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From Crisis to Opportunity?

Recalibrating Health Care in Southern Europe in the Wake of the Pandemic

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Introduction

Southern European welfare states have been going through turbulent times since the mid-2000s. The financial crisis that started in 2007–2008 was followed by austerity policies. It soon turned into a "Great Recession" that accompanied these countries for a good part of the 2010s. Once Greece, Italy, Portugal, and Spain seemed to have partially recovered from this socioeconomic crisis, the COVID-19 pandemic set in. This chapter focuses on the health care sector of the social protection system for two reasons. First, Southern European welfare states display a hybrid institutional design (Ferrera 1996): sectors such as pensions and unemployment protection are regulated according to a social insurance principle, while others follow a universalistic principle. Health care is the most important social protection sector, where the shift from social insurance to universalism took place in recent decades with the creation of National Healthcare Systems (NHSs). In other terms, it is one of the few strongholds of a universalist approach to social needs. Second, the pandemic hit health facilities hardest, and the capacity of NHSs to react played a pivotal role in the countries' strategies to cope with COVID-19. The NHSs of these four countries are financed mostly through taxation (Greece being the main and partial exception). The Spanish and the Italian NHS are highly decentralized at the regional level. However, when the pandemic broke out, their public per capita expenditure was lower in comparison to Nordic and Anglo-Saxon NHSs, and especially Italy and Greece faced greater access problems (Petmesidou et al. 2020). In light of the medium-term trends emerging over the last 15 years, the chapter addresses

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the question of whether the pandemic public health crisis and the recovery prospects—particularly under the Next Generation EU (NGEU) plan, which seemingly breaks with austerity—represent a “critical juncture” for health care policy change. Our main findings indicate a variegated picture of piecemeal recalibration trends that, however, fall short of addressing some longstanding challenges in a comprehensive way.

The first section of the chapter briefly introduces our analytical framework, followed by an overview of the situation before the onset of the COVID-19 pandemic. Then follows a detailed analysis of how the four health care systems have fared during the pandemic, and of the forward-looking policy options as laid out in the countries’ recovery plans. The conclusion provides an overall assessment of the combined effect of the crisis-induced policy changes during the Great Recession, the responses to the pandemic since its outbreak, and any ensuing game-changing triggers.

Analytical Framework

The assessment of change over time in this policy field will draw from two well established analytical tools. The first frames social policy change in terms of retrenchment versus expansion (e.g., Levy 2010), while the second looks at social policy change in relation to what extent recalibration has taken place (e.g., Ferrera, Hemerijck, and Rhodes 2000). Regarding the latter, we look mainly at three dimensions: functional, distributive, and institutional recalibration. Functional recalibration refers to the type of social risks against which the welfare state protects. Distributive recalibration concerns the rebalancing of social protection provision across different social groups. Institutional recalibration deals with the design of institutions, levels of decision-making, and the roles given to states, markets, families, and individuals within the policy regime. Applying the concept of recalibration specifically to health care means looking at the following issues:

- Functional recalibration concerns the type of care provided. In particular, health care systems currently have to deal with how to allocate resources among prevention, primary care, hospital care, and various forms of outpatient care (including long-term care—LTC—for a growing elderly population). Functional recalibration is expected to occur after decades in which hospital care has become the main pillar of health care systems, especially across Southern Europe.

- Distributive recalibration points to substantive and not only formal inclusion of specific social groups within health care systems' protection, depending also on the extent of the use of co-payments required for accessing public health care.
- Institutional recalibration refers, on one hand, to the role different government levels (central, regional, and local) play in the planning and organization of health care services, and, on the other hand, the role of private provision within (and outside) the NHS.

In the years prior to the 2008 global financial crisis, the trajectories and profiles of Southern European NHSs diverged considerably, as consolidation of universal coverage at all levels of care (including long-term care) and system integration proceeded faster in Spain and Italy compared to Greece and Portugal. At the beginning of the 2010s, austerity policies brought about a convergence trend, as all four NHSs underwent severe spending cuts. Though to varying degrees, this impacted access in care and the quantity and quality of provisions, indicating a "subtractive recalibration" (Guillén and Pavolini 2015). Retrenchment in expenditure disproportionally hit welfare services (childcare, long-term care, education, and health care) relative to social transfers (pensions and unemployment benefits). Austerity in the last decade also meant less investment in infrastructure, worsening labor conditions in this sector (freezes in salary increases, career progression and new hires), and significant functional and organizational problems. The pandemic put huge pressure on these (already weakened) health care systems, exacerbating their recalibration needs.

The Situation on the Eve of the Pandemic

At the outbreak of the pandemic the four Southern European health care systems were still recovering from a decade of economic crisis and austerity measures. Spending apparently picked up, though at varying pace among the four countries, but human resources deficiencies and health infrastructure inequalities persisted. In addition, Greece and Portugal were still confronting long-standing challenges of unequal distribution of primary care coverage.

Public Expenditure Trends

Public health expenditure grew in all countries in the noughties and then fell afterwards (Figure 5.1). Not only had they far less health care resources than Western European countries (EU-15) on average, but they also stopped converging toward the EU-15 average expenditure after 2007 (Table 5.1).

However, the trajectory of health care spending in Spain and Portugal partly differs from that of Italy and Greece. The two Iberian countries were able to recover from the austerity years' cuts quite rapidly: from 2012 to 2019, their per capita expenditure increased by 10.7% and 17.9% respectively, and overall, from 2007 to 2019 expenditure grew by 10%–11%. On the other hand, Italy adopted severe cuts between 2007 and 2012 and recorded a very slow growth afterwards, which was unable to get expenditure back to the 2007 levels (-3% between 2007 and 2019). Finally, Greece registered a collapse, with continuous cuts over time: expenditure decreased in real terms by almost a third between 2007 and 2019. The overall result was that in 2019, the Greek per capita public health expenditure (in PPPs) was around half of what was spent on average in the EU-15 (Table 5.1).

The availability of human resources was hit hard by the onset of austerity (Table 5.2). However, as with expenditure, Southern European trajectories varied over the decade (except for the shared decline in hospital beds). In Greece and Italy, the policy measures greatly accentuated staff shortages, as the hiring

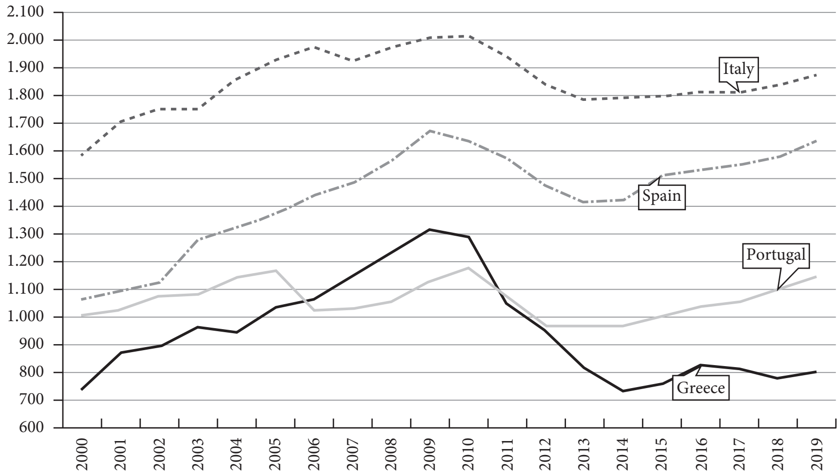

Figure 5.1 Public per capita current expenditure on health over time (2000–2019) in Southern Europe (constant prices; OECD base year; euros).

Table 5.1 Public per capita current expenditure on health over time in Southern Europe in comparative perspective (PPP constant prices; EU-15 unweighted average public expenditure = 100)

	2000	2007	2012	2019
EU 15 average	100.0	100.0	100.0	100.0
Greece	63.4	74.7	56.5	48.3
Italy	93.1	83.0	77.1	73.6
Portugal	78.3	69.8	64.0	69.6
Spain	70.7	76.6	72.4	75.0

Source: Authors' elaboration from OECD (2022)

Table 5.2 Variation in the availability of different types of health care resources between 2010 and 2019 in Southern Europe (percentages)

	Greece	Italy	Portugal	Spain
NHS employed personnel	n.a.	−6.6	+5.0	+5.0
Nurses employed by the NHS	n.a.*	−2.8	+11.2	+11.1
Doctors employed by the NHS	approx. −15**	−4.8	+12.9	+10.9
General Practitioners (contracted by the NHS)	approx. −25***	−7.5	n.a.	+3.1
Hospital beds	−10.1	−12.5	−2.4	−4.2

* According to data provided by the Panhellenic Federation of Public Hospital Employees, nursing and associated staff decreased by over 30% between 2010 and 2017. ** 2010–2017. *** 2013–early 2019. The data for 2013 include private physicians (GPs, pathologists, and pediatricians) contracted by EOPYY, while for 2019 they also include family doctors under contract in Local Health Units established in 2017. Pay cuts and unfavorable working conditions for contracted-out physicians, introduced in early 2018, partly account for the significant decrease of their number.

Sources: Istat Health for All (2021) for Italy; for Portugal, *Balanço Social Global do Ministério da Saúde 2010* and *Relatório Social do Ministério da Saúde e do SNS* (December 2018); for Greece, EOPYY data base (March 2013; January 2019) and Petmesidou (2020: 516); for Spain, *Recursos Humanos, ordenación profesional y formación continuada en el Sistema Nacional de Salud, 2019 (2021), SIS.*

freeze in combination with retirements contributed to a considerable decrease in the number of medical personnel, while at the same time many doctors left the two countries. Somewhat differently, in Spain and Portugal health care personnel grew in the public system between 2009 and 2019. However, salaries in Spain only grew by 0.2%, while working conditions worsened and job insecurity increased. In Portugal, despite significant cuts during the Great Recession, NHS human resources and wage salary expenditure rebounded after 2015, ending the decade respectively up 5% and 12% from 2010.

Functional Recalibration

Variations in expenditure were not evenly distributed across health care functions. Spain and Portugal were better able to recalibrate their health care systems than Italy and Greece (Table 5.3). In the former countries, outpatient care and LTC expenditure grew. Only preventive care did not recover from the cuts of the austerity years. Instead, Italy followed a path of "light" retrenchment, continuing to cut further all main functions apart from prevention, and only trying to functionally recalibrate its system to a limited extent. Finally, Greece acted through plain retrenchment, practically cutting down strongly on every function.

Nevertheless, Greece and Portugal attempted reforms with medium- to long-term functional recalibration goals, also due to their bailout programs. These attempts are not easily captured by the data reported in Table 5.3. In Greece, reforms implemented in the last decade aimed at solving long-standing problems of system fragmentation: the various health social insurance funds were amalgamated into a single entity (the National Organization for the Provision of Health Services, EOPYY); regulative mechanisms for prescriptions and referrals were introduced, and hospital reforms were implemented aimed at improving pricing of services and management (Petmesidou 2020). In Portugal, reforms rationalized the hospital network, expanded LTC, and set up a palliative care network. From 2015, some measures pursued long-standing orientations, for example, cost containment, systemic integration of care levels, and LTC. The service basket expanded in primary care, mental health, and LTC (Nunes and Ferreira 2019).

Distributive Recalibration

Distributive recalibration can be assessed on two grounds: the share of individuals with unmet health care needs by socioeconomic characteristics, and reforms and policy changes that might have affected social inequalities. Tables 5.4 and 5.5 provide data of self-reported unmet needs for medical examination by income quintile (Table 5.4 focuses on the lowest and highest quintiles) and by migratory background (defined in terms of country of birth). Four main findings emerge. First, social inequality in the access to health care was a much more pronounced problem in Greece and Italy than in Spain and Portugal, with the latter countries performing similarly

Table 5.3 Variation in per capita public expenditure on health by function over time in Southern Europe (percentages, constant prices)

	Greece			Italy			Portugal			Spain		
	2007–2012	2012–2019	2007–2019	2007–2012	2012–2019	2007–2019	2007–2012	2012–2019	2007–2019	2007–2012	2012–2019	2007–2019
Total	−17.1	−15.7	−30.1	−4.4	1.6	−2.9	−5.8	17.9	11.1	−0.8	10.7	9.8
Inpatient curative and rehab. care	−13.4	−19.1	−29.9	n.a.	−5.3	n.a.	−13.8	10.8	−4.5	6.1	14.2	21.2
Outpatient curative and rehab. care	−16.8	5.8	−12.0	−49.2	8.2	−45.1	1.7	17.4	19.3	−0.1	11.2	11.1
Long-term care (health)	407.0*	62.0	721.2	n.a.	5.2	n.a.	36.6	35.6	85.3	12.8	16.8	31.7
Ancillary services	−33.7	48.1	−1.8	n.a.	−0.1	n.a.	−18.8	15.4	−6.4	4.9	8.8	14.2
Medical goods	−21.9	−33.4	−48.0	−1.5	15.4	13.7	−25.8	15.1	−14.6	−18.3	2.4	−16.4
Preventive care	−18.6	6.5	−13.3	30.9	17.3	53.5	−23.7	4.8	−20.1	−13.6	11.3	−3.9
Governance and administration	−11.5	−2.0	−13.3	1.2	−16.1	−15.1	−4.6	−4.1	−8.5	−8.1	−3.4	−11.3

Source: Authors' elaboration from OECD (2022)
* Due to a very low figure at the base year, the high increase rates do not reflect any substantial expansion of this function.

Table 5.4 Self-reported unmet needs for medical examination due to costs, availability, or waiting lists by income quintile

	2008			2015			2019		
	Total	First quintile	Fifth quintile	Total	First quintile	Fifth quintile	Total	First quintile	Fifth quintile
European Union-27	3.0	5.7	1.4	3.3	5.6	1.5	1.7	3.2	0.7
Greece	5.4	8.8	1.8	12.3	18.3	4.0	8.1	17.6	1.0
Spain	0.4	0.7	0.4	0.6	0.7	0.4	0.2	0.1	0.2
Italy	5.2	10.4	2.0	7.2	15.5	1.5	1.8	4.1	0.4
Portugal	1.1	2.6	0.3	3.0	6.4	0.6	1.7	3.5	0.2

Source: Eurostat online database (2022) (indicator: HLTH_SILC_08)

Table 5.5 Self-reported unmet needs for medical examination due to costs, availability, or waiting lists by country of birth

	2008		2015		2019	
	Foreign country	Reporting country	Foreign country	Reporting country	Foreign country	Reporting country
EU-27	2.9	3.2	3.6	3.2	1.5	1.7
Greece	6.6	5.3	18.4	11.8	12.8	7.8
Spain	0.8	0.3	0.6	0.6	0.3	0.2
Italy	6.1	5.1	12.2	6.6	1.7	1.8
Portugal	0.5	1.2	3.9	2.9	1.6	1.7

Source: Eurostat online database (2022) (indicator: HLTH_SILC_29)

(Portugal) or better (Spain) relative to the EU average. Second, inequalities peaked in Greece, Portugal, and Italy around the mid-2010s, and then abated. Third, on the eve of the pandemic, social inequalities were still very strong in Greece and partially so in Italy. In these two countries (and mostly in Greece) access inequalities were related both to income level and migratory background. Last, in Spain all types of inequalities were persistently low, while in Portugal they were not very strong and mainly related to income level.

In Greece, reforms tried to tackle social inequalities but with limited success. For instance, the health benefits basket was standardized across occupational groups, but it became leaner, and co-payments for pharmaceuticals and laboratory tests (outside hospitals) increased (Petmesidou 2020). Drastic public expenditure contraction shifted the cost to patients, and barriers to system permeability and navigation rose, especially for the more disadvantaged groups (Petmesidou et al. 2020).

In Portugal, access inequalities worsened during the early 2010s. The reforms instigated by the 2011 bailout program doubled user charges. Excepting LTC, austerity across all functions undermined universal access, shifting costs to patients when private spending was frozen by the economic crisis without relevant efficiency gains. Overall, state responsibility narrowed while the NHS service basket shrank (Petmesidou et al. 2014). User charges were ended in 2019 for primary care and all primary care referrals within the NHS. Despite reversals from 2015, policies still adversely impacted access, for example through less scope and depth of provision (particularly of pharmaceuticals), personnel shortages, and system integration and rationalization issues (Petmesidou et al. 2020). Inequalities persisted due to fragmented ambulatory and hospital care and geographical imbalances (Perista 2018).

Similarly, the Italian NHS on the eve of the pandemic clearly showed severe inequalities in access to care, also related to the increase of fees to access provision. These inequalities were not just based on income level but also were territorial in nature, with a big gap between northern and southern Italy (Vicarelli and Neri 2021). Spain suffered from territorial imbalances too, albeit much less marked than the north–south divide in Italy, and in general Spain was the country that had fewer distributional recalibration problems.

Institutional Recalibration

As for institutional recalibration, all countries shifted decision-making from local/regional to central government level (Guillén and Pavolini 2013, 2015). This development was particularly important in Spain and Italy, where decentralization had been implemented in the previous decades. In both countries, the strong regional autonomy was limited by central governments during the 2010s, not through a legislative reform but simply by introducing more limits on public health care spending (Petmesidou et al. 2020). In Portugal and Greece, the weak regional autonomy was further undermined by a centralist turn, displacing decision-making to the top of the ministries of health and finance. Also, in Spain and Italy an incremental rise of supplemental private coverage (of an "occupational-mutualist" type; Petmesidou et al. 2020) indicated a "hidden privatization," though this has not led to substantial enhancement of the role of private provision. Portugal and Greece followed a different path. They never developed a fully-fledged NHS, given the large private sector (in both countries) and generous health insurance schemes for public servants and private subsystems, particularly in Portugal. During the past decade occupational subsystems and private insurance covered 16% and 26% of the population, respectively, in Portugal. Austerity stimulated the transfer of services to nonprofit institutions and an increase of out-of-pocket spending. As for Greece, where the shift to an NHS model remained deeply incomplete for about three decades, the financial crisis and bailout conditions enforced reform toward a more unified structure. But greatly strained budgetary conditions placed a brake on effective implementation, and private (mostly out-of-pocket) spending remained high.

Finally, no significant shifts in normative patterns were observed. By using citizens' satisfaction with health care services during the Great Recession (Petmesidou et al. 2014, 334–5) in combination with the size of private health spending as a proxy for normative orientation, we find two highly contrasting cases: sustained predominance of universalism in Spain (comparatively high satisfaction with public provisions and limited private spending) versus a highly negative appraisal of public provision and high private health spending in Greece. Within this range of proxy normative attitudes, Italy fell closer to Spain, and Portugal to Greece (though with some distance). Overall, Janus-faced trends were varyingly manifest in the four countries at the turn of the 2020s. Health care spending was on the rise, but upward convergence to the EU-15 average per capita rate was slower compared to the pre-crisis years. Rules regulating access were reviewed (e.g., some fees were reduced or abolished) but significant inequalities in access persisted (except for Spain). Strong public budget pressures during austerity largely ran counter to primary-care reform and system integration in Greece (and partly in Portugal), limiting universal coverage. Also, increasing surveillance capacity on spending by central governments in the first half of 2010s sparked off worrisome central/regional tensions, particularly in Italy and Spain, which continue to significantly impact upon service provision.

The Main Measures Adopted During the Pandemic

To analyze how the countries recalibrated (or intended to) during the first year and half of the pandemic, we shall focus on three issues: funding, emergency measures adopted to cope with the health threat, and measures seeking to tackle health issues in the medium to long term.

Funding

Figure 5.2 and Table 5.6 display long-term trends in per capita public health expenditure, the rapid spending increase during the pandemic after a decade of austerity, and future investment in the health care sector under the countries' recovery plans. Between 2019 and 2020, per capita public expenditure on health care rose significantly in real terms in Spain and Portugal (by 7.6% and 7.4% respectively; Table 5.6). The corresponding rates for Italy and Greece were 4.8% and 6.1%. Portugal registered a strong upward trend in 2021 too (10.5%). These are substantial increases, which (with the exception of Greece) brought per capita expenditure slightly above the 2007 level (in Italy), and well above that level in Portugal and Spain. Looking at medium- to long-term investment choices between 2021 and 2026, the Italian National Recovery and Resilience

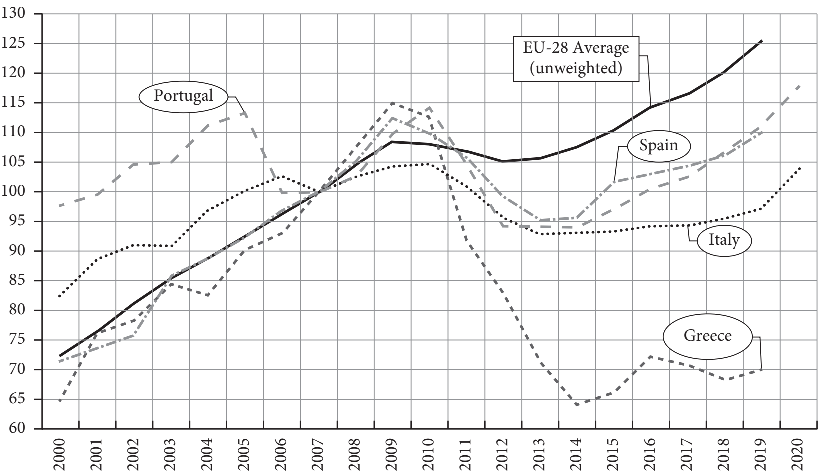

Figure 5.2 Public current expenditure on health care over time (2000–2020) in Southern Europe (per capita, constant prices; base 2007 = 100). Source: Author elaboration from OECD (2022).

Table 5.6 Expenditure and investment during the pandemic and in the road to recovery

	Per capita public health care spending*			Health spending as percentage of the total resources of the NRRPs (2021–2026)	Main health care sectors in NRRPs investment programs (2021–2026) in billion euros				
	Percentage change (in 2020 constant prices; euros) 2019–2020	2020–2021	In million constant 2020 prices; euros 2020 / 2021		Primary/ outpatient care and e-health	R&D, innovation and digitalization	Mental health	Infrastructure**	Public health and/ or other
Greece	6.1	n.a.	907 / n.a.	5.0	0.29	0.58	0.06	0.36	0.26
Spain	7.6	n.a.	1861 / n.a.	1.5***	0.10	0.09	0.003	0.79	0.08
Italy	4.8	4.7	2036 / 2131	9.0	7.00	9.60	-	-	-
Portugal	7.4	10.5	1273 / 1410	8.4	0.67****	0.3	0.09	0.31	0.01

* Government schemes and compulsory contributory health care financing schemes; ** Including investments for tackling territorial inequality in service provision; *** up to 2023; **** including LTC

Source: Authors' elaboration from WHO Global Health Expenditure Database (2022); NRRPs of the four countries

Plan (NRRP 2021) aims to devote €16.63 billion to health care, equal to around 9% of the total resources of the NRRP (QuotidianoSanità 2021). In Spain, a small increase (of 0.6%) was budgeted for 2021, 11% of which came from the Recovery and Resilience Fund (RRF) (MHyFP 2021; NRRP Spain 2021).

Portugal has witnessed a continuous and steep rise in public health spending since the end of the Memorandum of Understanding[1] in 2014 (by 28% up to 2020). Thus, in 2020 the NHS total expenditure rose by about €650 million (+5.8% compared to 2019) and in 2021 by another €1.4 billion (+11.9%). The government vowed to keep funding levels, and the NRRP included additional expenditure of €1.38 billion (12% of total NHS outlays) (NRRP Portugal 2021).

In contrast to the other three countries, where the government budget almost entirely covers public health spending, in Greece state budget sources fund only about 45% of public health expenditure. Between 2020 and 2022, government health spending ranged between 4 to 4.5 billion euros, 6%–7% deriving from EU resources (state budgets[2]; NRRP Greece 2021). Dedicated COVID-19 extra-budgetary funds were added to these, raising government spending by about 20% each year. These extra resources covered the increase of health care personnel (mainly on a temporary contract basis), the procurement of personal protective equipment, the expansion of intensive care beds and of diagnostic testing capacity, as well as subsidies to EOPYY to counterbalance its declining revenue due to falling social insurance contributions. However, this trajectory of government spending is insufficient for redressing decade-long, huge austerity-driven cuts.

Emergency Measures

As soon as the pandemic set in, Southern European countries introduced emergency measures (varyingly combining temporary and permanent elements), which addressed, to one extent or another, the demands for swift increases in the number of health care personnel, scaling-up of hospital capacity, improvement/reorganization of primary care response (including

[1] The MOU was a program of financial assistance signed in 2010 by the European Commission, the European Central Bank (ECB), and the International Monetary Fund (IMF), and separately by Greece and Portugal. Financial aid packages were provided in exchange for structural reforms and public debt reduction.

[2] https://www.minfin.gr/web/guest/oikonomika-stoicheia

home care), and acceleration of digital technologies. Logistics challenges linked to COVID-related procurement, mass testing, and vaccination had to be met, too. Italy had the most dramatic start of the four countries in terms of infections and deaths. The government passed two major bills (the "Care Bill" of March 2020 and the "Relaunch Bill" of May 2020) laying out the policy framework (Vicarelli and Neri 2021). Greece stands out for its early adoption of strict containment measures (March 2020), which contributed to managing at least the first wave comparatively better than the other countries. Yet, her performance deteriorated during the second and third wave of the pandemic due to public health capacity constraints and feeble random-sampling epidemiological surveillance (Kondylis et al. 2021, 65–70).

Health Care Personnel

Between March 2020 and April 2021, around 83,000 professionals (26% of which were doctors) were recruited ad hoc to cope with the pandemic emergency in Italy (Corte dei Conti 2021). This figure amounts to 12% of the total NHS employees and therefore represents a major effort to reverse the cuts in the personnel that were made in the previous decade (see Table 5.2). By the end of 2021, it was not clear if these new personnel would remain on a more permanent basis and/or if future retirements would not be replaced due to the ad hoc hiring during the pandemic. In Spain, retired doctors and medical students were encouraged to collaborate on a voluntary basis. New regulations (particularly those introduced in late March and September 2020) allowed the regional health care systems to recruit doctors, nurses, and other health care personnel. However, this was set up as an extraordinary measure: contracts were fixed-term for 12 months and could then be renewed every three months based on need. Approximately 92,000 contracts were signed from the onset of the pandemic up to June 2021. But only 8%–10% of all new contracts remained by the end of 2021. Several regions declared that all or part of the new take-ups were going to be kept due to personnel shortages related to retirement within the same year (Antena 3 Noticias June 6, 2021; Redacción Médica September 20, 2021). In Greece, more than 7,500 new medical, nursing, paramedical, and other staff have been recruited since March 2020, predominantly on short-term contracts. In addition, some permanent position openings were announced in 2020 and 2021 (for about 1,400 doctors and 4,000 nursing staff). As in Spain, doctors about to retire were asked to remain in the NHS for as long as the system was strained. Equally, special legislation simplified and facilitated the hiring of new professional staff in Portugal, as well as created banks of health students and retired professionals. There was a surge in hiring through fixed-term contracts, of which only a limited number had been converted into open-ended contracts by mid-2021 (NRRP Portugal 2021).

Hospital Capacity

In all four countries, the pressure on hospitals led to an expansion of acute care beds (partly through the transformation of hospital wards into Intensive Care Units [ICUs]), the designation of several public hospitals as dedicated CORONA hospitals for COVID-19 patients, the creation of field hospitals (including by the military), and partnerships with private for-profit and nonprofit hospitals (mainly in Portugal). In Italy, the above-mentioned bills fostered an expansion of acute care beds, especially those for intensive care. But, as with new recruitments, the two bills did not clarify if the measures would be just temporary or more long-standing after the pandemic. The goal of 3,500 ICU beds appears to be a medium to long-term choice. In Spain, under the steep increase in demand, 6,000 new ICU beds were added to the approximately 4,400 existing ones. In many cases, these were created in hospital wards previously used for other purposes and staffed with personnel that was quickly up-skilled (El País February 12, 2021). Many of such improvised ICUs were subsequently dismantled, except for those hospitals in which there was already a shortage before the pandemic (Redacción Médica June 1, 2020). Similarly, Greece increased the number of ICU beds in public hospitals from 565 to 840 at the height of the first wave, and added 32 ICU beds in military hospitals and about 145 in private hospitals. Total ICU capacity for NHS patients further increased during the second and third wave (close to 1,400 ICU beds in total). However, flexibility in the temporary deployment of acute care capacity has not been adequately matched with more lasting measures. Many of the new ICU units were makeshift arrangements within surgeries and/or "high dependency" wards; the ICU staffing shortage was largely met with the relocation of health care personnel (often lacking highly specialist intensive care skills) from other clinical areas, as well as from primary care units. Pressure to convert special ICUs for other diseases into acute care places exclusively for COVID-19 patients created serious treatment disruptions for patients with other critical diseases (like cancer, cardiac diseases, etc.). Therefore, about 45% of excess mortality was not COVID-19 related in 2020 (Kondylis et al. 2021, 73–75). Greece, also, stood out for the favorable treatment of the private sector, as private hospitals were shielded from COVID-19 incidences because the "requisitioning" of acute and non-acute care private hospital beds was mainly focused on the transfer of non-COVID-19 NHS patients, and at a very hefty compensation by the Ministry of Health (e.g., set at more than twice the cost in public hospitals). In Portugal, the further allocation of human and other technical resources resulted in a 35% increase in ICU bed capacity. Health services were reorganized to concentrate the response to COVID-19 cases in dedicated areas; military hospitals and hotels were deployed in the response to outbreaks, particularly those in nursing homes (Simões et al 2021). Yet, despite the surge of resources, a huge backlog of lack or delayed care emerged, especially worrying for acute and chronic care patients (e.g., hospital appointments fell by 1.2 million, and programmed surgical interventions by 100,000; NRRP Portugal 2021). A snapshot of the impact of disruption in service provision due to the pandemic is provided by a recent Eurofound e-survey of self-reported unmet need for health care. In all four countries, the rates of persons who declared that although they needed a medical examination or treatment, they had not received it, was well above the EU-27 average (20.7%), ranging from 23.2% in Italy to 34.2% in Portugal in February/March 2021.[3]

Primary and Community Care

Investment in and reorganization of outpatient and domiciliary care have been prominent in Italy. An important intervention (with potentially long-lasting effects) was the creation of special care community units (USCAs), which are special treatment units providing care at home for COVID-19 patients. For the first time since the NHS's creation in 1978, young primary care doctors were directly hired, instead of being contracted out, to make the USCAs work. Furthermore, nursing home care was strengthened, with the attempt to involve also voluntary and community organizations. The USCAs and the strengthening of home care are considered as innovations that should last beyond the pandemic.

In contrast to Italy, the reorganization of outpatient and domiciliary care was not high on the agenda in Spain, though minor policy adjustments have been going on, particularly with the aim to reinforce home care. Portugal and Greece—which, as mentioned above, had embarked on a path toward achieving universal primary health care coverage in the last

[3] https://www.eurofound.europa.eu/data/covid-19.

decade—exhibited divergent trends during the pandemic. In Portugal the coronavirus crisis offered an opportunity to improve outpatient and domiciliary care, a long-standing goal to be addressed also through the NRRP. National coverage of the population unserved by a general practitioner (GP) is improving, though still short of the universal goal, all while broadening the basket of care and diagnostic services. In Greece, however, the pandemic has greatly slowed (or partly thrown into reverse) the realization of primary care reform. And even before the coronavirus health crisis, the implementation of reform has not been straightforward. Instead of strengthening primary care to reduce vulnerability in the community and mitigate pressure on hospitals, staff relocation from primary care units to other parts of the NHS greatly weakened its service delivery capacity. Nevertheless, an accelerated adoption of digital technologies in health care through emergency measures could potentially have a beneficial impact upon primary care integration and public health promotion. Digital technologies have been progressively introduced in the Greek NHS since the early 2010s, such as the Electronic Patient Record and the National Network of Telemedicine, servicing mainly NHS health care centers and hospitals on the Aegean islands. The pandemic has given an impetus to the expansion of these measures that can facilitate interoperability in health care.

Forward-Looking Policies in the NRRPs

In Italy and Spain, no drastic reform was envisaged under the NRRPs. The Italian NRRP proposed investment in and expansion of two health care sectors (Table 5.6), partly linked with the emergency measures discussed previously, namely outpatient care and e-health (about €7 billion), research and development, and digitization (about €9.6 billion). The first line of investment focused on strengthening prevention, home care, and several forms of outpatient care. It introduced 1,288 "community centers" where interdisciplinary teams of GPs, pediatricians, medical specialists, nurses, and social workers will work together in primary care and in coordinating home and outpatient care. The goal is for home care to cover 10% of the elderly population (practically doubling the current coverage). Also, 380 "community hospitals" are planned, to be run mostly by nurses and intended for short hospital stays of patients with a medium to low care complexity, often after an acute hospital discharge. The second line of investment aimed to modernize the NHS technological infrastructure, promote biomedical research (setting up “excellence research centers”), and support lifelong learning for health care personnel (in particular GPs). As part of these goals, e-health is framed as an important element of the future NHS in order to make it more sustainable and effective.

Investment in health care did not figure prominently in the Spanish NRRP (just over €1 billion for 2021–2023, Table 5.6). About 90% of the funds will be allocated to the renewal of high-tech equipment, the rationalization of consumption of health products and drugs, and surveillance of the pandemic by the newly established Public Health Center. A meager amount (€62 million) will be devoted to disease prevention and health promotion actions, and an even smaller amount (€13 million) to up-skilling of health professionals. Investment in primary care improvement is not included in the NRRP but will be supported by national/regional funding and other EU financial tools.

In Greece, the NRRP milestones and goals to be achieved with funding allocated to health care (about €1.5 billion between 2021 and 2026; 5% of the total funding to be received by the country, see Table 5.6) strongly embraced the digital transformation of health through integrated information systems and advancement of health promotion and disease prevention. A previous five-year plan for health promotion and disease prevention approved by Parliament in March 2020 partly informed the NRRP: its strategic goals embraced primary prevention of diseases, early detection interventions, and rehabilitation/palliative measures. Other projects in the NRRP included the upgrade of NHS infrastructure and medical equipment through energy-efficient renovations, the expansion of mental health units and of academic curricula in family medicine, as well as the establishment of eight staffed home care units across the country (a care sector least developed).

In Portugal, the NRRP embodied the core reforms for the NHS in the medium term (up to 2026). Three major reforms and €1.38 billion in investments (8.4% of total funding, Table 5.6) seek to balance fiscal sustainability and expansion to underserved types of care and social groups, while at the same time addressing traditional issues of vertical integration, hospital governance, and rationalization, via mainly functional and distributive recalibration. More than a third of these investments will be in primary care. The key aim is to broaden the diagnostic capacity and basket of services of the primary community care network and its physical infrastructure, while expanding community and domiciliary outreach. There is also a sizeable investment in LTC and palliative networks (€205 million) for enhancing capacity (e.g., 5,500 new long-term beds will be added, as well as 500 community beds, 50 domiciliary teams, and 20 palliative care units). Mental health is a major priority, too. A €88 million investment will focus on de-institutionalization, better integration with ambulatory and specialized hospital care, and expansion of community care and the National Network of Continuing Integrated Care (RNCCI) in the entire territory. Most of the planned measures indicate a shift toward attending an increasingly large elderly population with more chronic and degenerative diseases and rising multi-morbidity. Changes in the governance of public hospitals set specific financial goals, enact internal markets, and better integrate different care levels under the oversight of the Ministry of Finance, curbing "wasteful expenditure" for efficiency gains. Lastly, the forecasted hiring of 8,400 health professionals seeks to replenish and rebalance NHS personnel toward more nurses and technicians and away from doctors (excepting GPs still needed to universalize primary care).

Conclusion: An Overall Assessment of Potential Changes in Southern European NHSs

The coronavirus crisis brought significant challenges to Southern European NHSs. Before the COVID-19 crisis, health spending was on a growth path in Spain and Portugal, but less so in Italy and Greece. The health crisis has accelerated this trend in all four countries, representing a boost in the short term and, potentially, in the medium term too. Contrary to the 2010s, the pandemic seemed to be no time for "subtractive recalibration." Rather, it foregrounded the need for a stronger and more resilient public health care system. At least this is what public opinion conveyed by the unprecedented public displays of appreciation for and gratitude to health care workers across Southern Europe at the peak of the health crisis. Indeed, it seemed as though the pandemic presented a "terrible occasion" for those actors who believed in the strengthening and fine-tuning of the public health care systems after a decade of austerity. But, until early 2022, there was no evidence of this juncture turning into a "window of opportunity" that policy and political actors could exploit for a radical rethink of public health care. Instead, our analysis has shown piecemeal recalibration trends to be present in policy proposals (and emergency measures). Overall, these trends indicate two different paths among Southern European NHSs.

In Italy and Spain, the relaunch of the NHS was not a priority in the political agenda, nor in public opinion terms, before 2020. An incremental but potentially transformative change was taking place in these two health care systems toward a kind of partial hidden privatization (Petmesidou et al. 2020; Guillén and Luque 2019). During the pandemic the ad hoc measures adopted in Italy, as well as the investment plans included in its NRRP, go in the direction of a notable functional recalibration of the entire system toward outpatient and home care, with a better focus also on LTC combined with technological innovation. Although this policy orientation does not seem to be radically innovative, it might partially suffice to avoid the hidden privatization of the NHS. Functional recalibration among levels of care, together with prevention and health promotion, is less pronounced in Spain, and private complementary insurance due to growing waiting lists may well continue to expand. Institutional recalibration, be it the interplay among levels of government or the role of private provision within the NHSs, has not been contemplated so far, and distributional recalibration (in terms of access) has not been on the agenda, either. Evidently, in both highly decentralized countries, the most worrisome problem that is not seriously confronted either by the pandemic-induced measures or any planned policies, is that of territorial social inequalities. The whole issue has practically been forgotten in the first two years of the pandemic in Italy. The fact that COVID-19 hit particularly hard the central to northern Italian regions, which was where the NHS already worked better before 2020, largely contributed to this. The issue remains uncontemplated in Spain as well.

While radical recalibration has not been the case in Greece and Portugal either, policy trajectories have borne a different character compared to Italy and Spain. The Great Recession brought into sharp relief the fault lines of the Greek and Portuguese NHSs (weak integration, fragmentation, high private spending), which since then have been the focus of varyingly effective reforms. In Portugal, as soon as the austerity and downward drift of the Troika years was reversed, NHS reform acquired a renewed political impetus. With a left-wing coalition in office (*Geringonça*) since 2015,[4] health care recorded a significant rebound in the pre-pandemic years: more equitable access, rising NHS expenditure with personnel rebalance, and a larger

[4] The coalition (under the ruling of the center-left Socialist Party) collapsed in late 2021. Early elections in January 2022 gave an absolute majority to the Socialist Party. This indicates policy continuity.

service basket in primary care. In 2019, the new Health Basic Law passed by the left-wing majority enhanced NHS's centrality vis-à-vis the private and nonprofit sectors and ended NHS user charges. In Greece, a deeper and more protracted economic crisis followed by a weak rebound in public health spending prior to the pandemic constrained any recalibration moves toward an integrated universal health care system. Still, the public health care budget (partly relying on the Next Generation EU fund for major investments) over the coming years falls short of undoing the drastic cuts of the 2010s.

Seemingly, the political conjuncture creates a more amenable time for reform in Portugal. Pandemic policy measures garnered broad political support, including from the center-right opposition and social partners. Government and opposition cooperation was the Portuguese pattern during the pandemic, unlike in the other Southern European countries (De Giorgi and Santana-Pereira, 2020). Pandemic politics created a "rally around the NHS" effect; hence support for a strong public system seems to be set. This is corroborated by the significant steps in recalibration planned under the Portuguese NRRP. Nevertheless, enduring features of the austerity era raise questions as to the breadth of reform. Such features are the recentralization of an already weakly regionalized NHS, and the lasting importance of the private for-profit sector (both in primary and hospital care) and private nonprofit sector (especially in long-term, palliative, and elderly care), even though the 2019 reform stopped any further privatization trend. However, the persistence of generous public (but also private) occupational subsystems for civil servants and the military needs to be mentioned, which directs a considerable amount of spending toward private providers.

In Greece, the pandemic has blatantly exposed the need for universal primary care built around community-based multidisciplinary team practices (embracing domiciliary care) and able to coordinate actions and ensure continuity across primary, secondary, acute, and aged care services. But reform that tackles this problem head on is still very slow. A window of opportunity is provided, though indirectly, by the intended digital transformation that figures prominently in the Greek NRRP. This has the potential to recalibrate system governance and to bypass some of the NHS's traditional constraints. It can promote interoperability across the system, uphold better and faster coordination of care, and underpin optimal spatial arrangements of networked health care entities (e.g., along the lines of a hub-and-spoke network). In a highly centralized system like the Greek NHS, it can also make possible some de-concentration of functions to semi-autonomous agencies (e.g., the newly established quality assurance agency). Yet, in contrast to Portugal, sustained political (preferably cross-partisan) commitment to leverage such reforms does not seem to be on the horizon. Rather, it is likely that once the pandemic is over, under the pressure of Greece's exorbitantly high public debt, recalibration will again prioritize cost-cutting and hence increasingly co-opt universal public health care into private operators.

To conclude, during the health crisis and on the path to recovery, Southern European countries have undertaken interventions in public health, varyingly triggering NHS recalibration. No wholesale reform has taken place, but some decisive changes in terms of functional (and partly distributive) recalibration can be ascertained (e.g., in Italy and Portugal). Digitization potentially can be an indirect trigger of recalibration (e.g., in Greece). However, system governance and the public–private mix are not at the foreground in all four countries, and a meager opportunity for enhancement of universalism (in terms of equity and service quality) that opened up during the pandemic does not seem to be sustained. Finally, a cautionary remark is needed given two uncertain parameters that may weigh heavily on policy options and funding. The first parameter refers to the shape in which the Stability and Growth Pact will be reapplied. The second parameter concerns the unfolding global energy crunch, likely to intensify due to the geopolitical conflicts that erupted in Europe during the time of writing. These can overstretch public finances in Southern European countries and take their welfare states—and the NHSs as a main component of them—into uncharted territory.

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