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THE IMPACT OF COVID-19 ON NURSING HOMES IN ITALY[1]

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The pandemic in Italy

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Italy has been the first western country strongly hit by the Covid-19 outbreak. The first two relevant clusters of infections were officially registered in two Northern Italian regions (Codogno, in Lombardy and Vo in Veneto) on February 21. At that time, the scientific information about Covid-19 and its potential dangers was still very scarce. WHO did not proclaim Covid-19 as a "high global risk" until February 28: on that same day, Italy already had 888 official infected persons, 345 hospitalized covid-19 patients, 105 patients in intensive therapy and 21 deaths. Not only did Italy face this tremendous health risk as the first western country, but it also could not rely on adequate information or indications from other countries or international organizations. A situation that has been common to many other countries but with particularly harsh effects on Italy as the country was not prepared to even recognize the diffusion of the infection in the population. It is ironic that the first Covid-19 case in the cluster of Codogno was detected only after that "patient n.1" spent two full days in a hospital emergency room with no protection and any distancing from the other not-Covid19 patients.

The epidemic reached its peak at the end of March and then, after some weeks of steady trends, started to decrease. At the end of April, 205,000 persons resulted officially infected and 28,000 died from Covid-19. The bulk of infection occurred in Lombardy, the wealthiest region of the country and equipped with a public health system considered of great excellence: 37% of the infected and 50% of the died were in Lombardy (April 30).

In this context, Italian nursing homes were probably the first residential institutions in the western world that have been hit by the pandemic. The same situation happened in many other countries (Comas Herrera et al. 2020) in later times. The diffusion of the infection in such institutions became visible and alerted the public opinion (and policy makers) only one month after the process started to happen: a strong delay in the capacity of the system to acknowledge the problem that had a tremendous impact in terms of number of deaths especially among older people. While the pandemic invaded nursing homes, these institutions were unable not only to prevent or limit the entry of the virus into their structures, but also to provide protection to the workers and adequate

medical care to their covid-19 patients. Nursing homes patients were actually lockdown in institutions clearly unable to take care of them. There is no surprise, therefore, that in April several legal prosecutions in many Italian regions started to investigate these situations with the aim clarifying causes and responsibilities.

The spread of infection in nursing homes has been documented by a National Survey conducted in 1,082 nursing homes (representing 33% of the total number of nursing homes in the country), carried out only on April by the Istituto Superiore di Sanità (ISS 2020), a national institution responsible for public health. The mortality rate due to Covid-19 was calculated to be 3.3% at national level, but it rose to 6.7% in Lombardy. According to the ILPN study (Comas Herrera et al. 2020), mortality rates due to covid-19 in nursing homes have ranged between 0.4% in Germany and 3.7% in Belgium (France: 2.4%, UK: 3.4%, Sweden 2.0%). The mortality rate in Lombardy (counting a total population of 10 millions people, close to the population size of Belgium – 11,5 millions) almost doubles that of other countries. Moreover, it has been estimated that deaths in nursing homes represent 34% of the total number of covid-19 deaths in the country (Pesaresi 2020). Even though these figures are only partially reliable, they show that mortality in nursing homes has been very high and significantly contributed to the total amount of Covid-19 deaths in Italy.

Exploring the spread of the pandemic in nursing homes

The strong spread of the pandemic in nursing homes has been undoubtedly favored by the high concentration of frail older people in these structures (Gardner et al., 2020). On the other hand, services specialized in providing health care to such frail people should have offered particular protection aimed at limiting the infection and related mortality.

A specific investigation of the policy process of risk management is necessary to understand the main raisons of such tragic impact.

In the search for possible causes, in this paper we investigate what the structural situation in such institutions was before the beginning of the epidemic. The underlying hypothesis is that policy legacy factors, coupled with a weak and problematic policy strategy during the pandemic, have played an important role in the way nursing homes have (poorly) dealt with the pandemic. The lack of public knowledge about the spread of the virus in these structures, and the weak response they could give to the pandemic, are to be seen as the result of the poor development of long-term care policy in Italy, and of the marginality of such institutions within such system.

The institutional context

In 2016 (last available data), in Italy there were 12,500 residential structures, with

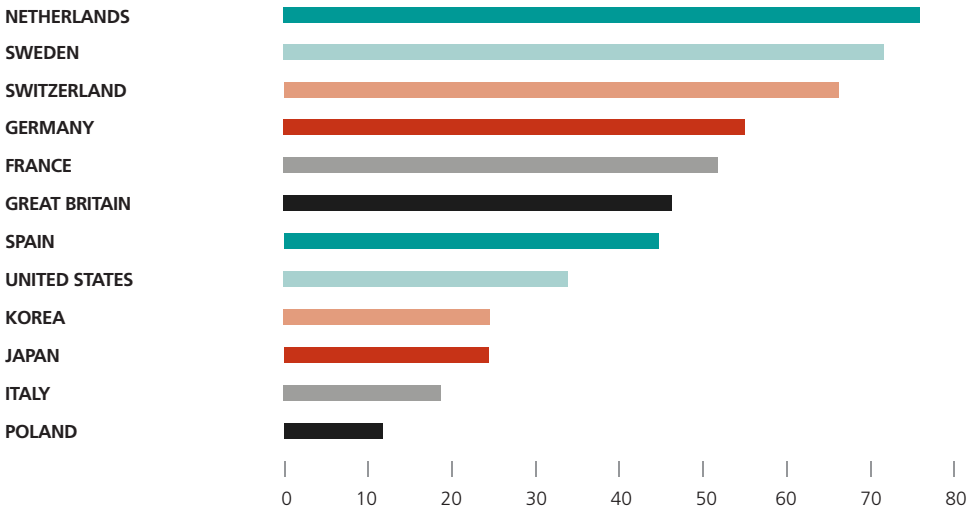
285,000 hospitalized aged over 64: a highly fragmented sector with huge differences in size and level of specialization among structures. The overall figure is that 2.1% of the entire population over 65 were in nursing homes in 2016. In Lombardy the coverage was 3%.

The distance of Italy from other countries is considerable. If we consider the coverage rate according to the number of beds in residential structure (see figure 1), Italy is about half that of Spain, one third of the German one, almost a quarter compared to that of Sweden and the Netherlands. Japan, Korea and even the United States also surpass Italy. Only Poland was behind Italy.

The poor development of elderly residential care structures seems to be linked to the centrality in Italy of strong family networks and migrant care workers, both favoring ageing in place. However, this interpretation is only partially adequate. The OECD data show that in other countries characterized by strong family ties (such as Spain and Korea), the coverage rate is considerably higher than in Italy. A complementary explanation stands in the fact that in Italy long-term care policies have been characterized by strong dominance of monetary transfers to families, under-development of care services (both home care and residential care services), and administrative tolerance for the growth of a huge informal care market based on the supply of undocumented migrant domestic care workers. All these facts together explain why the coverage rate of residential as well as home care services is the lowest of western European countries.

FIGURE 1

NUMBER OF BEDS IN RESIDENTIAL STRUCTURES BY COUNTRY, 2017 (DATA PER 1,000 OVER 64 YEAR OLD RESIDENTS)

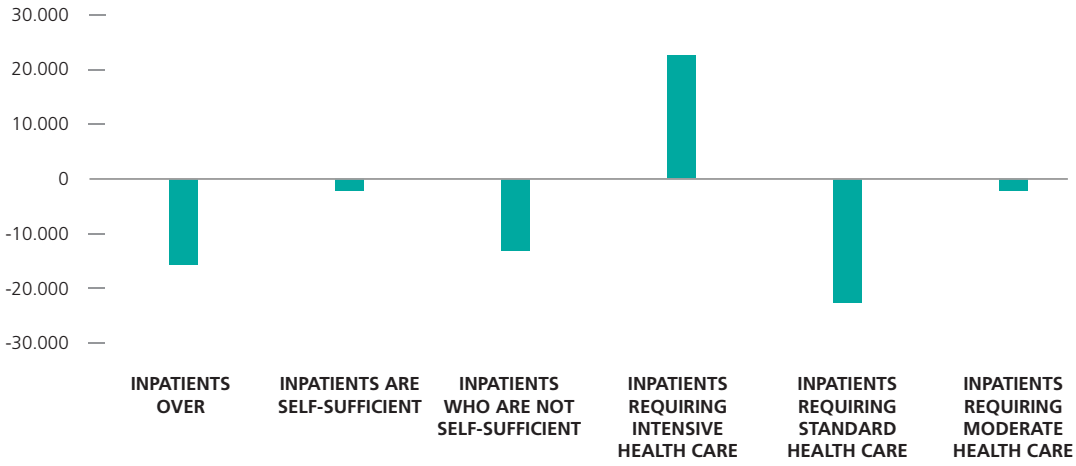


Source: OECD Health Statistics online database (March 2020)

Recent trends highlight the critical nature of this situation. In the face of the ageing process of the population, in the period 2009-16 (last year available) the number of hospitalized patients in nursing homes had decreased by 5%, equal to 15,000 people (see fig. 2). Self-sufficient patients decreased (-13,000 users) while severely impaired patients requiring intensive care increased (+22,000 users). Such changes in the number and profile of inpatients had been accompanied by an organizational change of the residential structures, which increasingly were transformed into "high health-intensive residences", i.e. nursing homes providing intensive treatments that are essential for the support of the vital functions of their patients.

FIGURE 2

CHANGES 2016-09 IN THE ABSOLUTE NUMBER OF HOSPITALIZED PATIENTS BY CATEGORY



Source: I.Stat online database (March 2020)

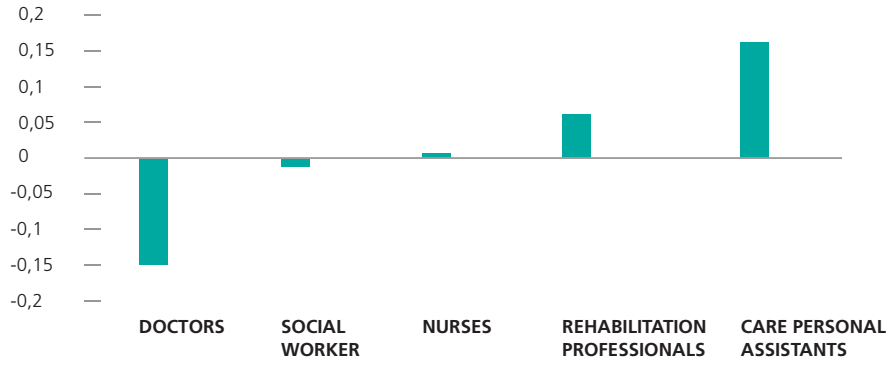
The form of management of nursing homes had also undergone a profound change.

First, there was a significant reduction (equal to 15%) of the medical staff, compensated by an increase of equal proportions in the personnel assigned to the care of people and the substantial stability of the nursing staff (see Figure 3, left side). As intensive health care increased, the presence of qualified medical personnel strikingly lowered.

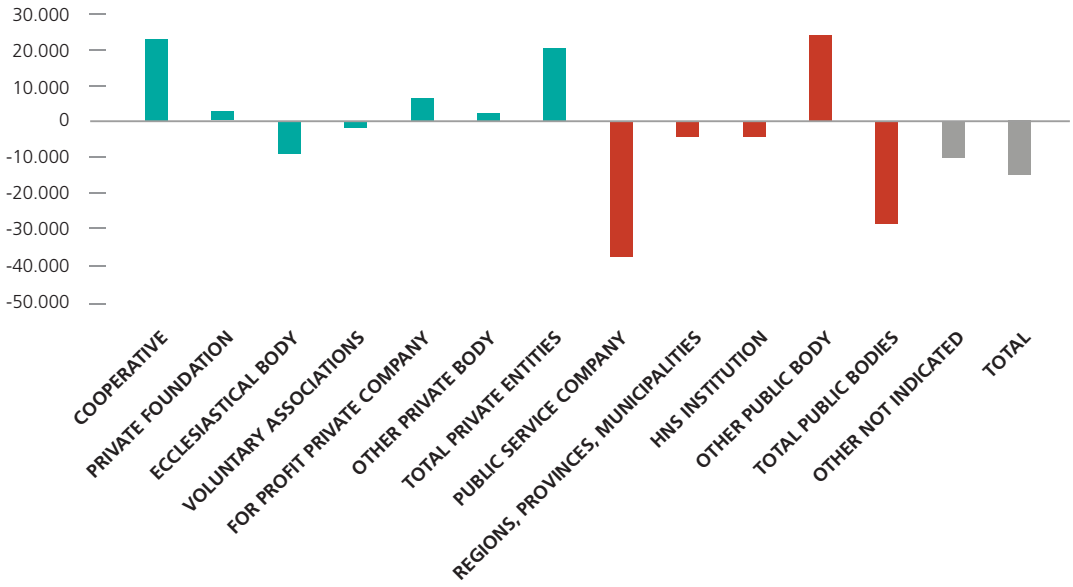
Secondly, the weight of nursing homes run by public institutions has dropped significantly. Against the overall loss of about 25,000 beds in public structures, there had been an increase of about 20,000 beds in private residencies. Most of such private structures operates on behalf of the NHS, being partially reimbursed for the health services provided to their inpatients. The reasons for such privatization include not only the idea that private institutions may provide greater efficiency, but also the possibility of reducing staff costs by adopting job contracts less expensive than those applied in public bodies.

FIGURE 3

CHANGES 2009-16 IN PROFESSIONAL FIGURES



CHANGES 2009-16 IN THE PUBLIC-PRIVATE MIX



Source: I.Stat online database (March 2020)

The combination of these trends has exposed nursing homes to great financial unsustainability. Increase in health-intensive services provided to patients with strong health care needs has hugely raised the costs of the facilities. However, this increase is offset by steady public funding. Although public funding should cover 50% at least of costs of hospitalizations in medium to high health-intensive residences by the law, in many regions the amounts have been lower. For example, in Lombardy, which covers 30% of hospitalized people throughout the country, the public funding per user paid to the facilities is on average 41.3 euros per day, while the fee paid by users is between 60 and 69 euro pro die. Tight

in the grip between rising costs and insufficient public funding, many structures have rationed the expenses through increase in fees (at the expense of the poorest users), cuts in medical personnel, or non-renewal of equipment.

Conclusion

It is in this situation that nursing homes faced the pandemic. They had both internal and external problems. On the internal side, they had to face the entry of the virus into their structures with inadequate medical staff and insufficient resources and capacity to implement distancing and other preventive actions. They were also unable to provide adequate health care to their covid-19 patients, and very often unable to send them to hospitals. On the external side, their situation was ignored for a long time by policy makers, who were mainly focused to face the emergency in hospitals. The policy strategy both at the national and regional levels has been very weak and problematic in coping with the emergency. The national lockdown of nursing homes regarding the access of relatives and external visitors – a crucial measure in order to prevent possible transmission of infection – was established only on March 4, about two weeks later the spreading of the infection. Furthermore, for many weeks not adequate attention has been paid to testing and monitoring activities among healthcare staff and patients: a priority for the implementation of such preventive activities in nursing homes was established only at the beginning of April.

When the number of deaths became important, and protests arose from workers and patients' relatives, legal actions had been carried out to find out what went wrong in these structures. We argue that most of the criticalities came from the pre-existent difficult condition of these institutions. The more nursing homes have specialized in the intensive-health treatment of seriously non-self-sufficient elderly, the more the quality of their services had been hampered by very precarious financial and organizational conditions, co-determined by the lack of public investment in these structures.

The covid-19 emergency has not only determined the massacre of thousands of nursing homes patients. We argue that such "focusing event" (Beland and Marier 2020) has clearly shown the structural weakness of this sector and the main critical problems affecting it, as well as the need for a quick recognition of the strategic importance of nursing homes within the NHS, which has long been too neglected by public health policy.

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