Coordination and Health Policy Responses to the First Wave of COVID-19 in Italy and Spain

By Paola Mattei and Eloisa Del Pino

Introduction

Since January 2020, almost all countries around the world have adopted strong healthcare and socioeconomic policy interventions aimed at containing the SARS-CoV-2 (COVID-19) virus and mitigating its devastating effects (OECD 2020). Despite the different healthcare models or types of policy instruments, no country was adequately prepared or anticipated the crisis to the extent that it was able to provide a rapid and effective response to the global pandemic.

Italy and Spain were the first European countries hit by the coronavirus and did not have the benefit of hindsight and policy learning, which resulted in significant death tolls as early as March 2020. During the first wave of the COVID-19 pandemic, the Italian and Spanish governments were, on one hand, forced to use the existing public health policy instruments and, on the other, to deploy, under extraordinary time pressure, new and adaptive policy strategies.

Both the Italian and Spanish healthcare systems show potential sources of coordination conflicts, because the national governments retain the basic legislative authority on health policies but regions enjoy a high degree of autonomy in their implementation (Moreno and McEwen 2005; Mattei 2007, 2016; Del Pino and Ramos 2018). To what extent have there been coordination problems in the health response to the pandemic crisis? What measures have been taken to address them? To answer these questions, this paper empirically examines the main policy responses taken by the national governments in Italy and Spain during the initial stage of the COVID-19 pandemic crisis, from January until March 2020, highlighting the coordination mechanisms between different levels of government. In the concluding discussion, some key policy lessons are drawn with the aim of advancing our understanding of the challenges associated with coordinating policy responses to an unexpected and unknown pandemic. For highly decentralized healthcare systems, policy coordination between different levels of government becomes a necessary condition to achieve a shared definition of the problem and its effective solutions, and for policy measures to be adopted, emergency resources allocated, and multiple levels of actors and organizations harmonized in a collective yet directed and coordinated effort. As Koop and Lodge (2014) have suggested, coordination "underlaps" when the exercise of public authority occurs during a crisis when policy issues fall within the remit of different organizations.

Italy: Central Policy Instruments in the Context of Variable Geometry

The main policy instrument of coordination was the emergency decree, associated with emergency powers used by the central state. Emergency powers fell under the central state prerogatives until 1998, when the Protezione Civile (National Department of Civil Protection) was reorganized to recognize greater responsibility to regions, especially in the field of prevention and healthcare management. During the COVID-19 crisis, this multilevel system of emergency powers enabled directly elected presidents of the regions frequently to issue regional ordinances with executive powers, not always coordinated with the central government.

The policy system of coordination was quite problematic during the first wave of the pandemic, and continues to be so at the time of writing as we are in the midst of the third wave of the pandemic. The Italian Servizio Sanitario Nazionale (SSN) was created by law in 1978 to reform the clientelistic system of healthcare of the 1960s and 1970s, based on 100 hugely indebted healthcare funds. Furthermore, the creation of the national healthcare system was concurrent with the definition of a new level of government, the regional government (Mattei 2006). A landmark reform in 1992 established that regions were to be given the authority for planning, organizing, financing, and delivering healthcare services. These responsibilities were previously shared by the municipal administration and the central Ministry of Health. Although the active involvement of regions was already embedded in the Constitution and 1978's law, the 1992 reform sought to activate the formal powers of regional governments and tighten their control on local health authorities. Regional planning was the logical extension of national planning (Mattei 2007).

The first case of COVID-19 appeared in Italy on January 30, 2020; a couple of Chinese tourists coming from Wuhan, China, were admitted to the Spallanzani Hospital in Rome. One of the first actions to manage the crisis taken by the Italian government was to coordinate the healthcare responses to the pandemic through an emergency decree (Decreto del Presidente del Consiglio). A six-month national state of emergency was issued on January 31. Three days later, Angelo Borrelli, chief of the Department of Civil Protection in Italy, was commissioned by Prime Minister Conte to coordinate the crisis management.

From the declaration of the emergency state until the first national lockdown, precautionary measures were taken by the national government. Until late February, only minor bureaucratic measures were taken to mitigate the contagion. On January 22, the Minister of Health requested all regional governments to update their regional pandemic plans despite the fact that the National Pandemic Plan itself had not been updated since 2010. Additionally, some scientists underplayed the virus as "nothing more than a flu" until the first registered death occurred on February 21. This event pressed political elites to make sense of a deadly threat capable of killing thousands, fostering strong public criticism around the decision not to intervene earlier.

On February 23, the Italian government decided to contain the spread of the virus by restricting the movement of people, targeting ten municipalities in northern Italy, where cases were rapidly increasing. To avoid further escalation, on this date an emergency ordinance jointly issued by the Minister of Health and the regional governments declared the so-called "red zones" (zone rosse) in Lombardia and Veneto. This measure affected 50,000 people. Local authorities ordered schools, businesses, and restaurants to close. Residents in the red zones were not allowed to exit, and the police established multiple checkpoints to enforce the restrictions.

The national government adopted the first national lockdown measure on March 11, 2020, and continued to use the emergency law decree instrument to manage the crisis throughout the first wave. Parliament was not involved in the decision-making process. The Italian government's approach to the lockdown significantly influenced the formulation of other European countries' strategies, including Spain's. Implementation of the lockdown at national scale occurred incrementally through three emergency decrees, issued respectively on March 8, March 11, and March 22. The first lockdown (Presidente del Consiglio dei Ministri 2020a)

affected Lombardia and some selected areas in Piemonte, Emilia-Romagna, Veneto, and Marche. The restriction of movement was extended to the whole national territory on March 9. Movement of people was banned and enforced by police forces, except for work or health reasons; these needed to be certified under all circumstances through a document justifying movement outside one's home. All sporting events were banned, schools and universities closed, and all public and private gatherings prohibited (cultural, sport, entertainment, religious, theatres, cinemas, etc.). Bars and restaurants remained open from 6:00 a.m. until 6:00 p.m., if compliant with precautionary measures and social distancing.

The March 11 decree issued by the Prime Minister shut down all commercial and retail activities (Presidente del Consiglio dei Ministri 2020b). Only grocery shops, newsagents, and pharmacies were exempted. Businesses were strongly encouraged to employ smart working arrangements. By March 21, Italy was overtaking China as the deadliest center of the outbreak. As the virus claimed a very high number of fatalities, regional governments in northern Italy were urging the government to take tougher measures, often imposing their own restrictions before the national government's directives. In Veneto, regional leaders extended swab testing to categories beyond those indicated at national level.

The third and final lockdown measure, issued on March 22, 2020 (30 days after the first registered death from coronavirus in Italy) closed all industries, firms, and businesses (Presidente del Consiglio dei Ministri 2020c). The entire national production system came to a halt. Lombardia banned all outdoor activities and sports, while in other regions free movement was allowed only within 200 meters of home. This very restrictive decree was initially planned to be valid until April 3, but was extended several times until May 4, when the decline in cases motivated the easing of measures.

To conclude, as the limited value of locally containing the virus only through bureaucratic and ad hoc localized movement restrictions within the so-called "red zones" became evident by the end of February 2020, the national government decided to gradually scale up the lockdown measures to the entire national territory and all industrial and economic sectors. It did so by concentrating emergency powers in central government. Concurrently, regional political leaders autonomously introduced policy measures which sometimes departed from the national coordination system. Regions were able to introduce more restrictive measures, when necessary. The approach was similar to a variable geometry which was the outcome of a poorly coordinated process.

SPAIN: Public Policy Innovation in a Multilevel Context

Since 2002, the universalistic Spanish National Health System (NHS) was decentralized to the 17 autonomous communities (ACs), which oversee 92.5 percent of healthcare spending in the country. The central government (CG) is responsible for regulating the rights to healthcare and establishing the basic organization and financing of the NHS; while ACs are in charge of managing the system. This multilevel system is managed by an intergovernmental body, the Inter-Territorial Council of the NHS (CISNS), composed of the central and regional health ministers.

General coordination of health policy is a constitutional responsibility of the national Ministry of Health. Within the ministry, the Center for the Coordination of Health Alerts and Emergencies (CCAES) sets up preparedness and response plans to deal with public health threats. The CCAES must also carry out a survey of the national capacity requirements set out in International Health Regulations (2005) and work with the regions to ensure their

implementation. In 2009, the ministry revised its preparedness plans to respond to the H5N1 influenza virus. According to this plan, the ACs should have developed their own plans. However, these were not known to some regional authorities (Del Pino et al. 2020). Spain had not conducted much-needed national training exercises to prepare a response to pandemics. In Italy, likewise, few regions had adopted stress tests and exercises (Mattei 2020).

On January 30, the WHO declared the outbreak of the new coronavirus. The following day, the first case of COVID-19 in Spain was confirmed. It could be easily controlled. Some days before that date, experts from the ministry and the regions adopted the first protocol in the event of suspected cases of COVID-19 (which would be modified at least three times over the following month). At the same time, a Coronavirus Monitoring Committee was set up within the ministry. The WHO declaration and the confirmation of the first case in Spain meant that the problem, which until then had been kept at a technical level, was now shifting towards the political arena. On February 4, the Ministry of Health held the first meeting of the NHS intergovernmental body (CISNS); and the CG established an Inter-Ministerial Co-ordination Committee.

At the national level, on March 1, some containment measures began to be taken (for example, holding all professional sports competitions behind closed doors or asking health professionals not to attend congresses) but these measures were not widespread. Some cities took more drastic measures. On March 8, massive events were held, such as the Women's Day demonstrations, with thousands of participants, including ministers (some of whom later tested positive for COVID-19). On March 9, the CG assumed the existence of community transmission and took the lead role in managing the pandemic. The CG announced that a group of experts was designing policy responses to the pandemic. In the health area this group coordinated with the ministry but the ACs did not formally participate in it, so it clearly lacked a relevant perspective on the functioning of the NHS. On March 14, the CG declared a state of emergency throughout the national territory and empowered the Minister of Health to take all measures deemed appropriate to strengthen the NHS. On March 15, the first Conference of Presidents (the Spanish Prime Minister and regional presidents of the ACs) during the health crisis was convened.

Between March 30 and April 9, all non-essential economic activity in the country was paralyzed. The maximum number of hospitalizations for COVID-19 and the peak of ICU occupancy were reached between April 2 and 5. About 50 percent of deaths were elderly people living in nursing homes; this fact caused a great deal of consternation (Del Pino et al. 2020). Throughout this period, the Health Ministry implemented numerous measures: it drew up protocols for professionals; it tried to make resources available to the ACs, mobilizing 81,000 health professionals, students, and private health resources; and it provided financial support. Likewise, it implemented a centralized purchase process for healthcare materials (PPE and ventilators, among others) but it lacked the administrative capacity to deal with the purchases. This was partly due to the increasing human decapitalization of the Ministry of Health over the past few years, as the belief spread that, due to decentralization, the ministry was no longer relevant. Although, in reality, according to the regulations, the ACs could have continued to buy materials, the measure caused some confusion in the regions, which probably delayed the acquisition of supplies.

On April 20, the CG approved a new plan for reopening, with four phases to reach the so-called new normal. The change of phase of individual regions was to be decided by the Health Ministry based on epidemiological criteria and, in principle, each phase would last two weeks.

Formally, the CG and the ACs made an impressive coordination effort in the field of health, which has certainly not occurred in other sectors such as social services. Throughout the period reported, two relevant intergovernmental political fora were very active: (1) the CISNS, until July, met around 40 times; the CISNS technical second-level committees were also very dynamic, with around 70 meetings; and (2) the Conference of Presidents met 14 times.

Several factors forced the CG to start shifting clearly towards the new phase in which the ACs would have more space for autonomous decisions. The CG assumed to some extent some of the criticisms made by the regions, for example its poor practical knowledge of the NHS. Politically, the CG started to have difficulties in obtaining the required parliament agreement for the extension of the state of emergency. In fact, in exchange for the support of the regional nationalist parties in parliament, the CG agreed that once phase III of the reopening plan was reached, the ACs will be the competent authority to fully manage the pandemics. Moreover, some ACs had begun to show a confrontational attitude to the CG (which undoubtedly put at risk citizen support for some public health measures). The CG seemed to increasingly acknowledge that it was much more practical to share responsibilities with the ACs. Finally, on June 10, a regulation approved the conditions for the so-called new normal. After six extensions, on June 21 the state of emergency ceased.

Concluding Discussion

The analysis of the Italian and Spanish central and regional governments' policy responses to the pandemic offers useful policy lessons on to how to coordinate crisis management in multilevel governance systems. In both countries under investigation, it was necessary to design new and innovative public policy responses to tackle the COVID-19 pandemic. This was not only due to the fact that the characteristics of the virus were completely unknown at the outset. The lack of experience in managing a global health crisis of such scale in multilevel decentralized healthcare systems as well as the lack of early preparation were also important factors.

As our results show, policy coordination between the central and regional governments was a key problem that emerged during the overall policymaking approach to containing COVID-19. Central governments concentrated emergency state powers as much as possible in order to manage the crisis. They had constitutional prerogatives to do so, and the transboundary nature of the COVID-19 crisis dictated such an approach. Yet both in Italy and in Spain, regions challenged the centralization of powers and claimed instead a role in policymaking and crisis management. In Italy, the centralization of the crisis management was challenged by autonomous executive ordinances by regional political leaders, who are directly elected. In Spain, despite the coordination effort, the central government was accused of not including the autonomous communities soon enough; the central government was also blamed for assuming responsibilities without having sufficient administrative capacity, thus delaying the regional management; in addition, the ACs complained about the opacity of the criteria for deciding on reopening and the identity of the experts who decided it.

Decentralized healthcare systems have advantages because they encourage innovation in regions that are trying to find solutions to the crisis more closely aligned with the specific needs of their populations (Saltman et al. 2007) and these answers can provide best practices and opportunities for policy lessons across regions. But decentralized policy systems make policy coordination more complex, as this article shows. Unpredictability about which level of government should take certain decisions that have never been adopted or implemented

before, as happened in the face of an unknown virus, can delay and distort the effective response to the crisis. As discussed in this article, pandemic response plans were not updated and, when they were, they were not always well known to authorities, and preparedness exercises were not conducted (Mattei 2021). Institutional mechanisms of coordination between the central and regional governments, that would work effectively during routine times, were no longer adequate to deal with this emergency (Capano, 2020).

Regarding policy lessons for the future, we suggest that a catalogue of tasks to be carried out during the global pandemic crisis be clearly elaborated and agreed upon by all regional governments (civil rights limitations, intervention in certain sectors of public policy, procurement of healthcare materials, managing data, composition of expert groups, evaluation of the main measures and mechanisms to correct them, among others) and that each of these tasks be assigned to the level of government that could perform them best. Finally, although the political game of blame avoidance and credit claiming during a crisis it is probably impossible to escape (Arceneaux and Stein 2006), perhaps these intergovernmental planning tasks could reduce their negative consequences on policy coordination, and result in effective policy responses to healthcare emergencies in the future.

In this article, we have mainly highlighted similarities across countries, focusing on central–regional coordination in Italy and Spain. However, there have also been some differences in the policy approach. We need further comparative research on the specificities of administrative and institutional coordination mechanisms which are normally associated with specific contexts and domestic politics. Our findings show that national emergency powers and their use by the central government, in a highly decentralized policy system, need to be carefully calibrated against regional responsibilities and constitutional arrangements. In Spain, the central government has adjusted its early centralizing approach in order to share more responsibilities with the autonomous communities. On the other hand, in Italy the ad hoc and piecemeal approach of the central government has left ample policy autonomy for regional political leaders to create their own measures from the very start of the crisis, not always to the benefit of a coordinated and concerted decision-making process. In Spain, the Ministry of Health took the lead in policy coordination in the framework of emergency powers, whilst in Italy it was the office of the Prime Minister and the Protezione Civile (not the Ministry of Health) that took on the leadership and ownership of crisis management. Despite these institutional differences, and constitutional specificities, Italy and Spain are useful cases for learning lessons on how to coordinate policy measures in a multilevel governance system under unknown external shocks.

Acknowledgement

The authors wish to acknowledge Lorenzo Vigevano for his student assistance. We would like to thank prof. Zuzana Kotherovà for construtive comments on an earlier version, and the participants of the ECPR Annual Conference where Paola Mattei presented this paper on 28 August 2020. We wish to thank the three anonymous reviewers for their excellent comments.

References

- Arceneaux, K. and Stein, R., 2006, Who is held responsible when disaster strikes? The attribution of responsibility for a natural disaster in an urban election. Journal of Urban

Affairs, 28(1), pp. 43–45. doi:10.1111/j.0735-2166.2006.00258.x [Taylor & Francis Online], [Web of Science ®], [Google Scholar]OpenURL

- Capano, G., 2020, Policy design and state capacity in the COVID-19 emergency in Italy: If you are not prepared for the (un)expected, you can be only what you already are. Policy and Society, pp. 1–19. [Web of Science ®], [Google Scholar]OpenURL
- Del Pino, E., Fuente, M., Javier, F., Cruz-Martínez, G., and Hernández-Moreno, J. 2020, La Gestión Institucional y Organizativa de las Residencias de Mayores y la COVID: Dificultades y Aprendizajes. Available at https://digital.csic.es/handle/10261/220460 [Google Scholar]OpenURL
- Del Pino, E. and Ramos, J. A., 2018, Is welfare retrenchment inevitable? Scope and drivers of healthcare reforms in five Spanish regions during the crisis. Journal of Social Policy, 47(4), pp. 701–720. doi:10.1017/S0047279418000077 [Crossref], [Web of Science ®], [Google Scholar]OpenURL
- Koop, C. and Lodge, M., 2014, Exploring the co-ordination of economic regulation. Journal of European Public Policy, 21(9), pp. 1311–1329. doi:10.1080/13501763.2014.923023 [Taylor & Francis Online], [Web of Science ®], [Google Scholar]OpenURL
- Mattei, P., Ed., 2016, Public Accountability and Health Care Governance. (Basingstoke: Palgrave Macmillan). [Google Scholar]OpenURL
- Mattei, P., 2006, The enterprise formula, new public management and the Italian health care system: Remedy or contagion? Public Administration, 84(4), pp. 1007–1027. doi:10.1111/j.1467-9299.2006.00624.x [Crossref], [Web of Science ®], [Google Scholar]OpenURL
- Mattei, P., 2007, From politics to good management? Transforming the local welfare state in Italy. West European Politics, 30(3), pp. 595–620. doi:10.1080/01402380701276444 [Taylor & Francis Online], [Web of Science ®], [Google Scholar]OpenURL
- Mattei, P., 2020, Digital governance in tax-funded European health care systems: From the back office to patient empowerment. Israel Journal of Health Policy Research, 9(3). [Crossref], [PubMed], [Web of Science ®], [Google Scholar]OpenURL
- Mattei, P., P. Antonelli and Paola Severino., 2021, Global pandemics and future responsiveness of European health systems, in A. Prencipe (Ed.) Saperi Pandemici. Gestire la crisi, programmare il futuro. Rome: LUISS University Press, pp. 17–27. [Google Scholar]OpenURL
- Moreno, L. and McEwen, N., 2005, Exploring the territorial politics of welfare, in: N. McEwen and L. Moreno (Eds) The Territorial Politics of Welfare (London: Routledge), pp. 1–40. [Google Scholar]OpenURL
- OECD, 2020, The Territorial Impact of COVID-19. Managing the Crisis across Levels of Government. (Paris: OECD). [Google Scholar]OpenURL
- Presidente del Consiglio dei Ministri, 2020a, Decreto 8 Marzo 2020 (DPCM). [Google Scholar]OpenURL
- Presidente del Consiglio dei Ministri, 2020b, Decreto 11 Marzo 2020 (DPCM). [Google Scholar]OpenURL
- Presidente del Consiglio dei Ministri, 2020c, Decreto 22 Marzo 2020 (DPCM). [Google Scholar]OpenURL
- Saltman, R. B., Bankauskaite, V., and Vrangbæk, K., eds, 2007, Decentralization in Health Care. (Maidenhead: McGraw-Hill/Open University Press). [Google Scholar]