out from the control of the commissioner, even if with not so high scores.

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[81] Italian Ministry of Health, "Monitoraggio Livelli essenziali di assistenza, i punteggi di tutte le Regioni in base alla Griglia LEA 2017, "http://www.salute.gov.it/portale/news/p3_2_1_1_1.jsp?lingua=italiano&menu=notizie&p=dalministero&id=3582

We can rapidly notice – after an analysis of these scores – that healthcare sectors in the North and in the South of Italy present quite relevant variations. For Northern Regions it is easier to have high rates of performance, but the same cannot be said about the Southern ones. Indeed, the latter – even though some progress has been made in few cases – seem floundering to stay abreast with the level of performance of the others.

2.3 Financing the system

The Italian SSN has been established with the aim of granting to everyone – without distinctions of any kind – universal and free coverage. At this point, having understood the main functioning of the system and its features, a spontaneously arising question is about the way in which a system of this kind is financed and how resources are allocated. Generally, we may answer saying that we can describe it as a fully tax-based public healthcare system, and the services "automatically cover all citizens and legal foreign residents"[82].

From an administrative view point, we may say that at the State level, at the "head" we have the Ministry of Health, "which oversees health care planning (such as determining the essential benefits package), health system ethics, the supply of health professionals, information systems, and other areas"[83]. Also, another organ is the

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[82] The Commonwealth Fund, "International Health care system profiles – Italy", https://www.commonwealthfund.org/international-health-policy-center/countries/italy

[83] Ibid.

National Committee for Medical Devices, with the aim of setting the prices of medical goods and services through conducting cost-benefit analysis. A sort of bridge between the national government and the regional ones is represented by the figure of the Agency for Regional Health Services, “the sole institution responsible for conducting comparative-effectiveness analyses, which is accountable to the regions and to the Ministry of Health”[84]. And, finally, there is the National Pharmaceutical Agency – in Italy known as AIFA[85] – which operates under the control and direction of the two ministries of Health and of Economy and Finance: it regulates another important sector of the healthcare system, the pharmaceutical one. We may say that the Ministry of Health has a sort of “horizontal” way of acting, in a manner that may be defined as intersectoral. As a matter of fact – as we have just seen in the example of how AIFA works – it strictly collaborates with other ministries: in particular, the Ministry of Welfare and Social Affairs and the Ministry of Economy and Finance.

After this brief digression about the ways in which the healthcare system is administered, we can now focus on the financial aspects of it. First of all, we should specify that it is the State law that determines – every year – the guidelines and the sanitary needs, at least for the expenses that the State itself is in charge of covering: indeed, as written in the Constitution, the government is the responsible of the determination of the funding and of the control of the resources to be allocated in any Region.

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[84] Ibid

[85] *Agenzia Italiana del Farmaco*

The largest share of contribution (in 2017, it covered the 74% of the total expenditure, that is the 6.5% of GPA[86]) derives from the revenues of the tax receipts that citizens regularly pay; to these, we have to add income taxes at regional level deriving from corporate income taxes and taxes on physical persons. To these, every Region contributes according to its own material capacity, depending on the economic and financial status of each one of them. The difficult part in this story is to make Regions respect a certain equilibrium in the balance of the taxes to be paid; for this reason, strict controls – coming from the State – are conducted every year. Thanks to them, almost all Regions are able to respects the imposed criteria: for instance, "in 2017 recovery plans under national supervision have been imposed only for 7 Regions out of 20 (Abruzzi, Calabria, Campania, Latium, Molise, Apulia e Sicily), a lower number compared to 2007"[87].

The remaining part of the tax revenues of the healthcare system is covered by the out-of-pocket expenditures of the patients. The OOP expenditures are the expenses directly borne by people and that are not reimbursed, when they – as patients – need a certain type of care. This kind of expenditure covers most of the remaining of the funding not already included in the general taxation. In particular, data show what follows:

> In 2017 Italy addressed the 8.8% of GPA to healthcare, positioning itself below the EU average of 8.8%. Per capita expenditure amounted to 2,483 € […], more than 10% less than EU average of 2,884 € (graph 7)[88]. After the 2009 economic

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[86] European Commission, "State of Health in the EU-Italia", https://ec.europa.eu/health/sites/health/files/state/docs/2019_chp_it_italy.pdf , 9

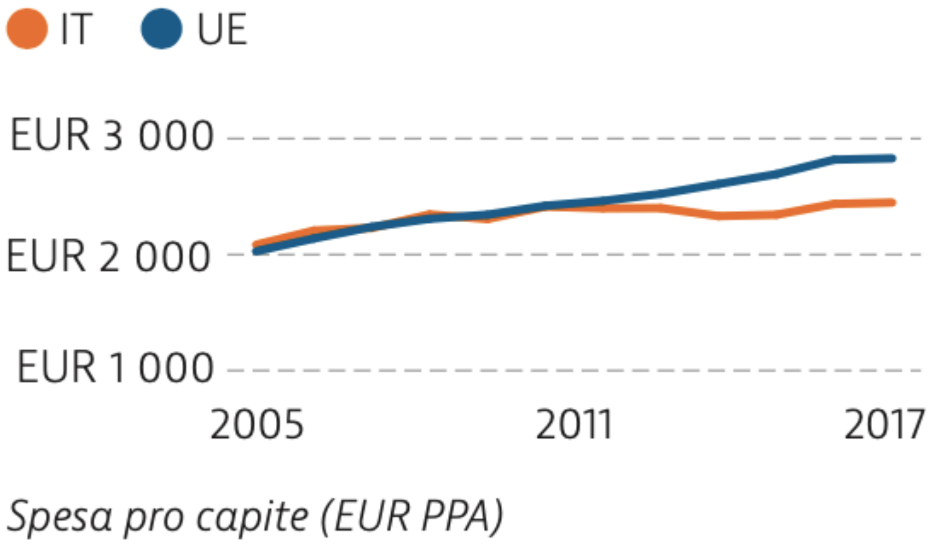
[87] Ibid.

[88] Ibid.

> crisis, per capita healthcare expenditure recorded a decrease until the year 2013, and then resumed to moderately rise. In 2017 healthcare expenditure was financed for the 74% by public funding (6.5% of GPA). Although the LEAs cover a wide range of services, the out-of-pocket expenses borne by families are quite high (24%) and constitute most of the remaining healthcare expenditure. Private health insurance has a marginal role, covering only 2% of the total healthcare expenditure[89].

Health expenditure in Italy is lower than the European Union average, as we can see in the graph.

Health expenditure



Source: European Commission, “State of Health in the EU-Italia”, 3

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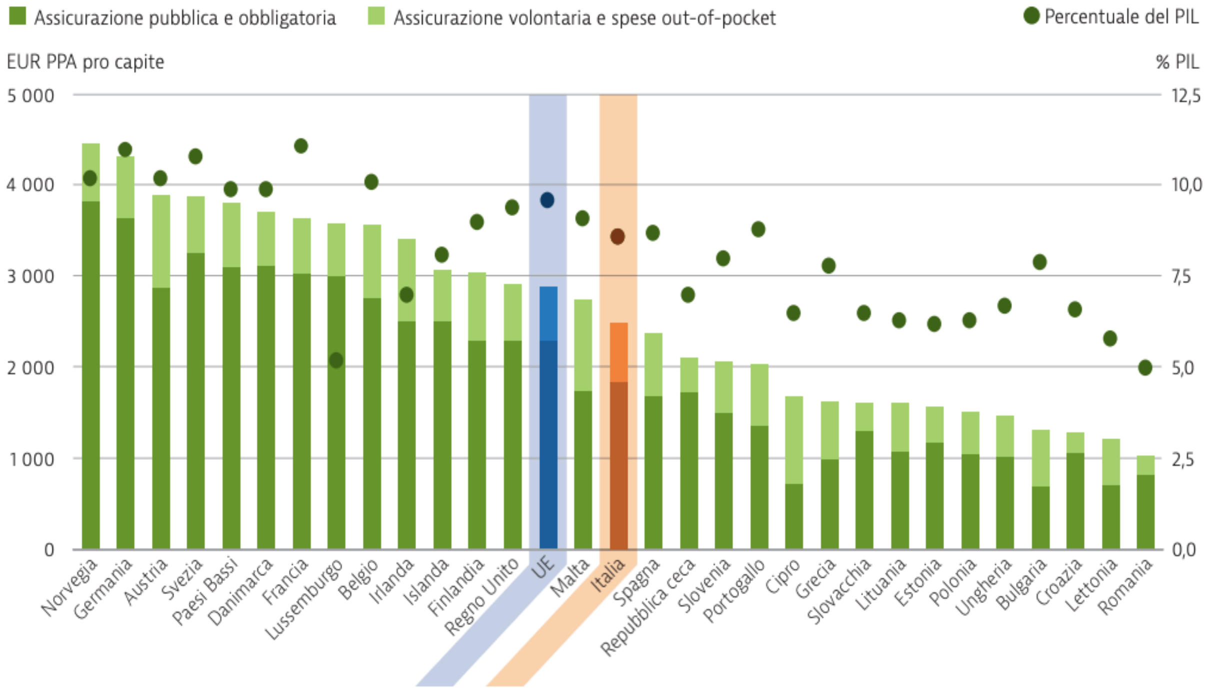
[89] European Commission, “State of Health in the EU-Italia”, https://ec.europa.eu/health/sites/health/files/state/docs/2019_chp_it_italy.pdf , 9

In particular, reading the data behind this exemplified graph, in 2017 the expenses in Italy amounted to € 2,483 that, compared with an EU average of € 2,884, corresponds to a difference of 15% of the countries. To have a clearer idea of the expenses, here there is another more specific graph:

Public expenditure for the healthcare sector



Source: European Commission, “State of Health in the EU-Italia”, 9

As we can notice, Italy is the last of the more developed countries in terms of health care expenditure, also considering the percentage of GDP. However, something that should be added to this discussion, is the fact that the expenditure has been decreased as a consequence of the financial crisis since 2009 up to 2013. From that moment, it has slowly started to increase, even though in a really limited way if compared with the other countries.

2.4 Social Indicators Data: Demography and Risk Factors

At this point, we should have a clearer idea about the history and the structure of the Italian SSN: we have analyzed the ways in which it has undergone several developments and reformations, adapting to the diverse necessities of a constantly changing Italian society. Furthermore, we have seen that the Italian NHS may be considered a quite efficient and accessible system, able to grant to its citizens good-quality healthcare services, despite the socio-economic differences among the Regions. Now, another important step is to highlight the main features of the population considering the health situation in Italy.

In general terms, we may say that Italian healthcare system registers really high levels of performance if we consider the quality of the services, the quite small size of the expenses and factors as lifespan and preventable mortality through prevention and the treatments offered by the SSN[90]. Moreover, Italy is the second country in Europe with the highest life expectancy[91], which is a quite relevant and objective indicator – as it has already been highlighted – to examine the level of the health in the nation. That said, we will now provide more specific insights about Italy, focusing specifically on indicators as the demographic context and the risk factors.

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[90] CNEL, "Relazione 2019 al Parlamento e al Governo sui livelli e la qualità dei servizi offerti dalle pubbliche amministrazioni centrali e locali alle imprese e ai cittadini", 19

[91] European Commission, "State of Health in the EU-Italia", https://ec.europa.eu/health/sites/health/files/state/docs/2019_chp_it_italy.pdf , 3

Italy has a high percentage of old population: of its 60,537,000 inhabitants, around 22% is more than 65 years old, which is a quite worrying datum considering the European average of 19.4%[92]. Another relevant factor to be considered is that also the fertility rate is lower than in the European Union – 1.3% compared to 1.6% of our neighbors[93]. Therefore, we are facing a situation of aging population that has many straightforward implications for what concerns its health status. For instance, with a high number of elderly people, a sector that should be invested a lot in has to be that of long-term healthcare. Instead, contrary to expectations, in Italy just a limited share of sanitary expenses is reserved to this necessity, also in comparison with other OECD countries that present a similar share of elder population. Specifically, only 10.1% of the total healthcare expenditure is allocated on long-term care, while in other countries as Sweden and France the expense is around 11% [94]. It follows that needs have to be satisfied by the patients themselves and their families through out of pocket expenses. This may have several implications for those families in bad economic situations.

Another indicator that is worth of attention for this discussion regards the risk factors met by the Italian population. As appeared in an OECD analysis,

> about one-third of all deaths in Italy in 2017 could be attributed to behavioral risk factors, including dietary risks, tobacco smoking, alcohol consumption and low physical activity. This is much lower than the EU average. About 16 % (98 000) of deaths in 2017 were related to dietary risks (including low fruit and vegetable

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[92] Ibid p. 2

[93] Ibid.

[94] Rapporto Osservasalute 2018, 516, https://www.osservatoriosullasalute.it/wp-content/uploads/2019/05/ro-2018.pdf

> intake and high sugar and salt consumption). Tobacco consumption (including direct and second-hand smoking) was responsible for an estimated 14 % (over 90 000) of all deaths. About 4 % (26 000) of deaths could be attributed to alcohol consumption, and 3 % (18 000) to low physical activity. All these shares are below the EU average except for low physical activity [95].

Among these issues, the one about tobacco consumption represents one major problem for the Italian population, whose rate of consumption is quite high. However, it is also possible to say that this datum is decreasing throughout the years, also considering the numerous attempts of policies activated by the Italian government. A worrying factor is, on the other hand, the smoking rate among adolescent, which has not been decreasing for years, remaining constant[96].

On the whole, it is possible to say that Italy maintains really high health standards, especially considering the brilliant level of its healthcare system despite the limited expenses destined for the sector. However – as said before in this chapter – Italy presents many discrepancies among its regions – especially considering the socio-economic differences between the North and the South – and this creates quite a heterogeneity for many aspects in the peninsula. Unfortunately, these disparities do not regard only geography, but are something related to many other factors that will be soon developed. This will be one of the focuses of the inequities in the healthcare sector that we are going to analyze in the next sections.

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[95] European Commission, "State of Health in the EU-Italia", https://ec.europa.eu/health/sites/health/files/state/docs/2019_chp_it_italy.pdf , pag 7

[96] ibid.

Chapter III

Inequality in Healthcare: the Situation in Italy

The following section will put into practice what has been said until now, representing the core of this dissertation. In the previous chapters, we have dealt with the theoretical framework of the object of this thesis, health care inequity and poverty and the ways in which they influence a society and its status of health. We have seen how the issue is defined and the attention that constantly is being paid within it. Then, in order to understand how inequity in health places itself in the Italian scenario, we moved towards the analysis of Italy: we have considered the way in which its National Health Service works and the health status of the Italian people. Having collected this piece of information, we should be ready to see in the practice how health care inequity appears in Italy and to what extent we may talk about it. The Italian peninsula is characterized by deep differences under various points of view. They regard an enormous number of aspects: just to make some examples, there are discrepancies in its economy, culture, society, geography, and even in the dialects spoken by citizens. It is possible to say that Italy is a country defined by its differences, strongly eradicated in the history that has accompanied its formation and unification: still today, Italians are carrying around the weight of centuries of division and struggle. The two specific components to which we will be referring to in this thesis are the geographical (or territorial) and individual differences: to be as clear as possible, we will refer to those differences among Regions and to those within themselves. In other words, it will be argued that both economic and socio-cultural disparities exist not only between the North and the South, but also within the same territory. In the latter case, variables such as biology, social capital, level of education or the role of the institutions play a crucial role in defining one's ability to enter health care system. Moreover, the question that we will try to answer is how and to what extent these diversities translate themselves in healthcare inequality.

3.1 Historical Background: Roots in the Structure of the Italian SSN

As we have largely specified in the previous chapter, the formation of the Italian SSN, in 1978, replaced the previous mutualistic system and all its incongruencies. One of its aims was, therefore, that of generating a system able to level out the differences created by its very nature of that way of taking care of patients. The value of the universalism of health is determined since the beginning; one of the most important pillars is the achievement of territorial equality. Indeed, in the art.2 it is stated that "the SSN – within its competences – strives for the overcoming of territorial discrepancies regarding the social health conditions of the State" [97]. The resolution of inequalities from a territorial point of view was, at that time, the only way in which the issue of inequity was addressed.

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[97] Law 833/1978

As previously seen, SSN has undergone many changes through the years with several reforms. Just to make a brief recap of what we already know about these reformations, we may say that they were especially aimed at reaching an increasing level of economic efficiency of the performances (transformation of the USL into ASL and implementation of the LEAs) and, then, a progressive autonomy given to the single Regions – also due to the fiscal federalism introduced with the reformation of Title V of the Constitution itself. All of them have contributed to the reduction of inequalities from a territorial and social points of view; however, as we will say later in this chapter, the combined effect of autonomy of the Regions and the reaching of financial efficiency is causing issues of inequity, and this should be a point to be discussed and modified, in the future. To be more precise, it has to be considered that funds are allocated in different quantities among Regions, according to their performances. In this way, however, it happens that those Regions already in trouble receive less than what they actually should need. "In the long term, this created a highly unbalanced situation, pitting a few well-organized regions, able to keep health under control, against others under a heavy burden of accumulated debt. Taken as a whole, the SSN deficit can be seen as almost entirely due to a few regions with a high and persistent deficit level"[98]. In this manner, a sort of vicious cycle is created, in which backward Regions get less because they do not perform well, and vice versa; obviously, this results a solution which is everything but coherent with the needs of the population and the principles of the SSN itself of equality. Moreover, even if this aspect should already be clear, it is important to underline that through the mechanisms of the LEAs, only some very basic health services and benefits

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[98] Maino, "The Italian Health System: Cost Containment, Mismanagement, and Politicization", https://www.jstor.org/stable/43486427?pqorigsite=summon&seq=3#metadata_info_tab_contents

are freely provided by the State to the population. This means that the disadvantaged individual easily struggles to get certain levels of care. Later in the chapter through data analysis, it will be clearer how the division of the sanitary funds leads to inequities in health care, which may be of two levels, territorial (geographical) and individual.

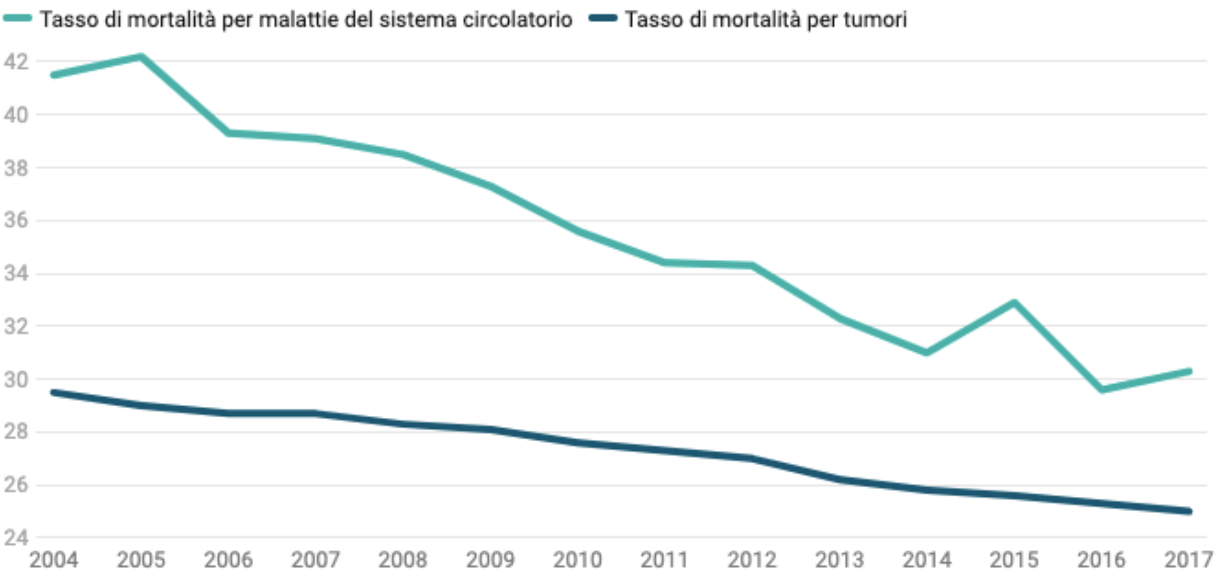
3.2 Data and Statistics

3.2.1 Health Inequality

It should be clear – arrived at this point – that Italy is a country in which differences and inequalities are perfectly placed, both because of its history itself and the way in which the health sector has been developed. Health inequality in Italy is an issue that is obtaining increasing visibility both at supranational – as extensively covered here – and at national level.

Let us start by assuming – and repeating – that the high performance of Italian healthcare system can be soon noticed also by straightforward data. Just to give an example, reported in the graph below, there has been in the last years a general decrease in the mortality rate.

Standardized mortality rates



Tassi di mortalità standardizzati (Valori per 10 mila abitanti)

Fonte: Istat, Rilevazione sui decessi e le cause di morte • Embed • Creato con Datawrapper

Source: Noi Italia 2020, http://noi-italia.istat.it/pagina.php?id=3&categoria=6&action=show

In particular, it is evident the fall in mortality due to tumors, and this is possible thanks to the success of primary prevention and innovative and technological measures to prevent and limit cancer diffusion. Even infant mortality is quite low, always compared with the European average. Italy registers 2.7 deaths for 10,000 live births, while the European average is 3.6 deaths for 10,000 live births. Malta, the European country with the highest rate, registers 6.7 deaths for 10,000 live births[99].

The excellent performance of Italy in the health care sector does not make it a particularly "unequal" country, especially if compared with others that do not offer a universal health system. In other words, it is obvious that, if compared with countries

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[99] Ibid.

under a Bismarck model of organizing health care, “Beveridgean” States – including Italy – do not suffer of high levels of health inequality; yet, despite this, even in our peninsula, there are situations of disparity that may not be ignored.

Demographic indicators, alone, already point out a certain level of inequality among a richer North and a poorer South. If we use the indicator of life expectancy, as already done for the European Union context, we have proof of this. In Italy, according to Istat [100] data, average life expectancy is 80.6 for men and 84.9 for women [101]. While the gender gap seems to be reduced, the same cannot be said about the gap between Northern and Southern Regions. As it can be noticed in the figure below, there are huge differences in life expectancy at birth between the Regions from the North (and a really few Southern exceptions) and those from the South.

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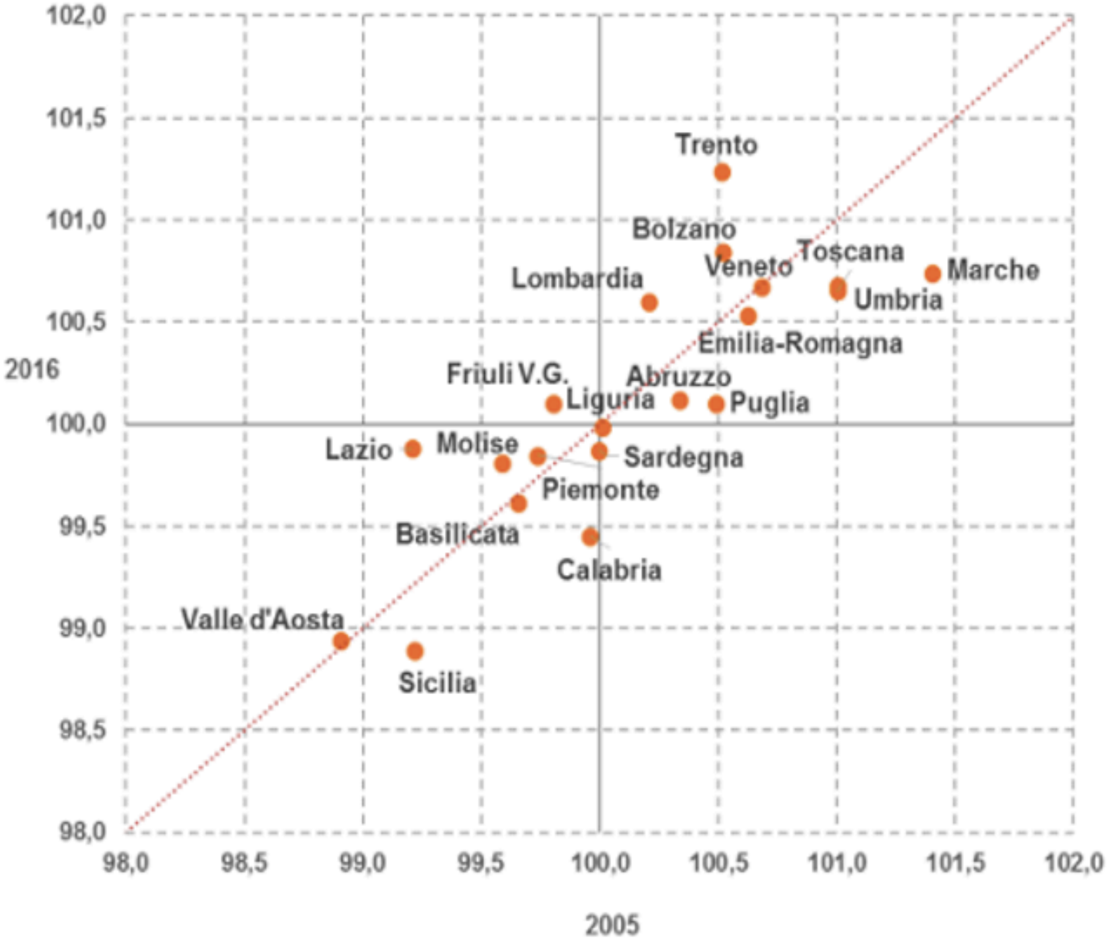
[100] Istituto Nazionale di Statistica

[101] “Istat, Indicatori demografici, 1
https://www.istat.it/it/files//2018/02/Indicatoridemografici2017.pdf

Life expectancy at birth



Source: Osservatorio Nazionale sulla Salute nelle Regioni d'Italia, "Le Disuguglianze di Salute in Italia" (PDF), 3

Namely, more specific data from the year 2017 report that "In Campania men live an average of 78.9 years and women 83.3; while in the Autonomous Province of Trento men averagely survive for 81,6 years and women for 86.3" [102]. This evident and pronounced

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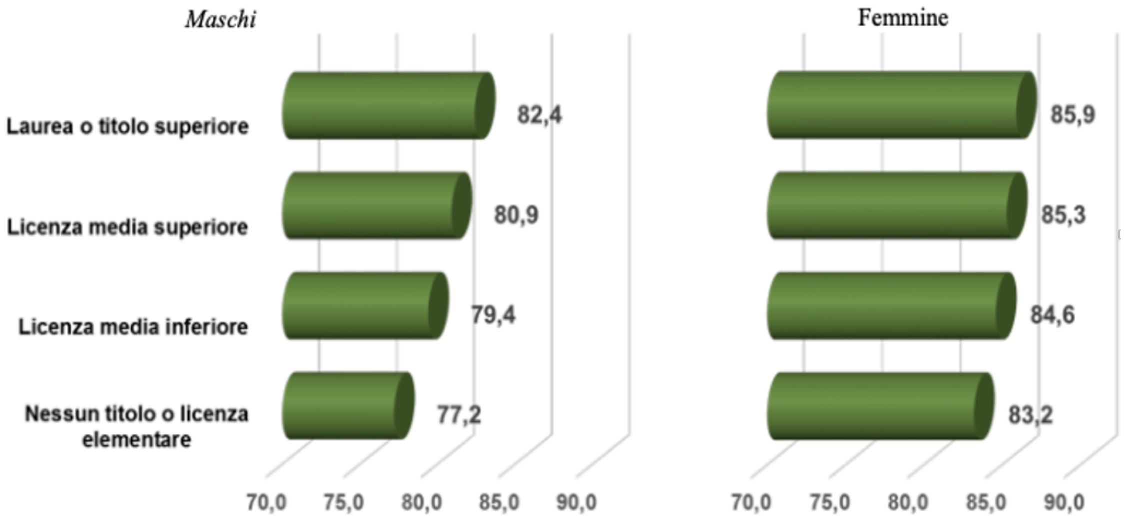
[102] Osservatorio Nazionale sulla Salute nelle Regioni d'Italia, "Le Disuguglianze di Salute in Italia" (PDF), 2

gap brings to light the existing territorial disparities among so diverse zones within the same country.

On the other hand, different data show how also different indicators may influence Italians' status of health. In the present case, we will consider the relationship between life expectancy and qualification.

Life expectancy for gender and qualification



Source: Ibid., 7

Here it appears evident that individuals with a higher degree live on average more than those with a lower level of instruction. The causes of this phenomenon are manifold and surely interconnected between them: greater predisposition to undergo controls and care, higher knowledge about health, healthier ways and places to live and so on. Moreover, another reason for these imbalances are linked to the availability of resources that a person may or may not have, and the extent to which one is willing to forego treatments, as we will in-depth illustrate in the following sections. As revealed by a study conducted by Istat, “In 2012 an Italian man with a degree may aspire to live 5.2 years more than a man with an elementary school diploma”[103]. Another important element to consider is the mental health of Italians and the differences among people. Data suggest a sharp deterioration in the conditions of mental health among young adults who are both unemployed or experiencing precarious economic situations: “For instance, an unemployed presents mental illness two and a half times more often than an employed both before and after the economic crisis”[104].

To conclude, what role does the family seen as institution play– considered the great importance that Italians use to give it? First of all, it has to be said that health inequalities linked to a different social status are quite worrying, since they do not regard only the individual in question, but also his/her family and the future generations: indeed, data show that the level of instruction of the mother or the father often represents the children’s destiny [105] On the other hand, however, family in Italy – and especially in the Southern zones – represents a sort of safety net for individuals in trouble. It is both a form of economic financial assistance for those in economic difficulty and moral support. Finally, family may also serve as an important help when in need for assistance for the elderly – essential for all those people who cannot afford to pay for long-term care. As a

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[103] Costa, “Come Fare dell’Italia il Paese che Tutela Meglio la Salute Uguale per Tutti”, 4

[104] Ibid., 8

[105] Osservatorio Nazionale sulla Salute nelle Regioni d’Italia, “Le Disuguglianze di Salute in Italia” (PDF), 8

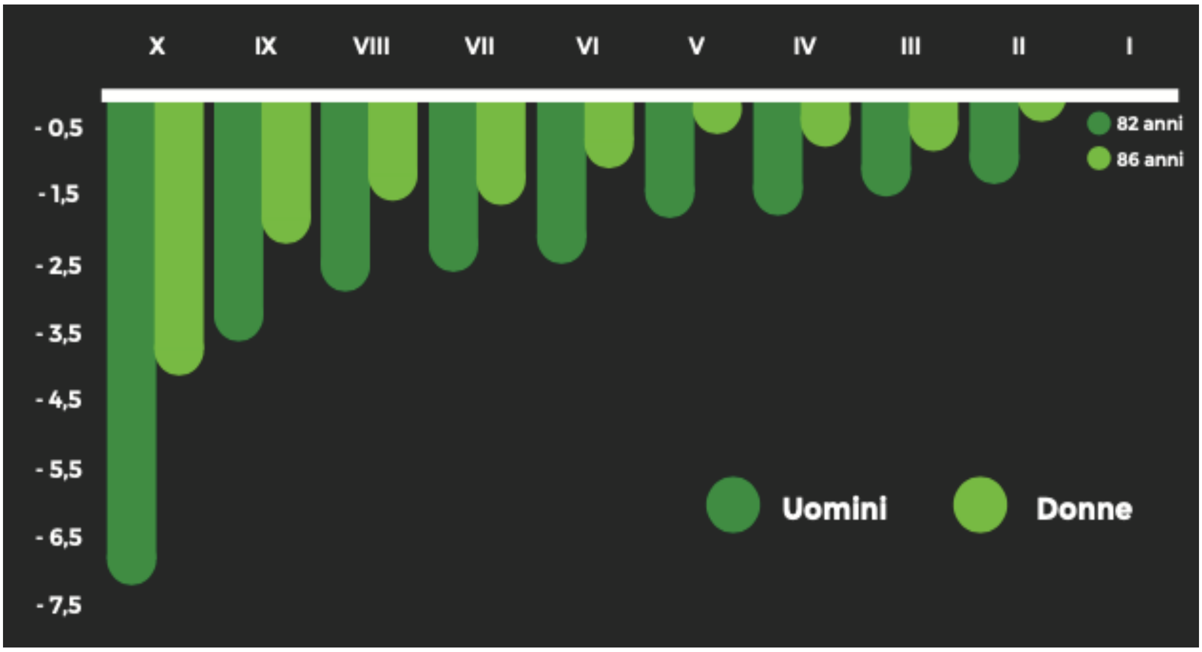
consequence, it is obvious that the strong presence of a family may become a way to ameliorate an individual's life and partially alleviate conditions of inequality.

3.2.2 Health Poverty

Poverty is a strictly related concept with inequality, especially in the healthcare field. With the two close waves of crisis of 2007 and 2011, poverty has become an increasingly-spread condition in Italy – even among those families who were not normally considered as poor or extremely poor: in other words, the poverty condition has been, in a way, normalized, becoming more and more common. Simply, families have lost those resources that could be spent in services, and among those services there is undoubtedly that of health care. Oftentimes, indeed, unexpected events such as the need for paying for cares that are not covered by the SSN may happen, and it is not that rare that families are completely unable to pay for them. Also, an even more direct consequence of scarcity of resources is that individuals have not access to basic goods and services (as food, a safe dwelling, decent-quality clothes and so on), compromising, in this way, their quality of life and health status.

Professor Giuseppe Costa conducted a study in Turin to practically show the effects of poverty on people's health. He analyzed the health status of different neighborhoods of the city in order to see how the economic situation influences health indicators. As drawn in the following graph, he found a quite relevant difference of life expectancy – similarly to what has been already analyzed for the territorial differences among Regions – between the richest and the poorest individuals within the same city.

Differences in life expectancy in Turin for decils of income



Source: “Le Disuguaglianze Social nella Salute e il Ruolo del Reddito”, 4

Having used just one city as a reference sample, and therefore with uniform social and demographic conditions, the value of difference is consistent and regards only the quantity of income that a person has at his/her disposal.

To conclude, another relevant datum to consider is the worrying condition of greater poverty due to Coronavirus and the consequences that it is having on Italian (and not only) society and economy. Italy was already in a situation in which absolute poverty was increasing since the crisis; in particular, from 2007 to 2014 the percentage of people paying under conditions of absolute poverty has risen from 3.1% to 6.8% [106]. Today, data are much more alarming. The whole lockdown period has started to cause severe problems not only to those who could already be considered as poor, but also to a larger

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[106] Ibid, 5

share of the population: this sphere of Italians in difficulty are now called “the new poor”. According to data,

> In 2019 4.6 million people were in condition of absolute poverty in Italy; among them, 40.5% living in Northern Regions and 45.1% in the Southern ones. […] During the months of lockdown, 15 out of 100 Italians have experienced a reduction of income of their family units of more than 50%. […] In short, half of the Italians (50.8%) has experienced a sudden drop of their own economic availability. [107]

Furthermore, what is worse is that the projections for the future – both immediate and not immediate – are all but reassuring, since unemployment will rise together with feelings of anger and concern.

In this scenario, health poverty and difficulties to receive care will be boosted by two factors acting simultaneously. First of all, they will be a direct consequence of the increase of the percentage of absolute poverty. Second, even more worrying, there is the concern that we will have a health care system too focused on the emergency of Coronavirus, not leaving much room to all the other diseases, especially those poor people are more affected by. Not to consider, to conclude, the higher risks of infection to Covid-19 poorer people are more exposed to, due to the precarious conditions they live in.

However, what has to be said to close this part about Italian data on health inequality and poverty, is that if we compare unequal health of Italy with other States,

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[107] “Censis/Confcoperative: Covid, baratro povertà assoluta per alter 2.1 milioni di famiglie”, https://www.confcooperative.it/LInformazione/Notizie-Quotidiano/censisconfcooperative-covid-baratro-povert224-assoluta-per-altre-21-milioni-di-famiglie

we notice that they are less pronounced. For instance, in those countries with the highest rate of inequality there is a 10-year difference in life expectation between people with a low and a high degree; in Italy this difference amounts more or less to 4 years among men and 2 among women [108]. Indeed, there is still to be considered the fact that in Italy a form of universal health care is provided, differently from other forms of States, except for those services that are not provided by the SSN, as we will see in the immediately following section.

3.3 Health Expenditure in Italy

It has already been specified that the budget that the Italian State dedicates to health care is particularly low and has undergone a sharp decrease since the economic crisis and the necessity of cost containment, especially if compared with other European Union countries[109]. Even though the provision of LEAs covers a large share of services and there is a minimum role of private insurances, the remaining part is on the shoulders of the individuals in the form of out-of-pocket expenses – also known as OOP. In particular, the single person has to pay for himself/herself for drugs, diagnostic procedures, specialist visits, elective surgery and for the cost sharing through the ticket[110]. Also, data show that – since the economic crisis – the share of OOP expenses

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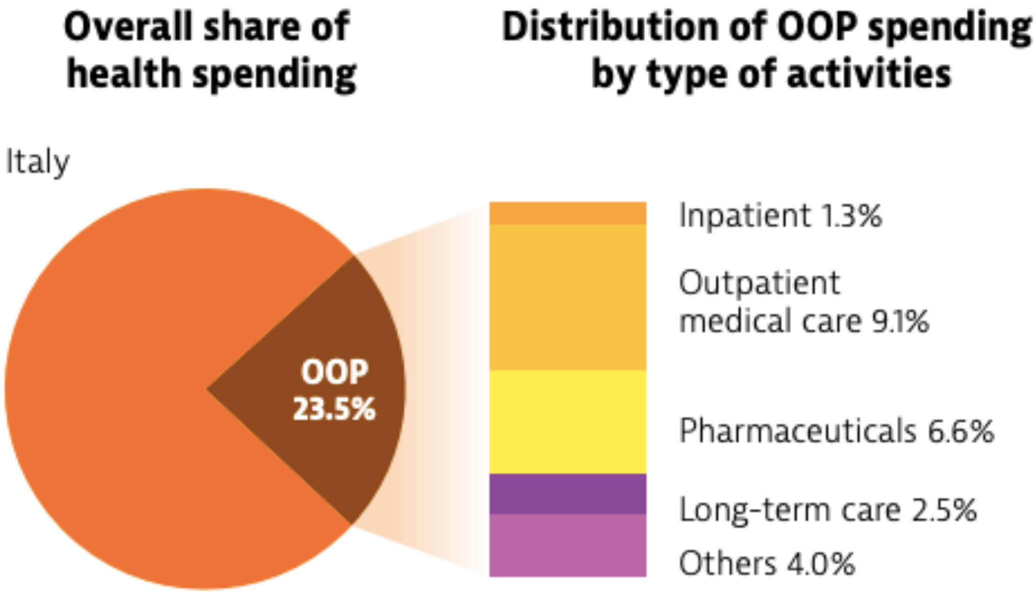
[108] Costa, "Cosa sappiamo della salute disuguale in Italia?", 9 www.disuguaglianzedisalute.it

[109] 8.8% of GDP, while the EU average is of 9.8% (State of Health in the EU – Italia – Profilo della Sanità 2019)

[110] : European Commission, "State of Health in the EU-Italia", pag. 10

in Italy is quite high and above EU average: indeed, among the other factors, several Regions have boosted the participation fee for health services and drugs. Translating this concept into numbers, while in 2009 the OOP expenses amounted to 21%, in 2017 they arrived at 23.5%, as illustrated in the graph below.



Source: Ibid., 16

Simultaneously, in the same period of crisis, the percentage of families that had to spend for health care has increased: "in the period 2011-2017 it went from 61.8% to 77.9%"[111].

Obviously, this results in serious difficulty for all those individuals and families who do not have enough resources to bear the costs of a health care system that becomes more and more parsimonious towards the needs of its population. As a consequence of the fact that not all the families can afford the same services, there are relevant differences in the amount of money spent for the health sector. If we consider the year 2017, for

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[111] CREA Sanità 2019, "XV Rapporto Sanità", 164

instance, “4.2 million people have declared that they have tried to limit health care expenditure and, among these, 1.1 million people actually have not born them” [112]. The last enounced phenomenon is better known in Italy as *rinuncia alle cure*, and this is a major defeat for a health care system like the Italian one that has at its core values as equality and universalism. As one may expect, inequality due to different levels of education plays a major role: “In the age group of 45-64 years, the renunciations to at least one benefit equals 12% among those who completed compulsory schools and 7% among graduates. The renunciation for economic reasons among low-education people equals 69%, while among graduates it equals 34%”[113]

Furthermore, in these very last years the phenomenon of impoverishment for health care expenditure is becoming increasingly relevant and worthy of attention and study. Always referring to 2017, “the national incidence of the phenomenon of impoverishment is equal to 1.7% and concerns 438,510 family units, that is 110,545 more with regards to the previous year”[114]. Moreover, if we compare the health expenditure of an average family with the expenditure of a poor one, we perfectly understand to what extent the situation is becoming dangerous. In 2012, poor families spent for health benefits €16, while non-poor families more than €93[115]. What is happening is running parallel with an increase – as already seen – of relative poverty among Italians, creating a vicious cycle from which it is always more difficult to escape.

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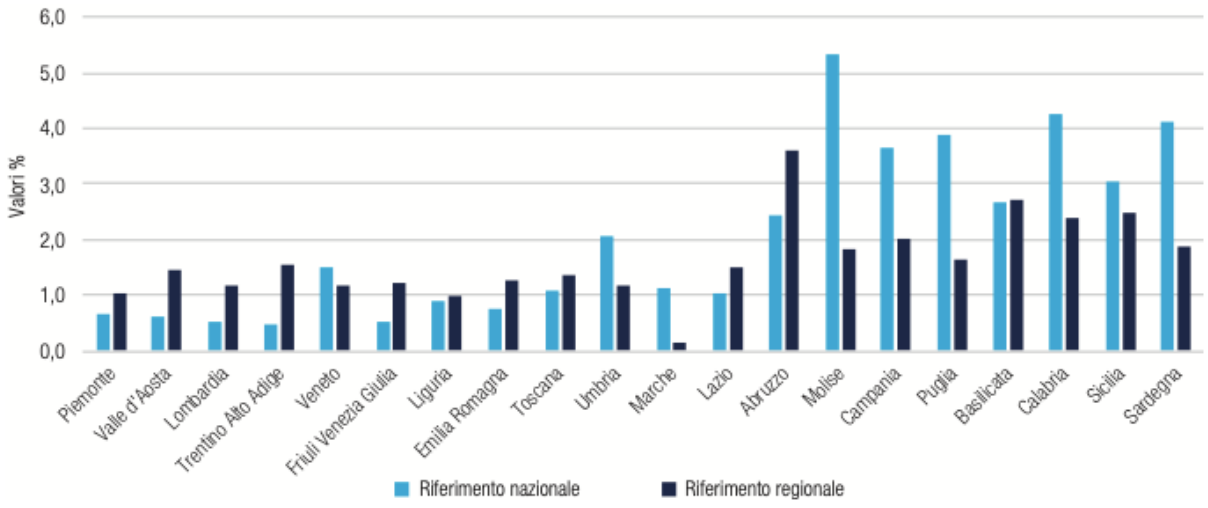
[112] Ibid.

[113] Osservatorio Nazionale sulla Salute nelle Regioni d’Italia, “Le Disuguglianze di Salute in Italia” (PDF), 9

[114] CREA Sanità 2019, “XV Rapporto Sanità”, 170

[115] Banco Farmaceutico, “Donare per Curare”, 20 https://www.bancofarmaceutico.org/cm-files/2014/11/26/26-11-2014-rapporto-2014-donare-per-curare-povert%C3%A0-sanitaria.pdf



[116]

In particular, data show that this phenomenon regards especially the Southern parts of the population – interested by a growing inequality mostly in the periods of crisis. Regions as Molise, Calabria, Sardinia, and Apulia are those which are suffering impoverishment the most. At the same time, Southern Regions are also those in which OOP expenses are more limited, since families prefer cutting a share of them in order to save money.

Among the OOP payments born by single patients, a large share (€ 9,051,000,000 in 2018 [117]) is occupied by medicines. For what concerns drugs in Italy, data comparing the two-year period 2017-2018 show that while the public expenses by the SSN are decreasing, those sustained by the private are increasing especially at the expenses of families.

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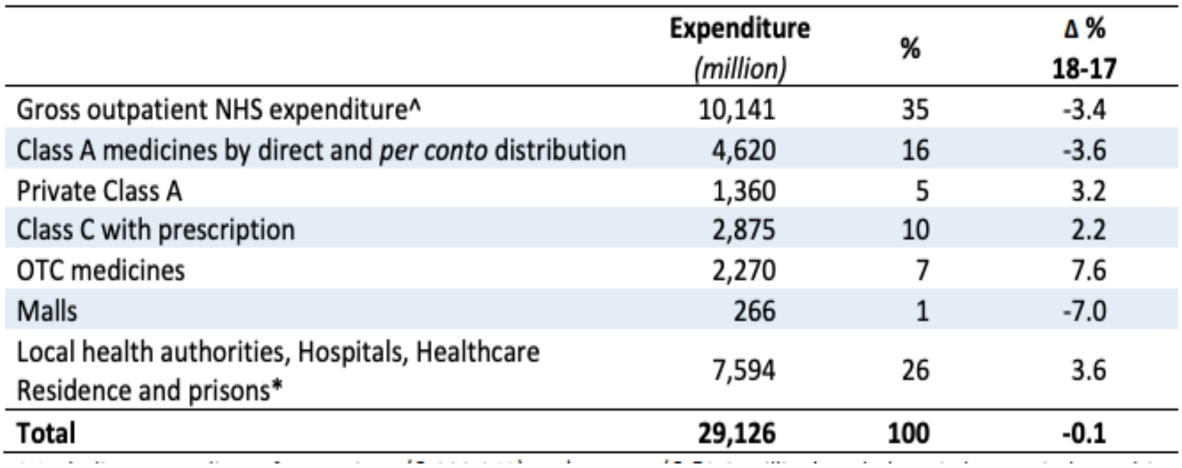
[116] CREA Sanità 2019, "XV Rapporto Sanità", 171

[117] Collicelli, "Quando per la salute si paga di tasca propria", https://www.lavoce.info/archives/63434/troppa-spesa-privata-nella-sanita/

Composition of pharmaceutical expenditure: 2018-2017 comparison



	Expenditure *(million)*	**%**	**Δ %** **18-17**
Gross outpatient NHS expenditure^	10,141	35	-3.4
Class A medicines by direct and *per conto* distribution	4,620	16	-3.6
Private Class A	1,360	5	3.2
Class C with prescription	2,875	10	2.2
OTC medicines	2,270	7	7.6
Malls	266	1	-7.0
Local health authorities, Hospitals, Healthcare Residence and prisons*	7,594	26	3.6
Total	**29,126**	**100**	**-0.1**

Source: The Medicines Utilisation Monitoring Centre, 8, https://www.aifa.gov.it/documents/20142/241052/OsMed_2018_Eng.pdf/29ebc13d-a9ba-3365-efef-8e2adfa61252

“The citizen pharmaceutical expenditure (OOP expenditure) amounted to € 8,379 million (+3.8% compared to 2017). […] The increase in citizen co-payment is mainly due to an increase of the co-payment for the reference price system for off-patent medicines”[118]. Again, the fact that the budget for public expenses has been limited requires that individuals pay a higher percentage of what they were used to for buying medicines. This situation is completely to the detriment of the less fortunate people both from a social and an economical point of view. For instance, elderly people cover a large share of medicines consumption: data show that people older than 64 consume more than 60% of the total drugs use [119]. On the other hand, we have already said that those economically disadvantaged families struggle to pay for care and oftentimes are forced to renounce.

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[118] Ibid. pag. 10

[119] Ibid. pag. 16

3.3.1 Increased Use of the Private Sector

A larger number of patients is starting to turn to the private sector when in need of health benefits. The reasons behind this choice are manifold and various and are typically linked to a growing discontent about what the public sector offers or, better, does not offer. The Italian SSN is indeed troubling for providing services and benefits, and what actually happens is that it is not able to satisfy its main scope and the requests of its patients. We have already seen as the increment of the OOP expenses makes people unhappy with the system; to this, it has to be added the fact that a series of inefficiencies cause real difficulties regarding the access itself to services.

First of all, the most common problem in which patients find themselves is that of extremely long waiting lists – *liste d'attesa* in Italian language: patients have to wait an indefinite quantity of time for receiving certain kinds of services, and this discourages them and especially those who have urgencies. Also, the fact that this is accompanied by increasing costs, as we have already seen, makes the situation even worse. In 2017 and 2018, CREA[120] conducted a study on waiting times for health benefits incurred in a sample of 8 different Regions both from the North and the South of Italy. While it is observable – as shown in the table below – a slight improvement in the waiting in 2018, we can still notice a huge difference between the requested time in the public and in the private. Suffice it to say that, in some cases, waiting times in the public result to be 10 times longer than in the private and in the public *intramoenia*.

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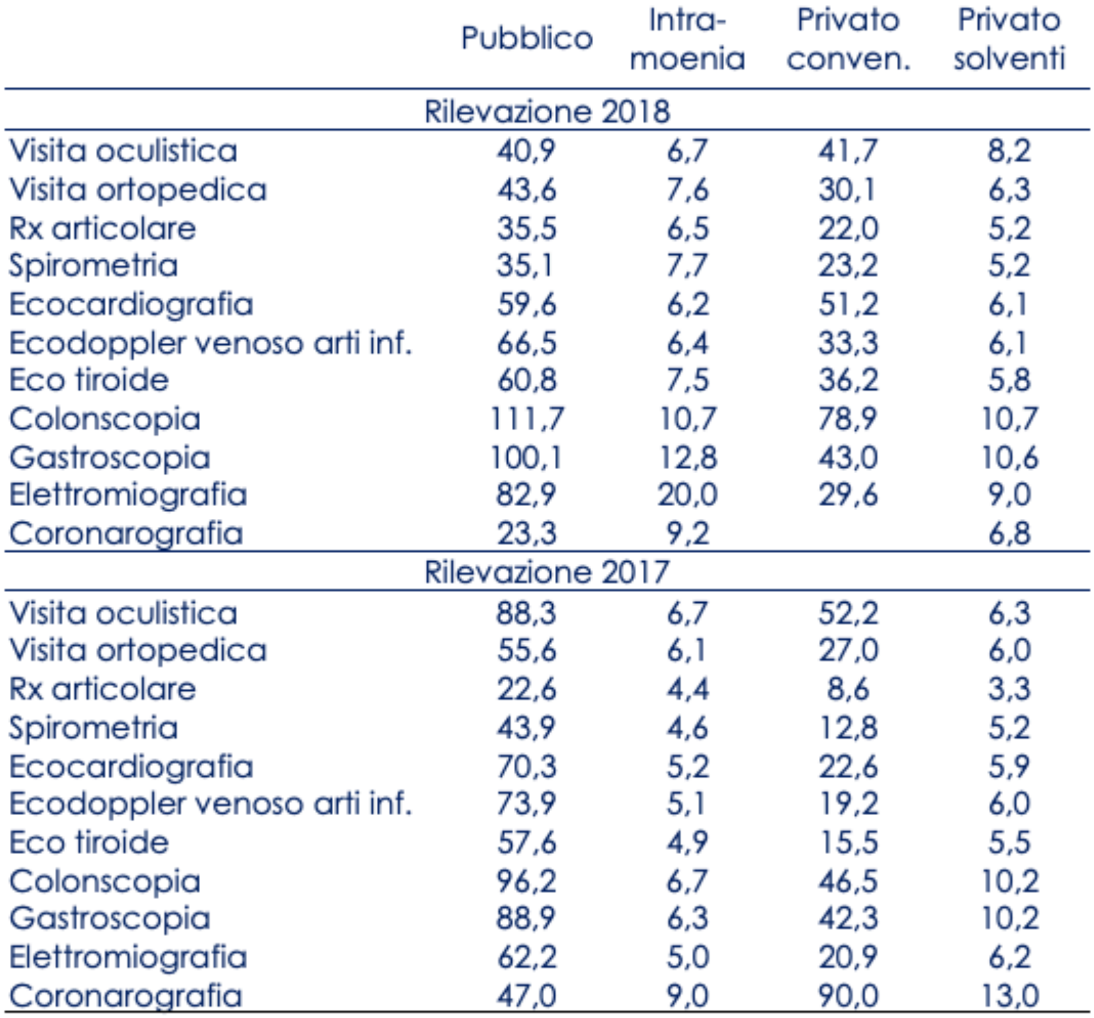
[120] Consorzio Per La Ricerca Economica Applicata In Sanità

Waiting times for benefits and regimes



	Pubblico	Intra-moenia	Privato conven.	Privato solventi
Rilevazione 2018				
Visita oculistica	40,9	6,7	41,7	8,2
Visita ortopedica	43,6	7,6	30,1	6,3
Rx articolare	35,5	6,5	22,0	5,2
Spirometria	35,1	7,7	23,2	5,2
Ecocardiografia	59,6	6,2	51,2	6,1
Ecodoppler venoso arti inf.	66,5	6,4	33,3	6,1
Eco tiroide	60,8	7,5	36,2	5,8
Colonscopia	111,7	10,7	78,9	10,7
Gastroscopia	100,1	12,8	43,0	10,6
Elettromiografia	82,9	20,0	29,6	9,0
Coronarografia	23,3	9,2		6,8
Rilevazione 2017				
Visita oculistica	88,3	6,7	52,2	6,3
Visita ortopedica	55,6	6,1	27,0	6,0
Rx articolare	22,6	4,4	8,6	3,3
Spirometria	43,9	4,6	12,8	5,2
Ecocardiografia	70,3	5,2	22,6	5,9
Ecodoppler venoso arti inf.	73,9	5,1	19,2	6,0
Eco tiroide	57,6	4,9	15,5	5,5
Colonscopia	96,2	6,7	46,5	10,2
Gastroscopia	88,9	6,3	42,3	10,2
Elettromiografia	62,2	5,0	20,9	6,2
Coronarografia	47,0	9,0	90,0	13,0

Source: CREA Sanità, “Osservatorio sui tempi di attesa e sui costi delle prestazioni sanitarie nei Sistemi Sanitari Regionali”, 20, https://www.fpcgil.it/wp-content/uploads/2019/05/FpCgil-Crea_SecondoReportListeAttesa.pdf

Obviously, it has to be kept in mind that these are not benefits requiring certain levels of urgency: however, it still has been detected a preference for private structures. As a matter of fact, the same study by CREA found that there is no so much difference in the costs between private and public, due to the increasing participation quota requested for the latter.

Indeed, another issue that makes patients particularly unhappy about the public SSN and that convinces them to refer to private structures is the excessive cost of the offered services, especially for specialist visits. Indeed, the second highest share of expenses sustained by patients after medicines is represented by them. In particular, in 2017 families have paid for them an amount of €7,049,000,000.

It must be said that something started to be made. One possible solution to this issue is the reformation about the abolition of the so-called superticket since September 1st, 2020: it is one first important step towards patients, causing a quite relevant reduction in prices for benefits. This aspect, however, will be largely treated in the following section about policies.

Chapter IV

Policies and Measures on Health Inequality and Poverty in the Italian Scenario

CONTENTS: 4.1 HEALTH INEQUALITY AND POVERTY: ADEQUATE POLICY RESPONSE? – 4.2 THE ROLE OF NON-PROFITS ORGANIZATIONS: 4.2.1 BANCO FARMACEUTICO ONLUS – 4.2.2 CORPORATE DONATIONS – 4.3 MODIFICATION OF THE *LEGGE DEL BUON SAMARITANO*: FROM LAW 155/03 TO LAW 166/16 – 4.4 ABOLITION OF SUPERTICKET: CONTROVERSIES – 4.5 NEED FOR POLICIES: 4.5.1 GENERIC MEDICINES –

The following section of this thesis will deal with the policies and measures – and their eventual adequacy – on the just treated issues of health inequality and poverty. An analysis of the existing ones will follow and, at the same time, there will be space for understanding whether the issues are appropriately addressed. Finally, the last part will be reserved to the measures that could be better designed for trying to contain these two pressing problems.

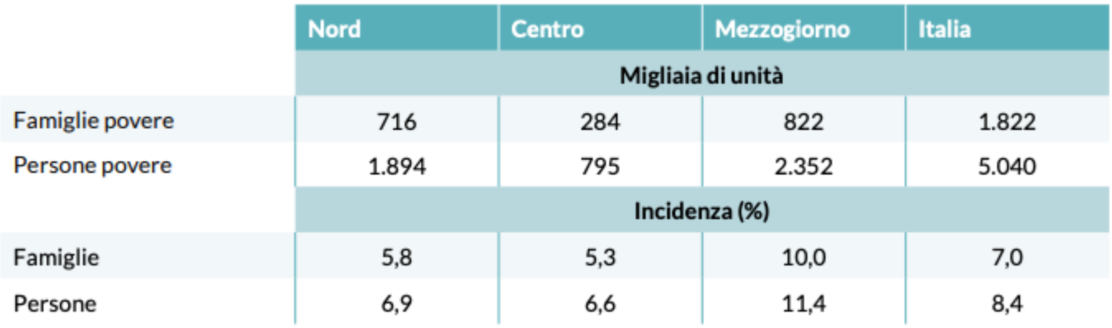
4.1 Health Inequality and Poverty: an Adequate Policy Response?

We have thoroughly seen, throughout the previous chapters, that in these last years there has been an increasingly growing interest towards the issues of health inequality (or inequity) and of health poverty as necessarily linked to it. There is finally the recognition of the existence of these problems both at intranational and national levels: even simply by searching on Google, it is particularly easy to find data, factsheets and statistics about the conditions of inequality in healthcare sectors under which people live. Furthermore, careful and meaningful examinations exist about the fact that in Italy we face different levels of inequality: a territorial (regarding the divide between the North and the South) and a socioeconomical ones, as we have previously explained. In other words, there is a clear empirical evidence about the issue, accompanied by a quite strong awareness; however, what appears to be missing is the necessarily following step, that is, a practical design from the part of policymakers in a way that could properly frame the issues and provide for practical resolutions. This absence of effective actions is highly demonstrated if we consider data on poverty in general and health inequality, which continue not to ameliorate.

In the following part of this chapter, we will offer a recap of what has been said until this point, to have a practical and statistical evidence of the strong need of policies that the health care sector is undergoing. In particular, specific data about absolute and relative poverty, health expenditure, difficulties encountered by patients when entering the healthcare system, and persistent territorial inequality will be provided to understand what is still not touched by policies and struggles to improve.

First of all, the example that will be provided about absolute poverty will serve as proof that targeted measures may actually limit the problem, but with the necessity of strong interest and constancy over time to get the expected results. In the 4-year period 2015-2018, the percentage of absolute poverty (immediately linked to health poverty) has constantly increased, arriving to interest the 7% of the Italian population, especially in the Southern part of the country.

Indicators of absolute poverty by geographical breakdown (2018)



	Nord	Centro	Mezzogiorno	Italia
	Migliaia di unità			
Famiglie povere	716	284	822	1.822
Persone povere	1.894	795	2.352	5.040
	Incidenza (%)			
Famiglie	5,8	5,3	10,0	7,0
Persone	6,9	6,6	11,4	8,4

Source: Banco Farmaceutico, *Donare per Curare 2019,* 25 https://www.bancofarmaceutico.org/cm-files/2019/12/04/itsb19024-bfa-report-009-1-web.pdf

In 2019, however, the absolute poverty rate started to slightly decrease under the effects of the welfare policy *Reddito di Inclusione*: that year, data registered a percentage of 6.4% (1.7 millions of families and 4.6 millions of total individuals)[121]. In addition, another relevant fact is that the absolute poverty is decreasing especially in the South and in the Center – the zones that are more at risk. Even though it is the first reduction, the numbers are still high if compared with the period before the financial crisis.

On the other hand, what about relative poverty? "In 2019 families in conditions of relative poverty are estimated at little less than 3 millions (11.4%), for a total of above

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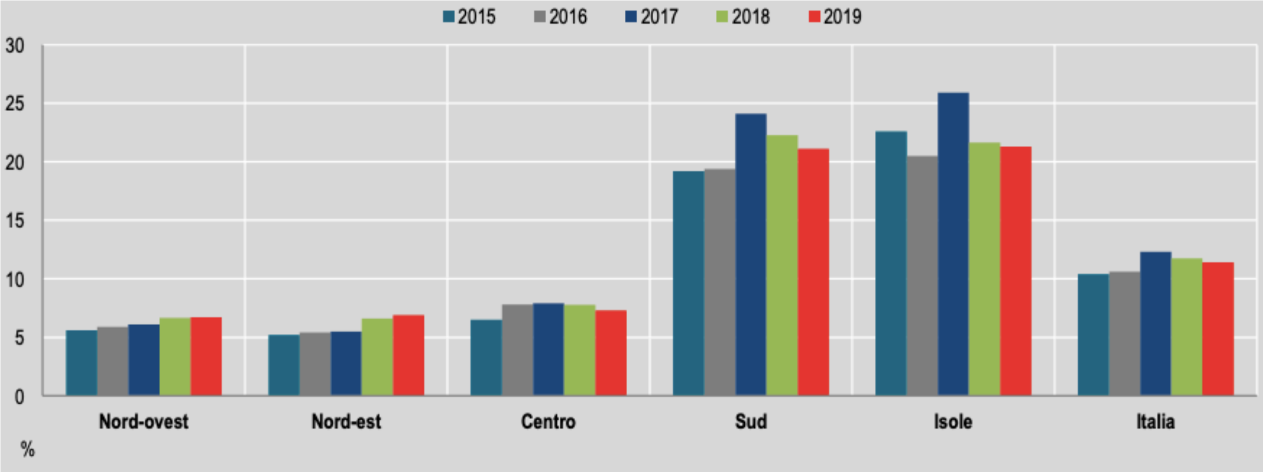
[121] Istat, "Le statistiche dell'Istat sulla povertà", https://www.istat.it/it/files/2020/06/REPORT_POVERTA_2019.pdf

8.8 millions of individuals"[122]. As shown in the graph, on average relative poverty is quite stable throughout the years: also here, however, it decreases in the Southern Regions, which still are hit by really higher levels if compared with the rest of the peninsula.

Incidence of familiar relative poverty by geographical breakdown (2015-2019)



Source: Ibid., 7

Both for absolute and relative poverty, we may affirm that the levels are quite worrying, especially if we consider the negative repercussions that these have on the access to healthcare.

Once considered the social situation of poverty, we can now focus on healthcare issues. We have already seen that the expenses that the State reserves to public health is too low compared to the needs of the population and to the expenses of other States. We can observe this statement the graph below:

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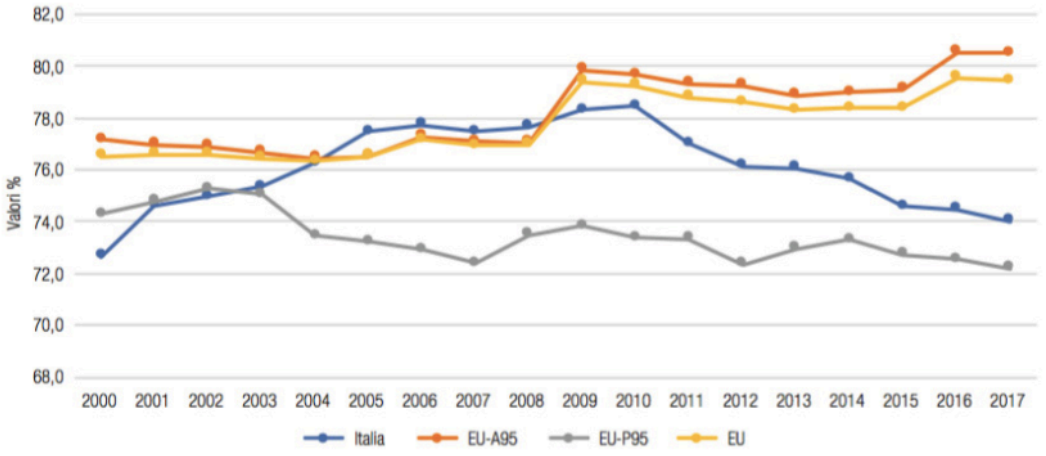
[122] Ibid., 7

Public financing of current health expenditure in Italy



Source: CNEL, “Relazione 2019 al Parlamento e al Governo”, 210

This graph represents not only the fact that Italy is the last country in terms of public expenditure in the healthcare sector, but it also underlines how this expenditure has decreased in the last years. At the same time, what also happens is the consequential increase of private costs incurred by citizens – OOP expenses – for which Italy is the second country among G7 ones[123].

Furthermore, it is also important to consider what patients think about the services offered by the SSN. Interesting the data provided by *PiT Salute* in their last Report (2019), in which they highlight the difficulties met by people in facing the Italian SSN. For what concerns access to care, the results are all but satisfying, underlining all the difficulties and the inconveniences that patients have in trying to access the system. Therefore, if we consider the reports made by citizens in relation to the access, we see how unsatisfied they are. The percentages are quite high: 57.4% of notices reporting

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[123] Ibid.

difficulties for the matter of waiting lists and 30.8% for the payment of tickets[124]. And, more importantly, these percentages have increased if compared with those of the previous year (2017), testifying a complete lack of interest in measures facilitating patients' access to care, especially in relation to costs – that, as already analyzed, increasingly push people to turn to the private sector, where waiting times are practically null and costs are sometimes equal.

Finally, the existing situation of territorial inequality cannot be neglected: it is impossible to consider the general health scenario in Italy without considering the internal differences that characterize it. It has already been pointed out that also differences among the North and the South of Italy have consequences for people in variables as life expectancy, mortality, and quality of offered services: even if this situation has been eradicated in Italy for decades, nothing seems to change. "for what concerns epidemiological aspects, from a territorial point of view, according to Istat statistics it was found that between Milano and Napoli there is a difference of almost three years in terms of life expectancy, while if we consider the poorest social groups of the South and the richest ones of the North the difference arrives to ten years"[125]. Moreover, another aspect to be considered is that even the public expenditure varies depending on the zone, being higher in the North and lower in a South that should be an absolute priority for the State.

As the evidence that we have just shown suggests – regarding costs sustained by patients, waiting times, and the situation of disparities – it appears that in Italy the matters

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[124] "Il SSN tra attese e promesse disattese", 17, https://www.fnopi.it/wp-content/uploads/2019/12/Rapporto-PiT-Salute-2019-2.pdf

[125] CNEL, "Relazione 2019 al Parlamento e al Governo", 218

of health inequality and, above all, health poverty struggle to be properly tackled. We may say that the phenomena of inequality and poverty have been able to be part of the systemic agenda; the greatest difficulty, however, is to enter the institutional one. Let us see what this statement means, explaining the difference between these two concepts.

At the beginning of the policy cycle we find the agenda setting, the process during which the problems to be treated through policies are chosen. Within this phase of building the agenda, the selection of the issues that will be eventually tackled is a matter of priorities, depending especially on external factors as the historical moment the society is living or even the political ideology of policymakers. It is for this reason that a certain issue may or may not be treated and be part or not of the agenda. In this latter case we may talk about non-decisions, that is to say the deliberate exclusion of certain issues from the agenda, which are as important as the inclusion in the agenda of specific issues. In the case of health poverty, we have surely overcome the "non-decision" phase, considering that the issue is gaining more and more visibility in the last years; however, considering the existing policies, we may not say that it has the importance it should deserve.

As a matter of fact, we may distinguish among two different kinds of agendas, according to a classification offered by Cobb and Elder. With systemic (or public) agenda we refer to "all issues that are commonly perceived by members of the political community as meriting public attention and as involving matters within the legitimate jurisdiction of existing governmental authority"[126]. On the other hand, institutional (or formal) agenda comprises "that set of items explicitly up for the active and serious consideration of authoritative decision-makers"[127]. For the case that we are analyzing,

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[126] Cobb and Elder, *Participation in American Politics: the Dynamics of Agenda Building,* 1983

we may say that health inequality and poverty are in the systemic agenda because there is the recognition that they deserve public attention; however, there is not yet the quantum leap that should be needed to actually get policies (institutional agenda).

4.2 The Role of Non-profit Organizations

The fact that health inequality and poverty have not gained so much space among the public sector – or, at least, not enough – has allowed an increasing responsibility of the third sector and the development of non-profit organizations involved in attempts to try to improve living conditions of all those categories who are suffering these social matters.

4.2.1 Banco Farmaceutico Onlus

In Italy, the greatest exponent of this – and the institution that the most takes charge of the issues – is *Banco Farmaceutico*[128]. The organization has been founded in 2000 from the recognition of a growing need of poor people to be granted – in addition to other services – medicines. Indeed, oftentimes the lack of resources for a family to buy products as drugs is underestimated, while a lot of value is given only to food and shelter. *Banco Farmaceutico* has thereby started to give voice to the need for medicines: not only

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[127] Ibid.

[128] Literally translated in English "pharmaceutical bank"

are they trying to spread visibility – that we know is missing – but also acting in practical terms to meet the necessities of the poor.

The most important action made by the organization is the collection of medicines through the institution of the so called *Giornata Raccolta Farmaco*[129] (GRF). Every year, the second Saturday of February[130], volunteers collect drugs donated by citizens: in particular, people are invited to buy in the pharmacies (those joining the proposed initiative) medicines that will go to the poorest beneficiaries. In particular, medicines collected by *Banco Farmaceutico* may directly go to poor individuals or through the mediation of charitable organizations. According to the numbers, "In 20 years the *Giornata Raccolta Farmaco* has collected above 5,600,000 drugs, for a commercial countervalue of about 34 million euros. The last edition, which lasted one week in occasion of the 20 years of *Banco Farmaceutico*, saw the involvement of 4,944 pharmacies and above 22,000 volunteers; more than 473,000 assisted people have benefited from 541,075 collected medicines"[131].

Although the *Giornata Raccolta Farmaco* is surely the most notorious, it is not the only action made by *Banco Farmaceutico* to meet the necessities of the poorer. The second "campaign" is named *Recupero Farmaci Validi*[132] , a collection of drugs that citizens would not need anymore for them. This collection is valid throughout the whole year, and anyone may go to the acceding pharmacies and donate. This is not only a way

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[129] Collection of medicines day

[130] "Giornata Di Raccolta Del Farmaco." Fondazione Banco Farmaceutico, https://www.bancofarmaceutico.org/cosa-facciamo.

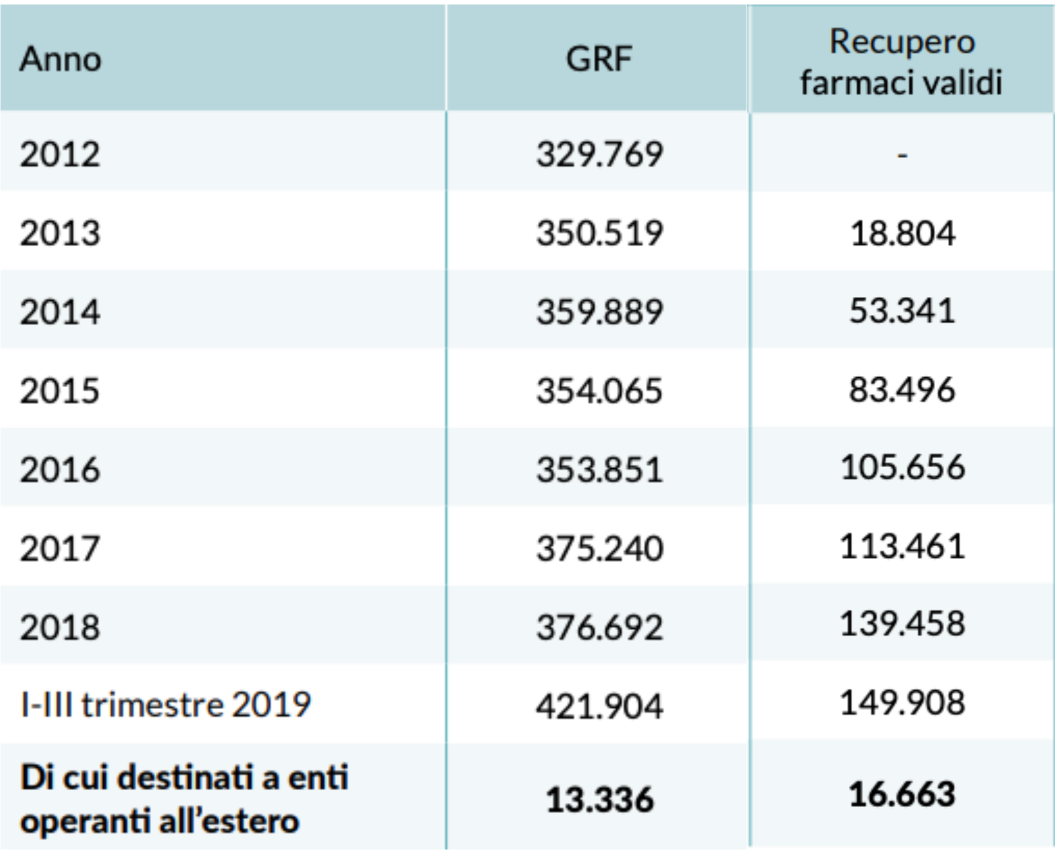
[131] Ibid.

[132] Recovery of valid medicines

of helping individuals and families in need, but also a way not to waste products that are not even easy to dispose, being medicines hazardous waste that cannot be dispersed as normal products.

If we see data about *Banco Farmaceutico*'s operate, we may understand how important their contribution is. As we may see in this table, donations since the year 2012 have constantly increased, both during the yearly event and during the constant collection of medicines.

Collected medicines (2012-2019)



Anno	GRF	Recupero farmaci validi
2012	329.769	-
2013	350.519	18.804
2014	359.889	53.341
2015	354.065	83.496
2016	353.851	105.656
2017	375.240	113.461
2018	376.692	139.458
I-III trimestre 2019	421.904	149.908
Di cui destinati a enti operanti all'estero	**13.336**	**16.663**

Source: Banco Farmaceutico, "Donare per Curare", 35

This is an important datum to understand that the action of this non-profit organization is going well beyond the mere collection of drugs: increasing in donations also mean that the action of promotion is working right. The issue of health poverty is maybe reaching visibility among civilians, who are increasingly more prone to donate and sensitive to the issue.

4.2.2 Corporate Donations

In addition to the initiatives as the *Giornata di Raccolta del Farmaco* and the *Recupero dei Farmaci Validi*, a great contribution is today given by other important entities, that is, companies. Indeed, a strong point of *Banco Farmaceutico* is the fact that numerous actors – volunteers, private citizens, institutions, pharmacies – operate for one single common goal.

Corporate donations are gaining an ever-increasing role: suffice it to say that, while in 2012 the collected value amounted to little more than 2 million euros, in 2018 they have collected through this kind of donations more than 8 million euros[133]. Indeed, while at the beginning just a little share of donations was coming from this kind of sector, more and more companies have started to actively contribute to the initiatives of *Banco Farmaceutico*, becoming the main characters of these activities. Thanks to them, a consistent number of medicines is granted throughout the whole year and distribute all around Italy and not only, since every year a share of donations is reserved to institutions operating abroad, especially in underdeveloped or developing countries. To be more

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[133] Ibid., 38

specific, just to give some practical insights of how *Banco Farmaceutico* operates even overseas, in 2018

> *Banco Farmaceutico* signed an agreement with the *Stato Maggiore della Difesa* and with the *Ordinariato Militare per l'Italia* in order to donate medicines to those populations who are living in poverty and in crisis areas, where the Italian Armed Forces operate in peacekeeping missions. [Always in 2018] *Banco Farmaceutico* has signed an agreement with Croce Rossa Italiana to strengthen the capacity to face emergencies together"[134].

Furthermore, another important aspect about corporate donations is that they also comprise prescription medicines, since there are doctors working for this[135].

However, it is important to specify that the action made by *Banco Farmaceutico*, although so relevant, is only circumscribed to the sector of medicines, while we perfectly know that health poverty regards many other needs. It is not possible, for so huge matters like health inequality and poverty – which are becoming increasingly relevant even in the Italian scenario – to rely only on the actions of the third sector. A practical insight to understand how serious the issue of health poverty is: "for the *Giornata di Raccolta del Farmaco* 2018, the medicines requirements amounted to 993,064 medicinal packages. In that occasion, 376,982 of them have been collected, covering in that way 37.9% of the total need"[136].

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[134] Banco Farmaceutico, "Bilancio Sociale 2018", 5 https://www.bancofarmaceutico.org/cm-files/2019/07/23/bilancio-sociale-bf-2018-bassa-15-17-19.pdf

[135] Banco Farmaceutico, https://www.bancofarmaceutico.org/cosa-facciamo/donazioni-aziendali

[136] Banco Farmaceutico, "Bilancio Sociale 2018", 6 https://www.bancofarmaceutico.org/cm-files/2019/07/23/bilancio-sociale-bf-2018-bassa-15-17-19.pdf

Surely, it has a stronger hold on citizenship who gets firsthand involved through volunteering or even through the donation of packages of drugs. But their contribution should be acting only as a support of the intervention of a State that does not leave its citizens in difficulty.

4.3 Modification of The *Legge del Buon Samaritano*: from Law 155/03 to Law 166/16

In this section, something related to the actions made by *Banco Farmaceutico* will be treated, concerning the way in which the Italian law regulates the donation and collection of medicines to be given to poor people.

In 2003 a law was enacted for the redistribution of leftover food: it was the law 155/03, also named "del Buon Samaritano"[137]. This law regulated the collection of great quantities of food left from schools, restaurants, or supermarkets and their redistribution to the poor[138]. It was a way both to avoid waste and to help the indigent. ONLUS organizations, also here, are in charge of this last step through the collection of what will be then redistributed. This law has been the instrument for simplifying and making this process more streamlined: it is a sort of facilitation of the job of the third sector, which was less obliged to undergo bureaucratic procedures[139] .

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[137] From the Christian parable of the Good Samaritan

[138] Law 155/03, https://www.gazzettaufficiale.it/eli/id/2003/07/01/003G0174/sg

[139] "La Legge 155/2003, Una Legge Italiana All'Avanguardia Al Fine Di Incoraggiare Le Donazioni Di Cibo Cotto e Fresco Ai Più Poveri." https://www.bancoalimentare.it/sites/bancoalimentare.it/old-files/Legge_155_20032(2).pdf.

Years later, in the footsteps of this regulation, something more was added. It is with the law 166/16 that the field of intervention is widened to medicines. “To the third sector entities it is allowed the free distribution of unused medicines directly to the most deprived people with medical prescription, if necessary […]. The entities carrying out assistential activities shall be treated as final consumer with respect to the detention and the storage of the drugs”[140]. Moreover, the category of donators has been enlarged, comprising “pharmacies, parapharmacies, wholesalers, companies”[141]. Also here, the fact that third sector organizations may directly distribute medicines accelerates the process and makes the redistribution more efficient, increasing the number of poor people covered.

As it has been said also in the previous section for the matter of the role of non-profit organizations, a different approach should be needed. The engagement of different levels of actors is essential in the struggle against health inequality and poverty. As declared by Mario Melazzini – general director of AIFA – “the antidote to this real disease is the synergy among institutions, non-profit, pharmaceutical companies and citizens. Public and private subjects’ energies, if united for a common cause, may stem the negative effects of social and economic conjunctures”[142].

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[140] Law 166/16, https://www.gazzettaufficiale.it/eli/id/2018/04/06/18A02359/sg

[141] Banco Alimentare, “Legge antispreco 166/16: ancora più semplice donare e ricevere eccedenze, https://www.bancoalimentare.it/it/news/legge-antispreco-donare-ricevere-piu-semplice#:~:text=%E2%80%9CLe%20misure%20introdotte%20in%20Legge,delle%20persone%20in%20condizione%20di

[142] Lucchini, “Banco farmaceutico: l’industria farebbe di più con l’emanazione del decreto attuativo della L.166”https://www.notiziariochimicofarmaceutico.it/2017/11/17/banco-farmaceutico-lindustria-farebbe-piu-lemanazione-del-decreto-attuativo-della-l-166/

4.4 Abolition of Superticket: Controversies

Since September 1st, 2020 a new measure has been enacted: the abolition of the so called “Superticket”. It was a 10-euro tax borne by the patient in addition to the ticket payed for specialist visits. It has been an attempt to grant equity and universalism in the healthcare sector, together with “an increase of 2 million euros in funding for the SSN and the allocation of two funds of 500 million euros each for innovative cancer drugs, laid down in the *Documento di Economia e Finanza* (DEF)[143] 2020”[144]. Presented as an instrument for boosting the idea of an equal health, is it really like this?

This superticket had been introduced in 2011, giving to the single Regions the freedom to choose how to apply it on the ticket. As we have already seen, there is a preference among patients for the private sector, considering not only the waiting times of the public benefits, but also the high costs of a system that should be universalistic. Part of the responsibility of this has been given to the price of the superticket: a year later its introduction, in 2012, there has been a decrease of 17.2% of the benefits provided by the SSN[145]. With its abolition, it cuts the tax that citizens had to pay to the Regions. Moreover, Regions applied its cost in different ways, since there were zones in which patients directly paid the 10 euros, others in which it was paid on the basis of income, and others in which it was not paid at all.

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[143] Document of Economics and Finance

[144] Collicelli, “Quando per la salute si paga di tasca propria”, https://www.lavoce.info/archives/63434/troppa-spesa-privata-nella-sanita/

[145] Usai, “Dal 1° settembre addio al superticket sanitario”https://www.altroconsumo.it/salute/dal-medico/news/superticket

This new measure surely resonates a lot, especially in a period like this in which healthcare system is so exposed and in the spotlight. However, is it really a fair measure? Is it right to cut a tax without considering the effects that it will have on public funding and with no respect of the income of the patients? This is one case in which the difference between equality and equity should be underlined. While equality is the provision of the same opportunities to everybody, with no distinction of opportunities and incomes, equity is something far more subtle: it is the distribution of support in accordance with one's needs. As a matter of fact, cutting indistinctly the superticket is probably an equality measure, but not an equity one.

4.5 Need for Policies

It appears evident how the issues of health inequality and poverty should be tackled in a proper and targeted way. After the recognition of the severity of the problems – that is starting to be present – the next step is absolutely something practical to be made. In this last section, some possibilities and reflections about new insights will be provided, also starting from already existing policies in Italy that could be better addressed in favour of the health poor.

4.5.1 Generic Medicines

Something that could result really useful for the poor – for what concerns expenditure on medicines – is the developing of the market of generic or equivalent medicines. "With generic (or equivalent) drug we mean a medicine with the same qualitative and quantitative composition in active substances and the same pharmaceutical form of a reference medicinal product, as well as a bioequivalence with the reference drug demonstrated by appropriate bioavailability studies"[146]. It is important to underline, moreover, that it is AIFA itself that controls the validity of the generic drugs, exactly in the same way as it controls their equivalent. In other words, what makes the difference between a generic and a reference drug is just the pharmaceutical company that, in the second case, is a well-known one. And, more importantly, generic drugs have much lower costs if compared with their "famous" corresponding one. This happens because generic medicines are produced since the date of expiration of the patent of the active substance. Once this patent expires, there are no research and production fees and these pharmaceutical companies may produce at a much lower cost. It is for this reason that an increasing in the purchasing of these items would be a positive answer against health poverty.

Italian people appear to be particularly skeptical about generic drugs: data show that Italy is the country in Europe that buys them the least[147]. Same thing for what regards OECD countries, as shown in the graph below.

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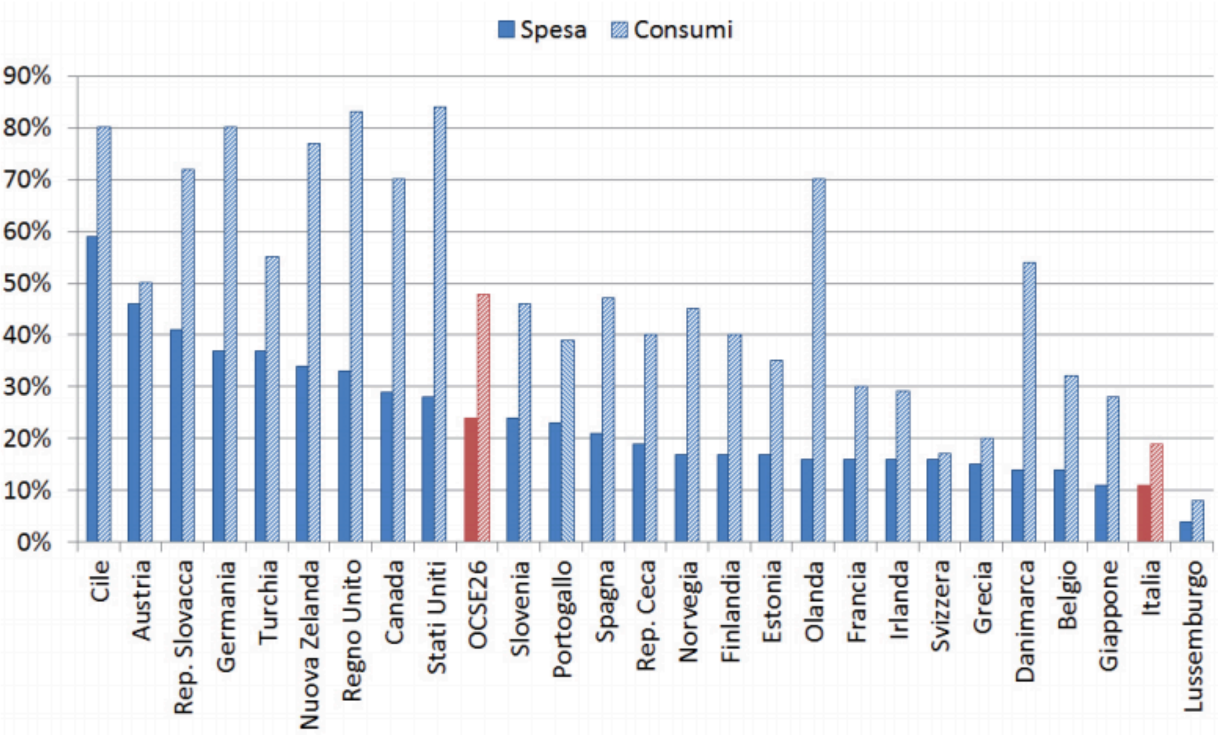
[146] AIFA. "Farmaci equivalenti", https://www.aifa.gov.it/farmaci-equivalenti1

[147] Leonardi, "Il paradosso tutto Italiano dei farmaci equivalenti"https://www.agi.it/blog-italia/idee/farmaci_equivalenti-5903937/post/2019-07-24/

Percentage of expenditure and consumption of generic medicines in OECD countries



Source: Gimbe foundation, “Dal 1° settembre addio al superticket sanitario” 2, https://www.evidence.it/articoli/pdf/e1000153.pdf

Generics cover only the 24.3% of the whole pharmaceutical market (considering both hospitals and pharmacies), which is a quite low percentage if compared with the 75.7% of the branded ones[148]. Suffice it to say that “in 2018, of the 1,609 million euros paid by citizens on prescription charge, only 30% refers to the fixed fee of the prescription (482.6 million euros, equal to 8 euros per capita), while the remaining 1,126.4 million euros (18.6 euros per capita) are attributable to the limited diffusion of generic medicines in Italy”[149] In particular, those who are more reluctant are Southern citizens, precisely those

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[148] Magnano, “Farmaci equivalenti, mercato in crescita ma l’Italia è divisa in due” https://www.ilsole24ore.com/art/farmaci-equivalenti-mercato-crescita-ma-l-italia-e-divisa-due-AEMDZplE?refresh_ce=1

who have less resources for health at their disposal and would need them the most. Specifically, “in the Central-Southern Regions, a higher than the national average (18.6 euros per capita) expense for branded medicines is observable. In particular, Lazio (€ 24.7), Sicilia (€ 24.2), Calabria (€ 23.6), Campania (€ 23), Basilicata (€ 22.1), Puglia (€ 21.9), Abruzzo (€ 21.5), Molise (€ 21.3), Umbria (€ 20.7) e Marche (€ 20.2)”[150] Is it only a problem of ignorance about the equivalence of this kind of medicines, or is it something linked to the nature of the society we live in?

In any case, in the last years generic drugs are experiencing an increase in consumption, although still not so relevant if compared with other European States. For instance, the first quarter of 2018 has recorded a slight rise if compared with the first quarter of the previous year: there has been an increment of 6.7% for unit, especially for class A and C drugs[151].

Despite this little increment, still there is the need of more information about the existence and the use of generic medicines. There is the perception, on the part of the patient, that lower prices (and unknown brands) automatically mean lower quality. Even medical doctors are influenced in this choice: studies have shown that a percentage of 25% of them has doubts about safety and efficacy of generics; this is a quite relevant issue, considered that doctors should help the patients in choosing the best for them considering their socio-economic status. The same thing should happen with the

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[149] “Farmaci generici: le differenze nel consumo in Italia e in Europa” https://www.docgenerici.it/approfondimenti/farmaci-generici-differenze-nel-consumo-in-italia-e-in-europa/

[150] Ibid.

[151] “La scalata dei generici”, 10, http://www.merqurio.it/wp-content/uploads/2018/08/Scalata-Generici.pdf

pharmacists, who should encourage people to buy generic drugs or, at least, inform them about their existence and efficacy, even though this would be to their detriment.

Being generics also a way to limit SSN expenditure – beyond those of the single patient – decision makers are looking for strategies in order to favour the consumption of generic drugs. For instance, an app for smartphones has been created, named "IoEquivalgo" as the homonymous communication campaign and promoted by *Cittadinanzattiva-Tribunale per i diritti del malato*. This app should help people to autonomously understand their advantages and savings, since it offers all the information and the names of the equivalent. This is a little step, especially if we consider that the average age of people who consume medical products the most is above 65 and cannot easily use an app. What is needed is knowledge that could overcome all this disinformation about the issue: a multilevel approach comprising doctors, pharmacies and decision makers in order to try to eradicate this wrong culture that Italian society has about generic medicines.

Conclusions

At the end of this analysis, we should have a complete picture of something that is affecting, in a particular way, Italian society: health inequality and health poverty. These two impelling phenomena are causing an increasingly growing attention and taking hold in the Italian social dialogue. Everyone talks about how they matter and awareness is growing, but is this enough? Let us proceed in order to synthesize our findings in this thesis, whose sense is, in practical terms, a call for new policies.

Since the very beginning of this work, the leading concepts have been illustrated in detail: we have understood the meaning of equality and inequality and the existing differences between levels of poverty; also, we have considered the historical and political dialogue about health seen as fundamental right, and how it has always been considered as strictly interrelated to an equal access to it.

Once having examined the theoretical framework at the basis of our objects of analysis, we have seen how the issues of health inequality and poverty place themselves in the Italian scenario, despite the universality and equality ideas at the foundations of the Italian National Health Service. It has been demonstrated that there are internal differences among Regions – especially among Northern and Southern zones – that are in the nature and in the history themselves of the Italian society: they unavoidably concur to the exacerbation of disparities, which also have healthcare connotation. At the same time, it has also been shown that the SSN itself is structured in a way that does not really favor poorer Regions and inhabitants – especially since the moment in which economic efficiency started to be the priority – causing unavoidable inequalities. Moreover, we have come to the conclusion that, despite some sporadic and isolated attempts to tackle the growing issues of inequality and poverty, there is not an adequate policy response: this has been largely demonstrated through the whole dissertation, considering the found data – all but optimistic. To conclude, these very basic attempts certainly are not succeeding to limit issues that are more and more taking ground.

We have proof, for sure, that there is the recognition of the cruciality and urgency of these matters: there is a huge literature about them, along with a great availability of data and statistics testifying how worrying, even in Italy, the situation is becoming. In particular, there is an extensive knowledge about the determinants and the immediate consequences of these phenomena. This awareness should, therefore, be an important starting point for the entrance of the issues in the institutional agenda, worthy of the attention of the public sector, too, and the formulation of effective policies, careful of the needs of all the strata of the population.

The main point of the dissertation, indeed, is that there is the high risk of an aggravation of health inequality and of poverty, consequently. There is not, until now, a firm commitment to make these issues enter the institutional agenda and be a priority for new policies. We have seen also a number of data confirming this possibility on the basis of the actual situation for all poor patients: they keep facing endless difficulties, the State struggles to finance healthcare sector in a proper and equal way, and both territorial and socio-economic inequalities are far from diminishing. Surely, some attempts have been made and some of them have been mentioned. However, they have demonstrated to be only sectorial measures or not really well addressed. We have seen, for instance, the modification of the law *del Buon Samaritano*, favoring the donations of medicines to poor people and facilitating the job made by non-profit organizations operating in that sector. Also, another measure that we have taken into consideration is the abolition of the so called *superticket*: although it may seem a first step to reach out to those who cannot afford to pay an extra tax on visits, there is the idea that it is not a so fair measure to be applied to all Italian people.

It has already been expressed, in the thesis, the necessity of collaboration of different policy levels for a policy design able to better frame both healthcare inequality and poverty, which are nothing but just one of the many faces of a larger issue regarding impoverishment and unequal society. It appears impossible – and quite useless – to tackle such issues with only healthcare policies, since we are dealing with strong socioeconomic problems. For this reason, there is the necessity of a multisectoral approach based on the collaboration of different intervention levels. As underlined also in the Agenda 2030 promoted by the UN, inequality reflects many different factors that, all together, contribute to the wellbeing of the single person. Among these factors we may cite education, exposition to risk factors, income, environment, social inclusion, family, social capital[152]. Welfare policies are another essential dowel to grant a dignified lifestyle, limiting inequality as much as possible: we have seen, for instance as the measure of *Reddito di Inclusione* has slightly limited absolute and relative poverty between 2019 and the previous years. These policies should begin to be considered also in the perspective of health inequality, despite the fact that Italy is quite reluctant to this kind of measures if compared with other European countries.

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[152] Collicelli, Cascelli. “Politiche Sanitarie e non Sanitarie nelle Disuguaglianze di Salute. Il Convegno dell’ASviS e dell’Istituto Superiore di Sanità” 1

One of the sectors to insist upon is the educational one. Something that could be considered is the importance of prevention of some risk behaviors that may lead to an exacerbation of inequalities. People should be granted a common ground, and this should be given to them since school age: in fact, health opportunities and threats are developed since one's first years of life. For this reason, school as institution – and in particular during compulsory schooling should fulfil this role first, especially in those cases in which family is not able to do so. Citizens need to be educated about the importance of their personal health as a value; the most vulnerable strata have to know since the very beginning the risks they can encounter following bad behaviors and habits – such as smoking, overdrinking or overeating, living unsanitary places.

The same reasoning adopted for children should be applied to workers within the working environment itself. A series of measures with the aim to promote healthy lifestyles both within and outside the workplace should be enacted, in targeted ways depending on the "audience" they are referring to. For instance, if data show that smoking habits are more common among manual workers, then actions of prevention or intervention should be mostly targeted to this particular working class[153]. And, most importantly, awareness-raising actions shall be made by the work environment itself, in order to make it as universal as possible – since workers would feel obliged, in a sense, to undergo this kind of re-education. Smoking is just an example, but this could be applicable to any sector, any risk factor, and any social class.

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[153] Costa, "Come fare dell'Italia il paese che tutela meglio la salute uguale per tutti", 13

To this, it should be added for instance a potential rethinking of the allocation of funds to the Regions, in a way that could become more and more coherent with citizens' necessities, despite the external financial constraints. The healthcare sector cannot be left alone in facing these matters: let us not forget, among other things, that the Italian one represents one of the best systems in Europe for efficiency and efficacy, even though we know how few resources are yearly allocated.

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Executive Summary

Even though the Italian healthcare system is one of the best in Europe - in terms of quality of services and efficiency – Italy is not exempt from social inequality processes that have direct consequences on Italian people's health status. We are well aware that the Italian *Servizio Sanitario Nazionale*, founded in 1978, is based on the pillar of health as an inviolable human right and revolves around two essential ideas, that is, equity and universalism, more than in line with what is expressed in the Italian Constitution itself: "The Republic safeguards health as a fundamental right of the individual and as a collective interest and guarantees free medical care to the indigent […] The Republic recognises and guarantees the inviolable rights of the person, both as an individual and in the social groups where human personality is expressed. The Republic expects that the fundamental duties of political, economic and social solidarity be fulfilled.". Despite these premises, considering the fact that not all services are freely provided, Italians often struggle to access part of what is necessary for their health, if interested by conditions of socio-economic disparity.

The object of this thesis is, therefore, an exploration of the social issues of health inequality and of health poverty as strictly interrelated to it. In particular, the main focus will be on the Italian context, in order to understand why and to what extent it is possible that these phenomena gain space in a universalistic system. The choice of this topic has been coherent with a strong interest that these social phenomena are increasingly arousing among the Italian context, considering the impact that they are having. Indeed, inequality and poverty started to rise since the financial crisis that hit Italy in 2009 and struggle to be contained; at the same time, another element that has boosted these phenomena was the need of contractions in the healthcare expenses in a series of reformation of the SSN coming from the necessity of improving economic efficiency. This has caused a reduction of resources to be distributed to the healthcare sector, increasing costs incumbent on citizens. In this situation, patients who cannot afford a certain type of care – even buying medicines or access specialist visits – are cut off from this system that should be a universalistic and equal one.

What the thesis is trying to answer, after having analyzed the conditions in which Italian society is regarding health inequality and poverty, is the fact that these two phenomena – although increasingly alarming – are still struggling to enter the institutional agenda, and there is no effective policy response coming from the public sector. There is awareness about the fact that inequality within the Italian scenario is becoming an impelling problem, which means being part of the public agenda; however, despite this, no targeted measures – or, at least not particularly effective – to tackle this issue are designed. We will see, throughout the whole dissertation, how we will come to an answer to this serious question.

This work is structured according to a sequence from general to specific, divided into four chapters, with a progressive focus on the actual situation in Italy.

In the first chapter, the definitions of the concepts that will be treated in the thesis itself – such as health, inequality and poverty – are offered. This will be instrumental for a better understanding of the following parts of the thesis: it is important, in fact, to have clear in mind all the meanings of these terms to better understand the rest of the work. The right to health has always been object of discussion because of its cruciality. As stated in the *Universal Declaration of Human Rights*, "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control". At the same time, however, there is a serious recognition of the fact that it is a difficult right to equally guarantee to anyone, not only because of the differences between the North and the South of the world – exacerbated by the economic development of the Western countries – but also within a same territory, such as for groups at particular risk like single-parent children, migrants, unemployed people and so on. Furthermore, another treated term is "inequality", a concept that cannot be defined in a single way being it too broad and presenting so many facets. For instance, we may talk about economic inequality if strictly related with the monetary conditions of individuals, or social inequality when other aspects have a role in this status. Likewise, even "poverty" is almost impossible to single out and, as for inequality, it may be fractured within more specific definitions to be better understood. For instance, we may distinguish between primary and secondary poverty, or between absolute and relative poverty. At this point, we can start to narrow down to inequality and poverty referred to the healthcare sector. To cite the words of the *World Health Organizations,* "Health inequities are systematic differences in the health status of different population groups. These inequities have significant social and economic costs both to individuals and societies. […] In all countries – whether low-, middle- or high-income – there are wide disparities in the health status of different social groups. The lower an individual's socio-economic position, the higher their risk of poor health". Diversities of this kind – together with poverty – unavoidably condition one's way of living. Then, the chapter continues by analyzing attempts at international levels that have been made in order to offer practical responses to the issues of health inequality and poverty: *Health for All* (1980) and *Health 2020* (2020). Finally, some data about the health situation in the European continent have been provided, using life expectancy as indicator. The longest-running countries are Spain and Italy (more than 83 years), with a couple of years above the EU average of 81 years. On the other hand, the lowest-rate countries are the Eastern ones, with a difference of around 7 years, which is quite significant. This differential says a lot about health inequality, considering the fact that underdeveloped countries have the lowest average; moreover, we may also say that people with a lower education – and that consequently may have lower wages and lower propensity and openness towards healthcare – are more likely to have diseases that cause a bad health status and mortality.

After having offered a general background about the concepts of equality/inequality and poverty in the healthcare sector, with the second chapter we can move our attention towards Italy as case study. The Italian National Health Service has a long history of transformations: the system as we know it today, the SSN, has been founded in 1978 replacing a quite inefficient mutual system made of numerous mutual societies. Since the establishment of the SSN, it became clear that the concept itself of health had to change starting from the flaws that used to characterize the previous model. Indeed, today's SSN is founded on the ideas of universality, equity, and equality, and tries to guarantee free health services to its citizens. Our SSN is a regional-based national system, providing a universal and almost free service. It is a "multi-level system", in the sense that it is decentered and organized along three levels: the national, the regional, and the local ones. In particular, at the national level we have the State – represented by the Ministry of Health and flanked by the expertise of several entities and agencies – coordinating the system and giving general directives to be followed. Secondly, the

Regions have to follow these directives, but they have the majority of powers and are the main responsible of the functioning of the system. And, finally, at the local level we have the figures of the so called ASL, or LHAs that are in charge – in practical terms – of delivering all the health services that people need. Another important peculiarity of our SSN is the fact that, since its foundation, it has undergone a series of reformation. The most relevant thing is that, through the years, there has been a progressive cost containment due to a necessity of rationalization of the public expenses: this has strongly conditioned the quantity of resources allocated by the public sector. This, together with a compelling need for waste reduction consequent to the financial crisis, weights on citizens' shoulders. For what concerns the financing of the system, we may say that the largest share of contribution comes from the taxes payed by citizens (both at national and regional level). Also, every Region contributes according to its own material capacity, depending on the economic and financial status of each one of them. Finally, the remaining part of the tax revenues of the healthcare system is covered by the out-of-pocket (OOP) expenditures of the patients. As we have previously said, Italy has rationalized healthcare expense a lot; in particular, data show that our country is the last of the more developed countries in terms of health care expenditure, also considering the percentage of GDP. This second section ends with a provision of specific insights about Italian society, regarding its demography and health status. In general terms, we may say that Italy has quite high standards, considering the brilliant level of its healthcare system despite the limited expenses destined for the sector. What hits the peninsula the most, however, is the great disparity existing within the territory; we will deal with this in the next section.

As just announced, the third chapter will focus on the inequality situation in the specific case of Italy, to which we can associate health poverty. We may affirm that two different levels of inequalities interest Italy: a geographical (or territorial) one, due to existing differences among Regions, and a socio-economical one in which variables such as biology, social capital, level of education or the role of the institutions play a crucial role in defining one's ability to enter the health care system – also within a same territory. Indeed, Italy is a country in which differences and inequalities are perfectly placed, both because of its history itself and the way in which the health sector has been developed. For what concerns regional inequalities, data give us evidence that they really influence people's lives a lot. For instance, if we look at life expectancy, we notice that there are huge discrepancies between the North and the South. As reported by 2017 statistics from the *Osservatorio Nazionale sulla Salute nelle Regioni d'Italia*, "in Campania men live an average of 78.9 years and women 83.3; while in the Autonomous Province of Trento men averagely survive for 81,6 years and women for 86.3". Similarly, also differences in the levels of instruction and of income have serious repercussions on the health status of citizens: better-instructed and richer individuals live more and better, being them able to easily access healthcare services, and also having a greater a greater disposition to do so.

To conclude, the final chapter is basically the core of this thesis and answer to the research question around which the dissertation is built. To do so, we proceed with an analysis of the existing policies and, at the same time, with space for understanding whether the issues of inequality and poverty are appropriately addressed. We have largely demonstrated, through the huge share of provided data, that in these last years there has been an increasingly growing interest towards our social phenomena. However, these all but optimistic data also show that in Italy the matters of health inequality and, above all, health poverty struggle to be properly tackled: they cannot enter what we usually call the institutional agenda – during the process of agenda setting – and no effective policies are formulated. Moreover, we have seen that the fact that health inequality and poverty have gained not so much space among the public sector has allowed an increasing responsibility of the third sector and the development of non-profit organizations involved in attempts to try to improve living conditions of all those categories who are suffering these social matters. For example, we have analyzed the work that the Onlus organization *Banco Farmaceutico* is doing for the collection and redistribution of medicines to poor people. They have a really relevant role: not only are they trying to spread visibility, but also acting in practical terms to meet the necessities of the poor through various campaigns and also through the involvement of citizenship, who gets firsthand involved through volunteering or even through the donation of packages of drugs. The action of the third sector – always for what concerns the redistribution of medicines, is facilitated by the law 166/16, which accelerates and regulates the free distribution of drugs to the poor in a more efficient way. Another example of policy is the abolition since September 1st, 2020 of the so called "Superticket", a 10-euro tax borne by the patient in addition to the ticket payed for specialist visits. Finally, while a call for new policies seems necessary, some possibilities and reflections about new insights will be provided, also starting from already existing policies in Italy that could be better addressed in favour of the health poor. To be more precise, we are talking about the development of the market of generic medicines, which have the same properties of the reference medicine, but at much lower costs. Italian people appear to be particularly skeptical about generic drugs, not having much information about them. For this reason, decision makers should be looking for strategies in order to favour the consumption of generic drugs, increasing knowledge that could overcome all this disinformation about the issue.

Arrived at the conclusion of this work, we should have a complete picture of how these social issues are affecting the Italian society. These two impelling phenomena are causing an increasingly growing attention and taking hold in the Italian social dialogue. In Italy it is common to heard about how they matter and awareness about them is growing, but we have seen – through this thesis that is effectively a call for policy – that this is not enough for trying to tackle them. Of course, there is the recognition of the cruciality and urgency of these matters: there is a huge literature about them, along with a great availability of data and statistics testifying how worrying, even in Italy, the situation is becoming. In particular, there is an extensive knowledge about the determinants and the immediate consequences of these phenomena. Therefore, this awareness should be an important starting point for the entrance of the issues in the institutional agenda, worthy of the attention of the public sector, too, and the formulation of effective policies, careful of the needs of all the strata of the population.

As a matter of fact, the main point of the dissertation is that there is the high risk of an aggravation of health inequality and of poverty, consequently. There is not, until now, a firm commitment to make these issues enter the institutional agenda and be a priority for new policies. A high number of data confirms this worrying possibility on the basis of the actual situation for all poor patients: they keep facing endless difficulties, the State struggles to finance healthcare sector in a proper and equal way, and both territorial and socio-economic inequalities are far from diminishing. Surely, some attempts have been made and some of them have been mentioned in this work, too.

However, they have demonstrated to be only sectorial measures or not really well addressed as, for instance the modification of the law *del Buon Samaritano* – referred also to the field of medicines redistribution – in order to make easier the job of the third sector.

Apart from this recognition of an urgent need for policies, the thesis concludes by suggesting the necessity of collaboration of different policy levels. In this way, it would be possible to gain a policy design able to better frame both healthcare inequality and poverty, which are nothing but just one of the many faces of a larger issue regarding impoverishment and unequal society. It is impossible for the healthcare sector to tackle inequality and poverty by itself, since we are dealing with strong socioeconomic matters. A serious commitment and redesigning of a multisectoral approach, based on the collaboration of different intervention levels, should begin. To this, it should be added a potential rethinking of the allocation of funds to the Regions through the LEAs system, in a way that could become more and more coherent with citizens' necessities, despite the external financial constraints. The healthcare sector cannot be left alone in facing these matters: let us not forget, among other things, that the Italian one represents one of the best systems in Europe for efficiency and efficacy, even though we know how few resources are yearly allocated.