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Article

Multi-Level Governance Feedback and Health Care in Italy in the Aftermath of Covid-19

David Natali [1,*], Emmanuele Pavolini [2], and Andrea Terlizzi [3]

[1] DIRPOLIS Institute, Sant'Anna School of Advanced Studies, Italy
[2] Department of Social and Political Sciences, University of Milan, Italy
[3] Department of Political and Social Sciences, University of Florence, Italy

* Corresponding author (d.natali@santannapisa.it)

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Abstract
At the crossroads of EU studies and public policy analysis, a vast literature identifies global crises as one of the main triggers of change. The present article provides a test of this hypothesis in the case of health care in the aftermath of the pandemic crisis that hit Europe between 2020 and 2022. We use Italy as an extreme case, where both the magnitude of the Covid-19 outbreak and the effect of the pre-existent domestic cost-cutting strategy potentially opened a large window of opportunity for change. Through the lenses of historical institutionalism, we aim to shed light on policy change in multi-level health governance systems. Evidence collected through semi-structured interviews, triangulated with secondary sources, proves that the governance of health care in Italy has experienced no paradigmatic change. We show that "governance feedbacks" have reinforced pre-existing dynamics and inhibited more radical forms of change.

Keywords
Covid-19; EU governance; feedback; health care; historical institutionalism; Italy; policy change

Issue
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1. Introduction

The recent Covid-19 pandemic represented an extraordinary crisis that allows the testing of hypotheses on the key role of exogenous shocks in the EU. At the crossroads of EU studies and policy analysis, this article sheds light on the case of health care between 2020 and 2022. We use Italy as an extreme case where both the magnitude of the pandemic shock and the pre-existent domestic cost-cutting strategy potentially opened a large window of opportunity for change. The framework we propose is inspired by historical institutionalism (HI) and uses a multi-level governance perspective to assess change and stability in the Italian health care system. Information gathering was based on the collection of primary and secondary literature as well as on 14 semi-structured interviews with experts and policymakers at EU, national, and subnational levels. The evidence proves that "governance feedbacks" are crucial in shaping self-reinforcing mechanisms. The same feedbacks help us understand the lack of paradigmatic change in the case of the Italian health care system.

In the health care field, the EU has focused on three main policy areas: health regulation in the context of the internal market, measures addressing health care provision through the EU economic and fiscal governance, and further health policy issues, such as cross-border threats and health and safety at work. In what follows, we focus on the second area described above: the regulation of and the support of health care provision. In the words of Brooks et al. (2022, p. 3), health care is the subfield of policy that addresses the "organisation and deliv-

ery of health services and medical care," meaning the panoply of medical professionals, health insurers, hospitals, and the taxes that pay for them, which dominate public discussions and electoral debates on health.

In particular, we look at the policy measures and governance of Italian health care after the Covid-19 pandemic and the role of the EU in this respect. For the sake of clarity and parsimony, we restrict the analysis to structural characteristics of the Italian health care system, and we deliberately avoid focusing on the whole policy process (including the part related to vaccines during the pandemic).

The article is structured as follows. Section 2 presents the key concepts and the analytical framework. Section 3 sheds light on the research design and the methodology at the base of our enquiry. Section 4 summarises the status quo before the pandemic crisis both at the EU and at the Italian health care policy levels. Section 5 provides evidence of the impact of the pandemic crisis and the measures taken at the EU and national levels. Section 6 concludes.

2. Health Care in Multi-Level Governance Systems at the Test of Covid-19: Theoretical Background and Analytical Framework

Much of the policy analysis literature outlines the key role of global crises in (EU) policymaking. We refer here to the definition proposed by Hupkens et al. (2023): A crisis is a threat to the core values of a society and life-sustaining systems in that society that must be addressed urgently under conditions of deep uncertainty. On the one hand, crises are seen as fundamental policy change triggers. On the other hand, they stimulate further EU integration. For many, the EU managed to tackle the many crises of the last decades through a path of effective change (Rhodes, 2021). For example, reforms in economic governance have proved the ability of European policymakers to learn from past mistakes (Wolff & Ladi, 2020). In parallel, in comparative policy studies, crises are seen at the origin of shorter phases of fluidity and change alternating with longer periods of stability and adaptation. Exogenous shocks cause economic and financial crises as critical moments pushing for reforms. In line with this, analysts expect that the recent pandemic crisis that hit Europe between 2020 and 2022 provides a large window of opportunity for change (Natali, 2022).

The present article provides a test to this literature while addressing the following research question: Do we see any evidence of changes in health care, a sector characterised by a multi-level governance system, in the aftermath of Covid-19?

The theoretical background of the article is inspired by HI. The latter focuses on the role of institutions, understood as sets of regularised practices which structure political-economic action and outcomes (Schmidt, 2012). For historical institutionalists, attention to the temporal character of institutions is crucial: Institutions established at one moment in time have lasting consequences over time. Temporal phenomena, including the role of timing and sequence, are seen as key determinants of policy and politics (Fioretos et al., 2016).

While HI was originally keen to explain stability more than change, non-deterministic interpretations have emphasised the combination of exogenous and endogenous factors to explain change. This is the case of the seminal contribution of Pierson (1996, 2004) in both EU integration and comparative policy. Pierson stressed that the role of the EU in social policies has changed and increased over time through "policy feedbacks dynamics." In HI, policy feedback is about the diachronic political effects of policies, which are no longer seen only as the effects of politics but also as a potential cause of it (Béland et al., 2022, p. 6). With this latter concept, the scientific literature refers to situations where institutions support and/or inhibit change. These dynamics can be assessed only through a long-term perspective. In fact, most of these processes have a temporal quality: Explanatory factors accumulate over the years.

HI is proposed here because it does not deny the role of exogenous shocks (e.g., crises), but it integrates them into complex causal chains where endogenous factors also matter. The capacity of crises to change policies inherited from the past largely depends on the effects those policies have already had (Jacobs, 2016). Both self-reinforcing (e.g., lock-in mechanisms) and self-undermining feedback processes (related to the shortcomings that given institutions might have) may operate simultaneously. In this sense, when change occurs, self-undermining processes might help to explain why the demand for change endogenously emerged in the first place, and self-reinforcing processes might help to account for the reasons why change takes the form it does (Terlizzi, 2019).

Taking inspiration from the literature mentioned above, we look at feedbacks in the case of health care throughout the pandemic crisis. In this respect, we innovate the literature in two ways. Firstly, we focus on "governance feedbacks." The reference to governance (the structures and practices involved in coordinating social relations that are marked by complex, reciprocal interdependence; Jessop, 1998) helps us understand the mix of different types of feedbacks (e.g., lock-in mechanisms, improvement of state capacities that are often treated separately and with different terminology) and how they overlap. Health care shows the characteristics of multi-level governance (e.g., the overlapping competencies among multiple levels of governments and the interaction of political actors across those levels; Marks, 1996), where the distribution of competences across levels and between institutions at a single level may shape change and/or stability. We look particularly at the *alignment*/*dis-alignment* between policy institutions—both at a single level of governance and across levels—and reform priorities discussed in the debate.

Second, we provide a more nuanced definition of the concept of feedback than has been proposed in previous literature. The *feedback mechanisms* mentioned above shape the direction of the same institutional dynamics and their effect. As stressed above, *feedback directions* may reinforce (self-reinforcing) or weaken (self-undermining) the policy inherited from the past. *Feedback effects* may consist of policy change or stability.

In order to assess the dynamics of change, in the next sections, we use the analytical dichotomy of paradigmatic versus parametric changes. Policy paradigms include the basic ideas shared within a policy community that help to define policy problems and solutions. Far-reaching policy changes often consist of paradigm change. Parametric changes, instead, occur when key principles are stable while instruments and their settings change (Vogeler, 2019). In what follows, we refer to three dimensions of change and stability:

1. The distribution of competences across levels of governance: We distinguish between EU, national, and subnational levels of government.
2. The role of institutional actors at each level: We distinguish between economic institutions (competent for economic and financial affairs) and social institutions (competent for the protection of social and health rights).
3. The policy substance: We distinguish between changes in the policy goals (e.g., universal versus selected protection), instruments (from coordination to money-based programmes), and settings (cutbacks versus additional financial resources; Hall, 1993, Vogeler, 2019).

Our analytical framework (Figure 1) allows focusing on endogenous and exogenous explanatory variables. In the context of the pandemic crisis, governance feedback (A) and the exogenous shock (B) have an impact on change and stability (C).

A major crisis, such as the Covid-19 pandemic, has the potential to destabilise the status quo. Yet, governance and policy of the past matter. Governance mechanisms (e.g., to distribution of competences across levels and institutional actors at each level) may favour or hinder change. Their alignment with new priorities may activate self-undermining processes, while their disalignment may activate self-reinforcing processes.

3. Research Design and Methods

To address the research question at the article's core, empirical material is drawn from semi-structured interviews conducted between March and September 2023. Interviewees' profiles include experts, policymakers, and key stakeholders representing the supranational, national, and regional governance levels. Interviewees were selected through snowball sampling, where the starting point was relevant experts and key informants in the health care field. Snowball sampling allowed us to conduct interviews with profiles that would otherwise have been difficult to reach.

Twenty-four profiles were identified, of which 14 were interviewed (Table 1). Interview questions were open-ended, adjusted to the interviewees' profile, and covered several aspects of the relationship between the EU and national health policy before and after the Covid-19 pandemic. Questions focused on the key measures adopted in 2020–2021, during the pandemic, from those linked to the emergency to those of a more structural nature, such as measures envisaged by the National Recovery and Resilience Plans (NRRPs in the context of the EU Recovery Plan), as well as on the constellation of actors involved in policymaking.

Interviews lasted between 15 and 45 minutes. One interview consisted of an email correspondence. Interviews were recorded, transcribed through speech-to-text applications, and manually checked for correctness. Interview transcripts were analysed by all three authors, who met on several occasions to openly discuss the key themes which inductively emerged from the interview data. The authors agreed on the presence of two key themes (Table 2).

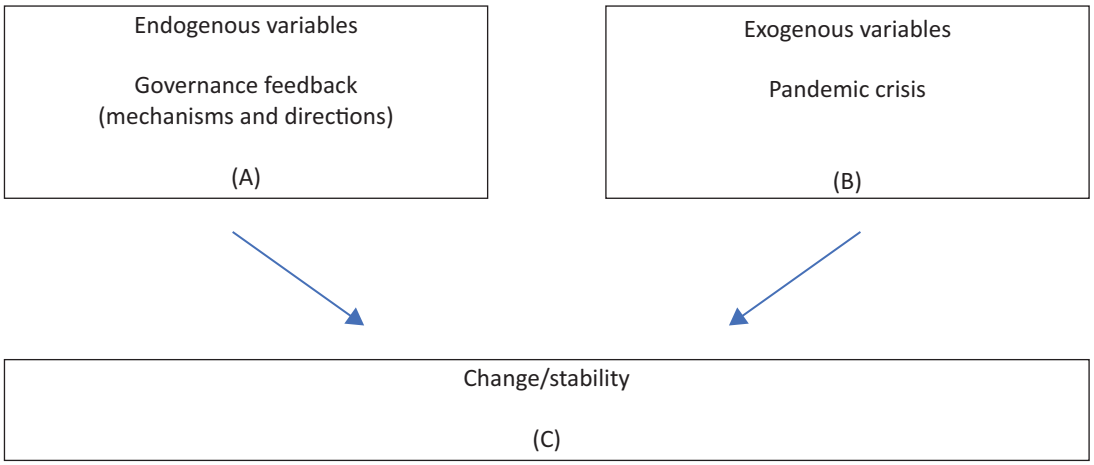

Figure 1. Governance feedbacks at work in times of crisis.

Table 1. List of interviews.

Profile	Date	Code
Academic expert with relevant health policymaking experience at national and subnational levels	31.03.2023	INT1
Academic expert	04.04.2023	INT2
Academic expert with relevant policymaking experience at the national level	12.04.2023	INT3
Academic expert with relevant policymaking experience at the national level	20.04.2023	INT4
Academic expert	20.04.2023	INT5
Policymaker at national and subnational levels	Email correspondence	INT6
Academic expert	04.05.2023	INT7
Member of the Recover Task Force, European Commission	17.05.2023	INT8
Member of the Recover Task Force, European Commission	01.06.2023	INT9
Representative of the European Commission in Rome	01.06.2023	INT10
Stakeholder from a national trade union	17.06.2023	INT11
Policymaker at national and subnational levels	11.09.2023	INT12
Non-academic expert at supranational level	28.09.2023	INT13
Policymaker at the national level	17.10.2023	INT14

To increase the reliability of findings, we triangulated interview data with secondary sources and documents, including EU and national legislative acts and reports.

4. The Multi-Level Governance of Health Care Before the Pandemic Crisis

This section summarises the main features of the multi-level governance of health care policymaking before the pandemic crisis (Point A in the analytical framework of Figure 1). This section presents the EU's competences in health care and the Italian case to show how it was governed at national and subnational levels.

4.1. EU Health Care Policymaking Before the Pandemic Crisis

Over the past decades, the role of the EU in health care has been marked by its weak legal basis and the reluctance of member states to cede power to the EU (Brooks et al., 2021, p. 33). Health care reforms have become the object of EU coordination, especially since the Great Recession. In the field of economic governance, health care represents a large proportion of national expenditure. It thus became a target of the European Semester—the EU's annual economic coordination framework—through which the EU began making CSRs to member states, calling for cost containment. As stressed by Lilyanova (2023a), in 2019, just over half of all member states received health-related CSRs. Many countries, especially in Southern Europe, received indications for cost-effective measures that contributed to austerity and the underfunding of health care (Baeten & Vanhercke, 2017).

The European Semester is designed to monitor structural and investment funds and their alignment with the key objectives of the EU. Yet, the limited role of the EU budget (e.g., structural funds) for health care confirms the structural bias in favour of market integration and cost-containment rather than increased public spending. Data for the financial period of 2014–2020 shows the European Regional Development Fund and the European Social Fund planned to invest about 16.8 billion euros in health care infrastructure, services, and ICT solutions (European Commission, 2023).

In the words of Brooks et al. (2021, p. 39), "relying on regulation means the EU can…create a competitive market for health goods and services, but it (the EU) cannot affect the distribution of entitlements to the same goods and services in the member states."

In terms of governance, the European Commission's DG ECFIN and the Economic and Financial Affairs Council have started to play a major role, focusing more on recommending health care measures that contain public spending than those which improve access to and quality of care (Baeten & Vanhercke, 2017, p. 487). The Directorate-General for Health and Food Safety (DG SANTE) has traditionally had a minor role in healthcare governance (INT13; Table 3). Economic actors (the DG ECFIN within the Commission) developed a strategic relationship with the European Commission's Secretariat-General to lead the coordination process (see Muraille, 2021, also confirmed by INT5).

Two important facets are underlined also by the interviews with key informants (INT1, INT2, INT13). Firstly, while the EU focuses on different dimensions of health policy, the one on health care and its budgetary implications have proved the most relevant ones for reform

Table 2. Key interview themes and exemplifying quotes.

Theme	Exemplifying quotes
1. Very limited role of the EU in health care agenda-setting and decision-making at the national level	• The NRRP is not really a matter of health policy…it is a matter of economic policy. (INT1) • The NRRP accelerated, by providing resources, processes that were already underway. (INT2) • There is a universal shared agenda of which many actors have been aware for some time….Some agenda items are supported by the EU. For example, research projects financed through HORIZON2020 have helped to spread a European culture on a number of topics. But then it is up to the individual countries to decide on this, regardless of the EU. I have found no reference to European initiatives in the NRRP. I saw the result of a very domestic work….I do not see the imprint of a European policy that influenced the definition of the NRRP. (INT2) • A European dimension in health care is absent! (INT2) • There were "projects in the drawer," which had been there for 20 years and were pulled out with the NRRP. (INT5) • There was no need for a pandemic to define what national and international needs are indispensable to protect people's health, aggravated, moreover, by the current climate and environmental crisis. (INT6) • The themes of the NRRP were already strong themes among experts. The EU was used as a backbone to ensure that the measures could be implemented in Italy. (INT7) • The EU recovery strategy was conceived as an anticyclical economic plan for growth…the priority was to give money to the member states whatever they put in their plans. (INT8) • The hierarchical structure is well-defined. Those directly involved are SECGEN (the European Commission's Secretariat-General), DG ECFIN (Directorate-General for Economic and Financial Affairs), and Task Force Recovery. In the end, it is the DG (director-general) of ECFIN who signs the cheque. (INT9) • There is clear continuity—even in terms of the personnel involved in the process—between the European Semester Officers and the Recover Task Force. (INT10) • "Europe" has not been on the radar in any significant way when it came to defining the specific type of interventions that had to be fostered through the NRRP. (INT11) • The NRRPs are inspired by the country-specific recommendations (CSRs) of the European Semester….The 2020 CSRs were clear in their orientation towards short-term, emergency-based health objectives….It is difficult for me to understand the enthusiasm about the increased resources, in light of their emergency nature. (INT13) • If we look at indicators, there will be no recovery for health care systems: Investments and progresses are too few. (INT13) • The role of EU economic institutions, like DG ECFIN, is evident in the design of the Recovery and Resilience Facility (RRF)…the aim was to address long-term problems of the EU political economy, more than the challenges related to the pandemic. (INT14) • DG ECFIN is always present in the meeting for the review of the progress on the Italian RRP. (INT14)

Table 2. (Cont.) Key interview themes and exemplifying quotes.

Theme	Exemplifying quotes
2. National institutional settings in the health care arena constrain opportunities for significant reforms	• Regarding the institutional set-up, after the pandemic season of centralisation, we are on the (same old) path to strengthening regional autonomy. (INT1) • Regional fragmentation and the scarcity of human capital undermine opportunities for change and discontinuity. (INT3) • One struggles to see any real change. (INT4) • The obligation to comply with budgetary constraints has led to an overall weakening of health care governance…and has placed the centrality of the Ministry of the Economy and Finance far beyond the functions of monitoring spending capacity and compliance with economic-financial balances….This has consequences for achieving radical change. (INT6) • Health policymaking has become much more complicated after the 2001 constitutional reform that has made the boundaries of responsibilities between the central government and the regional ones more conflictual and uncertain. The result is that even for the NRRP, the central government has set up very broad and general goals that regions can hardly contest and that will distribute resources, leaving ample room for regions in the implementation phase. (INT12)

Table 3. Health care multi-level governance and policy before the pandemic crisis.

Role of different levels	
EU level	Minor role; increased focus of the European Semester on member states' health care budgets
National level	Central and increasing role in health care budgets
Subnational level	Declining role on health care budgets but persistent (increasing) role in setting of health care programmes
Role of key institutional actors	
EU level	Key role of DG ECFIN in coordinating health care policy and investments
National level	Central and increasing role of the Ministry of Economic and Financial Affairs (MEF)
Subnational level	Central role of regional governments
Policy programme	
Goals	Cost-containment, efficiency, and technological innovation
Instruments	Regulation, coordination, and budgetary measures
Settings	Cutbacks on public spending

Source: Authors' work based on Pavolini et al. (2023).

at the national level (see also León et al., 2015). Second, the EU agenda before the pandemic crisis on reforming health care was not a coherent paradigm but a set of indications marked by ambiguity. Apart from very general goals set in the 2017 *European Pillar of Social Rights* (e.g., strengthening access to good quality health care provision), no major support was formulated at the EU level neither in terms of the specific type of institutional architecture (e.g., national health system [NHS] vs. social health insurance) nor in relation to the organisation and functioning of the health care system (e.g., the level of decentralisation, the role of community care services). Austerity was the only main (implicit) point in the EU agenda in the 2010s (Brooks et al., 2022).

4.2. The Italian National Health System Before the Pandemic Crisis: Leading Institutions and Policy Reforms

In terms of governance, the Italian NHS was introduced in 1978, and it was increasingly decentralised during the 1990s and early 2000s. A major change took place in 2001 when the role of the regions was further reinforced through a constitutional change. Since then, whereas the central government maintained overall planning functions and had the authority to define a standard set of services ("essential and uniform levels of care") that must be guaranteed in each region, regional responsibilities in organising and managing the NHS in their own territory were strengthened. This institutional arrangement

fuelled legal conflict in the Italian Constitutional Court, with regional governments claiming that central government intervention in health care interfered with their discretional powers and vice versa.

Because of shared competences and institutional conflicts, in the last decades, the central government did not pass any major reform regarding NHS organisation and functioning (INT8 and INT9). By contrast, the central government acted through its remaining budgetary competences to control public spending at the regional level. In the mid-2000s, the so-called Budgetary Balance Plans (*Piani di Rientro*, agreements between the national and regional governments) were introduced to contain costs in the regions with health budgetary deficits. Through the Budgetary Balance Plans, the MEF assumed important monitoring and control powers over regional health spending and, therefore, has been taking on an increasingly important role in governing health care (Terlizzi, 2019).

The re-centralisation of decision-making was matched by personnel hiring freezes and more limited budgetary transfers from the central government to regional authorities. While in the 2000s, public expenditure registered a robust expansion, in the 2010s, there was a contraction (on average, 0.6% at the per capita level on a yearly basis). Overall, regional governments were forced to accept significant cuts and greater budget supervision. Nevertheless, the central government had no major competences to design health care because this was still a task for regional governments.

Health care governance changed in two further respects. First, the Prime Minister's Office became pivotal in promoting and monitoring health care policies, acting as a strong gatekeeper for coordination among ministries and, in turn, gaining increased responsibility for reporting to EU institutions. Secondly, the most important decision-making competences were essentially taken away from the Ministry of Health and transferred to the MEF in order to pursue fiscal consolidation (León et al., 2015).

The policy changes mentioned above made the whole NHS increasingly fragile and ineffective. Cuts reduced the capacity to address health problems. The freezes in hiring personnel were the starting point for a professional labour shortage in the medium term. In such context, both (centre-)left and centre-right governments followed similar patterns of action. In this case, politics did not play a relevant role in the decisions adopted during the 2010s.

5. Policy Initiatives in the Aftermath of the Covid-19 Outbreak

The pandemic crisis had a massive impact across Europe with huge economic consequences. According to the most recent information, EU countries saw about 277 million cases of Covid-19 and 2.2 million deaths. This was also the case in Italy, the first country severely hit by the spread of the virus. Between 2020 and 2022, we counted 190,000 deaths and 25.8 million cases, with a decline in GDP of about 10% (Statista, 2023). On top of that, previous governance and policy changes mentioned above had already put the health care system under pressure and in need of resources.

In the aftermath of the pandemic, European and Italian policymakers and analysts stressed the need to improve the resilience of health care systems. Health rights were seen to be key for promoting well-being and the recovery of the EU member states. Discourses on increasing health spending represented the potential for a turn in the EU and national health care priorities. Leading analysts supported an increase in public investment in health care and the ending of austerity in this field (Crouch, 2022). Policy documents from international organisations and national institutions also stressed the need for more robust health care systems (for a review, see Natali, 2022). To sum up, social, economic and political conditions were consistent with a major crisis and opportunities for change (Point B in Figure 1).

5.1. EU Policy Initiatives

In the aftermath of the pandemic crisis, the EU launched different initiatives to address major health problems (Brooks et al., 2022). For health care (of major interest here), the EU set up new programmes with additional resources. In what follows, we focus on the RRF, which represents the most important programme for reform and investment in the Next Generation EU, with 672.5 billion euros of resources (338 billion euros of grants and 385.8 billion euros of loans). Table 4 summarises the main traits of this strategy while showing that reforms and investments promoted by the EU and included in the NRRP consist of a parametric change: new instruments and settings but persistent policy goals.

In line with the recent Commission annual report on the implementation of the RRF, total investments in the member states' health care systems amount to more than 43 billion euros (Lilyanova, 2023b). This sum represents more than twice the investments planned in the Cohesion Policy (through the European Regional Development Fund and European Social Fund) for the period 2014–2020 and eight times the budget allocated for the EU4Health programme. Through the EU4Health programme, the EU activated a budgetary line of 5.1 billion euros (2018 prices) to provide resources for improving and promoting health in the Union, strengthening health systems, addressing cross-border threats, and improving medicines, medical devices, and crisis-relevant products. The RRF is designed to address challenges to economic growth, job creation, and economic and social resilience of the member states. It is a temporary programme (active between 2021 and 2026) organised around six pillars: (a) green transition; (b) digital transformation; (c) smart, sustainable, and inclusive

Table 4. Health care multi-level governance and policy after the pandemic crisis.

Role of different levels	
EU level	Temporary increased role of the EU: New investments and reforms through RRF
National level	Central role in health care budgets
Subnational level	Declining role on health care budgets but persistent role in the setting of health care programmes
Role of key institutional actors	
EU level	Persistent key role of DG ECFIN and European Commission's Secretariat-General on coordination of health care policy and investments
National level	Central role of the MEF
Subnational level	Minor role of regional governments in the design of the NRRP, persistent role in its implementation
Policy programme	
Goals	Persistent focus on long-term financial sustainability, efficiency, and technological innovation (e.g., labour shortages largely out of the agenda of the RRF and NPRR)
Instruments	Integration of regulation, coordination, and additional budgetary measures (RRF and NPRR)
Settings	Temporary increase in public spending

growth and jobs; (d) social and territorial cohesion; (e) health and resilience; (f) policies for the next generation, education, and skills. The focus of the fifth pillar—the only pillar specifically dedicated to health care—measures to overcome structural weaknesses of NHSs (e.g., shortages of health staff and working conditions, infrastructure for e-health, limited access to care).

While the RRF has been seen as a major innovation in the EU healthcare strategy (Brooks et al., 2022), several elements prove much continuity with the past and some limits. As already mentioned, only one pillar out of six is specifically concerned with health care. The Next Generation EU and RRF are mainly conceived of as instruments for economic recovery. As stressed by an interviewee (INT9), the EU aimed to support economic growth in hard times, whatever the policy measures included in the package (Table 2).

The staff working documents pertaining to the design of the EU recovery strategy were drafted by key services of the European Commission (SECGEN and DG ECFIN). The first of these documents proves that the whole strategy was driven by economic ambitions (European Commission, 2020). As stressed by Casalino (2021), the document had three major axes of intervention and needs to address: (a) liquidity and capitalisation needs of enterprises, (b) public and private investment needs, and (c) the need for intervention in social spending. These priorities were defined well before the emergence of the pandemic, while the investment in health care systems was—already in May 2020 at the peak of the pandemic—put at the margin of the strategy. We see in this the evidence of feedbacks that shows the role of economic institutions (the already mentioned DG ECFIN with its alliance with SECGEN and the Economic and Financial Affairs Council) in shaping the recovery strategy more in terms of economic growth than strengthening health care systems and governance. This is further confirmed by two interviewees (INT13 and INT14) who stressed the key role of DG ECFIN and the limited role (and expertise) of the DG SANTE in drafting this type of document (see Table 2 above).

Moreover, some analysts have outlined the limits of the EU approach. A recent report by EuroHealthNet (2021) stresses that the strategy has not seized opportunities for a convincing renewed health programme at a scale necessary to reduce inequalities and strengthen public health in the member states. The priorities set in the RRF were not new but, instead, replicated policy objectives that have been put at the top of the EU agenda in the last decade. As a matter of example, the EU Health for Growth Programme for 2014–2020 set the same priorities of the post-pandemic strategy, for example, boost innovation, increase access to better and safer health care, promote good health and prevent disease, and protect citizens from cross-border health threats (Regulation of the European Parliament and of the Council of 11 March 2014, 2014). What is striking is that even in the context of the pandemic, the fiscal sustainability of health care is prioritised by the EU, with explicit reference to cost-effective strategies and the need to ensure that public finances are able to cover this increase without causing public debt to rise (European Commission, 2020). On top of that, while labour shortages are often referred to as a major problem, RRF is mainly for capital investment (i.e., infrastructure) and not for current expenditure (Corti et al., 2022).

Beyond the drafting of the new strategy, even its implementation has been in the hands of economic institutions. In fact, the Commission created the Recovery and Resilience Task Force within the Secretariat-General.

The latter, jointly with the DG ECFIN, was in charge of steering the RRF's implementation and coordinating it with the European Semester (INT10). The Recovery and Resilience Task Force and DG ECFIN also involve other policy DGs (including the DG SANTE) but only through country teams whenever it is deemed necessary. The political guidance comes from the high-level steering board chaired by the president of the Commission and with the three executive vice-presidents, the commissioner for economy, the secretary-general, the head of the Recovery and Resilience Task Force, and the director-general of DG ECFIN, as well as reports to the College of Commissioners (Lilyanova, 2023b).

The same DG ECFIN and the Economic and Financial Affairs Council were key actors in the activation of the General Escape Clause that suspended the Stability and Growth Pact while maintaining—after a one-year hiatus—economic coordination through the European Semester. The more limited resources distributed through the Cohesion Policy were decided with the active role of the Directorate-General for Regional and Urban Policy, the Directorate-General for Employment, Social Affairs and Inclusion, and DG SANTE for social and health care.

Our interview data provide evidence of the disalignment between the health care reform priorities and the persistent role of economic institutions, with the latter outlining the economic rationale of the RRF (Point A in Figure 1 above), which inhibited paradigmatic reforms in the health care policy field (INT9 and INT13).

All in all, while several interviewees welcomed the new EU initiatives, for most of them, the organisation of health care has remained a national matter (e.g., INT5, INT6, INT11, INT12). Apart from vaccine procurement, interviewees see no real change (INT4, INT6, INT11, and INT12), and some of them highlight the persistent lack of health care coordination at the European level (INT2; see Table 2).

Furthermore, the EU did not show a clear reform agenda for national health care systems, as it had not done before the pandemic (INT1, INT2, INT11, INT12). In other terms, the EU did not have any major paradigm to propose and to foster in health care. As a result, when the EU sat around the table with the Italian national government, it did not have major requests to be fulfilled in terms of specific health policy reforms for Italy—except for the (generic) CSRs in the European Semester—but just a general interest in fostering (anti-cyclical) investments in an economy that was trying to recover from the health and economic crisis (INT8). This is consistent with the dominant role of economic institutions at both the EU and national levels in health care governance (governance feedback in Figure 1).

5.2. Italian Policy Initiatives

In the aftermath of the first wave of Covid-19, public spending on health care increased by 4.7%—about 5 billion euros in 2020. While part of this increase is exceptional and justified by the need to address the short-term effects of the pandemic, other measures were of a more structural nature. It is the case of the investment to increase the health personnel: By March 2021, the number of workers had increased by about 83,000. Further investments were targeted at hospitals and territorial care, in the form of home care for Covid-19 patients (Bressanelli & Natali, 2022). The temporary stop to the EU fiscal rules left Italy and other member states more room for increasing public spending: The general escape clause of the Stability and Growth Pact played a fundamental role in this respect (INT5, INT12). Recent research helps to contextualise the entity of these first investments: in 2023, the Italian health care system is still short of 30,000 hospital doctors and 70,000 nurses (FOSSC, 2023).

Beyond the first investments set at the national level, the NRRP represented a key step for a renewed focus on health care. The Italian NRRP, definitively approved by a Decision of the Council of the European Union on 13 July 2021, consists of 191.5 billion euros (2018 prices) then supported by national funds. The document proposes six missions, with the sixth one being specifically related to health. The mission of the Italian NRRP related to health has two components: (a) proximity networks, facilities, and telemedicine for territorial health care (seven billion euros); and (b) innovation, research, and digitalisation of the NHS (8.63 billion euros) for a total of 15.63 billion euros. The first component aims to strengthen the Italian NHS, to reinforce local health facilities and services (e.g., community homes and hospitals), and to develop telemedicine in the territory (with the activation of Territorial Operating Centres for coordinating home services). The second component aims at developing a health care system that enhances investment, boosts scientific research, and strengthens the technological and digital structure of the NHS. In particular, two investment macro-groups have been defined: (a) technological and digital upgrading (7.36 billion euros in total); and (b) research and training for 1.26 billion euros that aims to enhance biomedical research and the development of technical, administrative, and managerial skills.

While the NRRP represents a novelty (the first investment increase in health policy in two decades), the measures envisaged in the NRRP are unlikely to trigger a radical change in the governance of the Italian health system (INT1, INT2, INT11, INT12). Reports published by stakeholders confirm the general disappointment about the Italian NRRP. Caritas Italiana talked about both its strengths and weaknesses, with some figures that provide evidence of the latter (see the special issue edited by Geraci et al., 2002). Estimations by the same government at the early stage of the pandemic referred to the need for new investments of at least 37 billion euros, much more than the 15.63 billion euros set by the NRRP. Still, Caritas then refers to the main limits of the

same plan and the subsequent Decree No. 71 of March 2022. The reference to primary care seems partial and still oriented towards protective rather than preventive strategies. Territorial health care is also seen as partially defined in the plan, with the persistent role of hospitals and the top-down approach to governance.

Medical trade unions did express doubts about the NRRP. As for the policymaking process, the position of the Federazione CIMO–FESMED (Medical Managers Union Federation) was that "not even the pandemic was able to entrust the relevant ministry with the role of main actor" (Federazione CIMO–FESMED, 2021, p. 2) of the reform and investment initiatives. The Italian NRRP was also viewed as a missed opportunity in that "it seems short-sighted, in a chronic context of inequality in access to care, to use new resources in favour of a health care system still organised in 'silos' and above all fragmented" (Federazione CIMO–FESMED, 2021, pp. 1–2).

The Italian NRRP was, in fact, drafted by the Prime Minister's Office and the MEF, while other ministries had a minor role. Under the Draghi government, MEF represented the contact point with the Commission for monitoring and control of the implementation. Interview data (INT8, INT9, INT11, and INT12) confirm this was a matter of continuity with the recent past. Moreover, regarding policy substance, none of the NRRP health-related measures come from the EU agenda. The NRRP includes old policy measures over which Italy was lagging behind (INT1 and INT4). The NRRP has somewhat accelerated ongoing processes (e.g., digitalisation and territorial assistance) that had a large consensus across policymakers (INT2, INT4, INT5, INT11, and INT12; see also Table 2 above).

If the EU did not play a major role in drafting the contents of the measures adopted, the same is true for the regional authorities. As stated by one interviewee (INT12), there was practically no formal involvement of the subnational level of government in formulating the measures to adopt (see also Lippi & Terlizzi, 2023). At the same time, the regions did not challenge the central government in the Constitutional Court for not having been involved in the plan for two reasons. First, the core set of measures envisaged in the plan (the strengthening of territorial health care and investments in research and technology) answer to well-known needs and shared priorities by both regions and the central government. Second, the formulation of such measures in the plan was broad and vague enough to leave the regions with ample room for manoeuvre on how to allocate the financial resources in the implementation phase.

Moreover, the monitoring process of the different missions has shown that, as of November 2022, little seems to have been accomplished. In fact, the only action currently underway is the re-organisation of the technological and digital stock of hospital facilities. In this respect, the regions have become vocal and have started to protest the absence of a clear line of action in the implementation phase of the plan in relation to health care (INT11; Conference of Regions and Autonomous Provinces, 2023).

6. Conclusion

The pandemic crisis and its intensity made it a potential trigger for change. The Covid-19 outbreak seemed to open a window of opportunity to prioritise health care while reversing the old paradigm consistent with the low level of EU integration on the one hand and austerity on the other. Nevertheless, while new programmes emerged, the evidence shown throughout the article does not confirm a paradigmatic change in the Italian health care system. Through the analysis of the RRF and the Italian NRRP, we have provided evidence that the temporary increase in investment has consisted of a mere change of policy settings (e.g., more financial resources) and policy instruments (new resources distributed through RRF and NRRPs), while policy goals have remained those that were set before the pandemic.

The triangulation of interviews, official documents, and primary and secondary literature from analysts and stakeholders has confirmed a typical parametric policy change. While investment in Italian health care has increased in recent years, this improvement has been temporary (related to the extraordinary EU recovery strategy that will end in 2026) and partial (insufficient if compared to the magnitude of the challenges at stake). Moreover, the health care system and its multi-level governance settings have remained stable.

To explain such an apparent paradox, i.e., huge exogenous shock followed by parametric reforms, the present article has investigated the combination of endogenous and exogenous factors that have shaped post-pandemic health care reforms and investments. As for the endogenous factors, the article outlines the key characteristics of the multi-level governance of health care and the typical governance feedbacks that constrained the room for change. Here, again, the triangulation of different sources provides evidence of the lack of European guidance over the allocation of resources to the NRRP funds.

At the EU level, Council formations and directorate generals responsible for economics and finance had a major role in shaping the recovery strategy, while DG SANTE had a more marginal role. This confirms an ongoing trend: Economic institutions that dominated well before Covid-19 shaped the post-pandemic EU strategy more towards economic recovery rather than strengthening health systems. Consequently, no clear indication came from the EU on the national health reform agenda. This is governance feedback related to the dis-alignment of the distribution of competences and the reform priorities. The former were mainly in the hands of economic institutions, while the latter represented the potential for change (more attention to social policy and public spending) but lacked institutional support.

At the domestic level, emergency measures represented a short-term turn compared to austerity. However, the NRRP is unlikely to trigger a paradigmatic change in the Italian health system. The health policy-making process has remained in the hands of economic institutions that, since the 2010s, have been assuming an increasingly important role in the governance of the health system. The same economic institutions were in charge of the design and implementation of the NRRP. The increased resources through the RRF were passed as part of the economic recovery strategy, more than as part of innovation in health care governance. This shaped the actors' perception of the measures. Interviews confirm that many saw the NRRP as a temporary strategy with no long-lasting consequences. None of the NRRP health-related measures were inspired by the EU. However, they accelerated some of the reform measures that were already in the pipeline. Moreover, regional institutions that are competent in health care reform strategies had a minor role in the design of the Italian NRRP.

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Conflict of Interests

The authors declare no conflict of interests.

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About the Authors

David Natali is a full professor of comparative and EU politics at the Sant'Anna School of Advanced Studies in Pisa.

Emmanuele Pavolini is a professor of economic sociology at the Department of Social and Political Sciences of the University of Milan.

Andrea Terlizzi is an assistant professor of political science at the Department of Political and Social Sciences of the University of Florence.