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Healthcare Ethics in Urban Europe: Between Charity and National Welfare

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Charity and the 'Common Good'

Contemporary historians provocatively trace the origin of the welfare state to the role of hospitals in medieval society (Garbellotti 2013). In medieval Europe, the Christian charity ethos stimulated the establishment of hospitals as places of 'hospitality' to assist pilgrims and the urban poor — *pauperes et inopes*. By the late-Middle Ages, rich merchants were increasingly investing in these religiously-run institutions or in the creation of new 'lay' hospitals. Their philanthropy was in part stimulated by the effects of the emerging market economy on cities. On the one hand, philanthropic donations represented a form of wealth redistribution, stemming both from a religiously-inspired charity and a sense of civic duty. On the other hand, as municipal governments began to recognise the benefits of hospitals to the 'common good', wealthy citizens were encouraged by the ensuing tax incentives for donations in this field (Cipolla 1997). Private philanthropism and the urban administrative approach were inspired by a rediscovery of Aristotle's work — and his view of the city-*polis* as a 'political community that bridges the gap between the private sphere (the household economy) and the public sphere (the common good)' (Prato 2017: 56) — and the idea of *caritas* intended both as individual spiritual choice and as public instrument of assistance.[1] Late-medieval hospitals embodied a new relationship between political-administrative powers, market economy and citizens. Hospitals gradually acquired diversified social purposes, providing free services mainly, but not exclusively, in medical care and spiritual and moral support against suffering.

The above-described conception of hospitals as a 'holistic' healing environment — one that cared for a person's body, mind and spirit — has gradually moved towards the institutionalisation of hospitals as specialised 'bio-medical facilities' and, in line with the principles of twentieth-century neoliberalism, hospitals have been reduced to 'companies' where budget is a priority and medical performance is periodically audited and ranked. Parallel to this, faced with financial strains and higher public expectations, the role of state government has changed, too, to one of broker between people and private service providers. The UK and Italy are often singled out among those 'advanced' countries that are implementing such a shift, leading to the increasing marketization of the health system.[2]

Interestingly, in his book *Medical Nemesis* (1976), the philosopher Ivan Illich describes how, in the twentieth century, medicine has abandoned the 'holistic' approach and has been

[1] This idea of *caritas* is famously represented in Lorenzetti's allegory of 'good government'. See also Pardo 2022: 16.

[2] Pardo (2022) on Italy and Spyridakis (2022) on Greece address similar questions in their respective essays.

reduced to the application of a series of protocols for the cure of specific symptoms. Such an approach now pervades all healthcare sectors; from the work of family doctors to the services provided by public medical institutions. The relationship between doctor and patient is regulated like a contract between an 'operator' and a 'customer'. In order to 'promote' the quality and efficiency of the service, doctors are expected to perform their 'technical duty' in line with the audit regime, which restricts their attention to patients.

Healthcare: From National Welfare to Devolved Services

Since the end of World War II, a key aspect of welfare policies in Italy and the UK has been the provision of 'free' healthcare and the protection of public health as a 'duty' towards its citizens. In Italy, the Italian Constitution and Regional Statutes pledge to fulfil such a duty. In the UK, the long tradition of welfare policies is embodied in various legislative acts.

Health, intended as a state of 'complete well-being', is also at the centre of international attention as one of the global 'sustainability goals'. Accordingly, national healthcare performances are periodically assessed and ranked in international reports that evaluate the effectiveness, accessibility and resilience of a country's healthcare system.[3] These report use data on: (i) the health status of the population (meaning, the life expectancy at birth); (ii) risk factors (such as smoking, drinking and obesity); (iii) health spending per capita. However, while the overall ranking seems to provide a positive image, the unpacked data reveal a different picture. Tellingly, *The Lancet* (2018) points to important limitations of the way in which these performance and quality indexes are constructed, stressing that they do not 'account for all potential factors related to health-care access and quality' (2018: 2259), including 'catastrophic health spending', insurance/private coverage and 'social determinants' (ibid.) of health, including discrepancies by socioeconomic status and across regions.

The 2019 OECD report ranks Italy and the UK among the best healthcare systems worldwide (OECD 2019).[4] In reality, these two countries have experienced serious drawbacks, especially due to an accelerated move towards the 'marketization' of healthcare. An outline of key legislative changes will help to put this situation into context.

The Italian national health service (Servizio Sanitario Nazionale, henceforth SSN) is fraught with serious limitations, due to frequent legislative changes on healthcare, cumbersome bureaucratic and administrative procedures, regional disparities and the financial burden placed on citizens though the imposition of out-of-pocket payments. Significantly, in Italy, public health spending is lower than the EU average (9.8%); most important, only 6.5% (about three-quarters) of the reported 8.8% of the Italian health spending is publicly funded, the rest is paid by the citizens through the so-called '*ticket'*.[5] Major

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[3] Koening and Diarra (2022) analyse these issues in relation to health institutions in Mali.

[4] A new 2021 report, to be published in 2022, will take into account the impact of the Covid-pandemic.

[5] Out-of-pocket payments on drugs prescriptions were introduced in 1982. The new *ticket* introduced in 1989 (d.lgs 23/03/1989) was presented as a form of partial cost-sharing — a citizen's duty — and a

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legislative changes between 1991 and 1993 have extended this 'co-payment' to practically all health services and introduced a tripartite classification of drugs — specifically, Class-A drugs available on payment of a fixed ticket on the prescription; Class-B drugs, available on payment of 50% of their cost; Class-C drugs to be fully paid by the patient. In 1999, several paediatric antibiotics and life-saving drugs for chronic illnesses were re-classified as Class-B and Class-C drugs.

Another key aspect is that nowadays the SSN is territorially-based, often allowing for grey areas in the distributions of responsibilities between the State and Regional Administrations — this has critically emerged during the recent Covid-19 pandemic. Significant steps in this direction were introduced by the legislative decrees of the 1990s giving more power to the Regions,[6] which became increasingly responsible for the collection of *tickets* and the administration of the newly-established Local Healthcare Units (Unità Sanitarie Locali, henceforth USL); Regions also had the power to increase the *ticket* at their discretion, including the *ticket* on drug prescriptions.[7] The 1999 Bindi legislation strengthened the power of Regions and introduced a corporative approach in health planning and administration; thus the USL became Local Healthcare Corporations (Aziende Sanitarie Locali, henceforth ASL), in practice transforming healthcare services into 'commodities' and the patients into 'consumers'.[8] In 2001, the Reform of Chapter V of the Italian Constitution (Constitutional Law n.3, 18-10-2001) delivered the final blow. This reform entrusted the 'protection of citizens' health' to Regions and autonomous Provinces; thus, critics say, leading to 21 different healthcare systems. A month later, a new Prime Ministerial Decree (DPCM 29-11-2001) introduced the bureaucratic division of the so-called 'Essential Levels of Assistance' (Livelli Essenziali di Assistenza, henceforth LEA) into three main areas: (i) public health and collective health assistance; (ii) territorial services (for example, family doctor, pharmacy/chemist, home services for the elderly and seriously ill, and so on); (iii) hospital services. Subsequent legislative updates, justified in terms of efficiency and resilience, added further complication, not necessarily easing people's access to healthcare; exemplary are a new agreement between Sate and Regions in 2006 for the development of 'Complex Unities of Primary Care' (UCCP), the Monti government's health reform (Law-8-novemebr-2012-n.189), the DM 2-aprile-2015-n.70, leading to the closure of local hospitals, including those that had been established with philanthropic bequest (Prato 2023), the 2017 DCPM that increased the financial burden on the Regions. Significantly, a new revision of the LEAs began in January 2021 (AGENAS 2021)

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deterrent against potential abuses of the services by the medical personnel. On abuses and various forms of 'moral' corruption among health personnel, see Pardo 2022.

[6] The capital letter is used when the word Region refers to the regional administration.

[7] The same test, or drug may have a different cost in different regions. Between 2009 and 2017, the *ticket* increased by an average of 2.5%, raising citizens' contribution to health spending to 23.5%.

[8] In 2000, the National Health Fund was eventually abolished (d.lgs 18-02-2000, n. 56), transferring almost all responsibility for health spending to the Regions.

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as a consequence of a buck-passing 'debate' on responsibility between national government and regional administrations during the Covid-19 pandemic.

Ordinary Italians have given up trying to understand what they are actually entitled to. When they can afford to do so, they opt for private care. Most important, they see the 'legal imposition' of the *ticket* and certain legislative changes as a betrayal of the fundamental principles of *universality* and *equality* that had inspired the establishment of the SSN in 1978, raising serious issues of legitimacy and trust (Pardo 2000, Pardo and Prato 2019).[9] Furthermore, as I have mentioned earlier, the regionalisation of the system has increased disparities in healthcare provision and in life expectancy and personal wellbeing more generally. In particular, those who live in the southern regions often have to bear the extra cost of having to seek medical care in the northern regions; specifically, travel, lodging and living expenses for accompanying family members. A forthcoming work (Prato 2023) addresses these aspects drawing on ethnographic material collected in the Apulia and Tuscany regions.

The British National Health System (NHS) was established in 1948 as part of the post-WWII social reforms. It is an umbrella term for the public healthcare systems of the four UK 'nations' — England, Wales, Scotland and Northern Ireland. All four systems are funded out of general taxation and share the principle that healthcare should be comprehensive, free and universal. Since 1999, healthcare has become a devolved responsibility, meaning that each nation's NHS operates independently; it is regulated by, and accountable to the relevant government. [10] Thus, the way in which services are organised and paid for have diverged; each nation has its own planning and monitoring frameworks and its own public health agencies, resulting in differences across some policy areas, as it happened during the Covid-19. However, international reports tend to make a joint evaluation of the healthcare profile of the UK, pointing out that the four systems face similar challenges and often adopt similar solutions (OECD 2019), especially in addressing waiting times and the shortage of doctors, nurses and care workers. Generally, health spending across the UK is higher than the EU average and is said to deliver good health services.

Having done field-research in Southeast England, I focus on the English NHS. Like the Italian counterpart, the organisation of NHS-England (from now on, simply NHS) has

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[9] Before 1978, healthcare services were provided by the employment-based *casse mutue/enti mutualistici* (mutual-aid funds), which left out self-employed and unemployed. The *casse mutue*, established in 1958, followed the model of INAM (National Institute for Workers' Illness Assistance) introduced in 1943 (Law 11-01-1943, n. 38) as the crowning outcome of the 1926-1943 welfare reforms that established a stronger State control while compelling employers to provide medical assistance to their workers and their families. Differently from the previous 'mutual-aid societies' based on workers' voluntary subscription, INAM required compulsory contributions paid mainly by the employer and in small part by the workers.

[10] Scotland, Wales and North-Ireland are responsible for their respective Healthcare Service; NHS-England is regulated by the British government. With 80% of the UK population living in England, NHS-England is the largest.

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changed overtime to address shortcomings and meet new needs. For example, prescription charges were abolished in 1965, but reintroduced three years later.[11] Throughout the 1970s and early-1980s, revisions of the original tripartite system (hospital services, primary care and community care) and of Local Health Authorities led to the establishment of Regional Health Authorities. Major reforms have occurred during the Thatcher and Blair governments (respectively, 1979-1990 and 1997-2007).

Key points of Margaret Thatcher's health reforms were the introduction in the 1980s of a 'modern' management process and the so-called 'internal market' in order to shape the structure and organization of health services. The 'internal market' model was outlined in two White Papers, 'Working for Patient' and 'Caring for People', which were opposed by the British Medical Association.[12] The model was revised, resulting in the 1990 'National Health Service and Community Care Act', whereby Health Authorities would stop running hospitals and instead would 'buy' care from their own or other authorities' hospitals. The 'providers' of the services were organised as 'NHS Trusts'.[13] Critics have argued that, while aimed at encouraging efficiency, the ensuing competition also increased local differences.

On becoming Prime Minister in 1997, Tony Blair promised to replace the 'internal market' with 'integrated care' that would combine 'efficiency and quality'. However, in his second term, he strengthened the 'internal market' as part of a modernising process that would increase standards, expand patients' choice and contain government expenditure. He also encouraged outsourcing of medical services and support to the private sector. Devolution (see footnote 10) increased differences between healthcare services across the UK.

Private sector involvement in the NHS intensified with the 'Health and Social Care Act 2012', provoking mass demonstration led by health workers. That year, the Department of Health published *The NHS Constitution for England* (DHSC 2012), which outlines the NHS commitments to patients and staff, and the reciprocal responsibilities between public, patients and staff 'to ensure that the NHS operates fairly and effectively'. It also sets out the government's commitment to produce up-to-date statements on NHS accountability on their decision-making.

In 2018, the British Government announced that NHS-England would receive a 3.4% increment in funding every year until 2024. This raised concern that funding would be used

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[11] Prescription charges are paid by almost all adults aged 16-60.

[12] In British politics, a White Paper is a 'tool of participatory democracy' that performs the dual role of presenting government policies while at the same time inviting opinions upon them, and can therefore be amended.

[13] In the English Common Law, a Trust is a legal arrangement for managing assets; it indicates a legal relationship in which the legal title to the assets is entrusted to a person or legal entity with a fiduciary (that is, in trust) to hold and use it for another's benefit. NHS Trusts are legally independent Public Benefit Corporations that remain fully part of the NHS and are monitored by an independent organisation — called Monitor — which is directly accountable to Parliament.

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to pay NHS debt rather than to improve patient care — two-thirds of hospitals were in deficit (SkyNews 2018).[14]

Interestingly, although reforms have often led to conflict between government and healthcare personnel, especially on the issue of outsourcing to the private sector, ordinary people claim to be proud of 'their NHS', saying say that, overall, the system meets their needs. Such positive attitude of the general public is in part explained with other aspects that are usually ignored in the official 'quality reports', but guarantee the NHS's efficiency and resilience; in particular, the role of charities and voluntary work, which I analyse in the aforementioned forthcoming work (Prato 2023).

How the Pandemic Exposed the Urgent Need for Change

In an earlier publication titled *Pandemic Ruptures* (Prato 2020b), I reflected on the immediate impact of the ongoing Covid pandemic on people's social and personal life. There, I also pondered what course of action governments would take to prevent the NHS from being overwhelmed again (Prato 2020b:108). The Covid-19 emergency has shown that the unpreparedness of the Italian and British health services was mostly due to increasing privatization. It also brought out that healthcare cannot be reduced to a series of bureaucratic protocols and statistical indexes[15] on ambiguously measured 'efficiency' and 'resilience'. The pandemic emergency has once more exposed the dilemma of State intervention in the regulation of such an important public service and the protection of public health. As I argued elsewhere, during the pandemic, governments appeared 'to be using the "state of emergency" as a political strategy to establish new forms of control, while skirting their responsibilities' (Prato 2020a: 8), raising questions on the legitimacy of their action (Pardo 2000, Pardo and Prato 2019). In this scenario, existing inequalities have been exacerbated and new injustice generated (Prato 2020a; Pardo and Prato 2021). Meanwhile, doctors and health personnel have been hailed as heroes. Indeed, they went above and beyond their bureaucratically-demanded duties, working tirelessly and daily risking their lives (Prato 2020a). Their heroism has been supported by people's volunteering and charities' work, in recognition of the difficult situation in which they had to operate. Sadly, however, the governments' *verbal* glorification of such personnel is overshadowing the dramatic reality of the public health services. While health security has become an essential part of international political strategies, such glorification is misdirecting governments' attention from the urgent need for changes; meanwhile dissatisfaction and disillusion among doctors and nurses as well as patients rise. In Italy and the UK, thousands of doctors abandon the public health service each year.

[14] In early-2022, the UK government announced an increase of 1.25% in National Insurance Contributions (NICs), to be spent on the NHS, health and social care. NICs are social security contributions paid by employers and employees, and self-employed.

[15] Armstrong and Rosbrook-Thompson (2022) address similar issues in their analysis of the public health approach to urban violence in the UK.

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Conclusion: The beginning in the end?

Across society there is a growing demand for a better health system. Promises made during the pandemic remain unfulfilled. Future historians might describe the ongoing pandemic as a time of generalized 'crisis' — in economics, politics, international relations — which, unsurprisingly, generates social turbulence (see Nugent 2022). We should not forget, however, that 'crisis' does not simply carry the meaning of 'danger', but it also signifies 'to discern', 'to judge', 'to choose'. It compels people to make decisions and, thus, provides an opportunity for change.

As I mentioned earlier, the pandemic 'ruptures' only exacerbated an already critical situation, which national governments have tried to remedy through several legislative changes. In the UK, a greater involvement of the local community and of patients has been proposed, building on the tradition of volunteering, philanthropism and charities' work. In Italy, relatively new schemes, such as the 'Supplementary health care funds for businesses' and the so-called 'Health Cooperatives', are promoted as a reliable enterprise model for health and wellbeing (Prato 2023). However, the legitimacy of some initiatives is questioned both by the health personnel and by the patients. This reminds us that legitimacy is not automatically granted to abstract legislations and to actions that strictly abide by bureaucratic regulations. In contrast, the legitimacy of the system is questioned when bureaucratic regulations, instead of facilitating common welfare, generate inequalities and increasingly jeopardise people's physical, emotional and psychological wellbeing.

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