Research Article

The Italian Response to the COVID-19 Crisis: Lessons Learned and Future Direction in Social Development

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Abstract

Against the backdrop of a continuously changing situation, the aim of this paper is to discuss the impact of COVID-19 crisis in Italy, the government response to cope with the crisis and the major lessons learned during its management. The analysis shows how Italy's response has been characterised by some rapid measures to tackle the health crisis, but few plans in the mitigation stage and a lack of community involvement. This contribution stress the importance of a cultural shift, through the effort to apply in practice the principles already indicated in the main global policy frameworks to guide disaster management. A community social development approach can help to build concrete actions in this direction.

Keywords

COVID, coronavirus, disaster management, local level development, social development

Introduction

Against the backdrop of a continuously changing situation, the aim of this article is to discuss:

- the impact of COVID-19 crisis in Italy;
- the Italian government's response to cope with the crisis;
- the major lessons learned;
- the implications for community social development in the post-crisis context.

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The first section of the article presents a brief demographic and economic profile of the country. The second part analyses Italy's response to COVID-19 pandemic, focusing on actions taken in different stages of the management of the crisis (World Health Organization [WHO], 2019). The last two sections discuss the impact of the crisis and lessons learned during its management. The discussion will consider if the global and the national institutions have referred to the available international frameworks to guide the action before, during and after crisis, in particular the WHO's Health Emergency Disaster Risk Management (Health EDRM) framework (WHO, 2019) and the Sendai Framework for Disaster Risk Reduction (SFDRR). The SFDRR aims to enhance national and community capacity to cope with disaster risks through a comprehensive approach, to address multiple hazards (technological, biological and environmental). The SFDRR explicitly includes pandemics among biological hazards (UNISDR, 2015). The Health EDRM model refers to the systematic analysis and management of health risks, posed by emergencies and disasters. This framework indicates a combination of actions in different stages of the crisis management cycle, to prevent and mitigate risks, prepare the response and intervene with recovery measures (WHO, 2019). The expected outcome of Health EDRM is that countries and communities have stronger capacities in the reduction of the health risks and consequences associated with all types of emergencies.

The analysis will show how Italy's response is characterised by some rapid interventions to counter the health crisis, but few plans for prevention and a lack of community involvement. This has led to some delays and implied an overwhelming effort to counteract.

The following two paragraphs provide a brief description of the Italian context in which the COVID-19 outbreak occurred. A disaster is not just an aberrant phenomena, but a reflection of the ways societies structure themselves and allocate their resources (WHO, 2019). Therefore it is important to understand risk and protective factors that influenced the impact and the management of the crisis.

Demographics and Economic Profile of the Country

In 2019, the population in Italy was estimated to be 59 million (Statista, 2020d), among which non nationals were about 5 million (Fondazione ISMU, 2020). The country has one of the world's oldest populations, those ages 65 and above (United Nation Population Division, 2019). In 2018, the growth of the elderly population continued both in absolute and relative terms: the over–65s were 13.8 million (22.8% of the total population), whereas young people up to the age of 14 were about 8 million (13.2%) and individuals in working age 38.6 million (64%) (Italian National Institute of Statistics (ISTAT), 2019a). The total fertility rate was unchanged from the previous year (1.32 children per woman), being one of the lowest in the European Union (EU) (ISTAT, 2019a). Italy has the fourth highest life expectancy across the Organisation for Economic Co-operation and Development (OECD) countries, at 83 years at birth (OECD, 2019). Few Italians

die prematurely, with 143 deaths per 1,000 people from preventable and treatable causes, compared to an OECD average of 208. Less than 6% of people rate their health as bad, compared with an OECD average of 8.7%.

Italy has an open economy and is a founding member of the EU. It is also a member of major multilateral economic organisations, such as the Group of Eight (G-8), the World Trade Organization and the International Monetary Fund. Italy is the eighth largest economy in the world, the fourth largest in Europe (Statista, 2020a), and one of the main export countries worldwide. In 2019, 3.72 per cent of the workforce were employed in agriculture, 25.62 per cent in industry and 70.66 per cent in services (Statista, 2020c). The basis of Italy's economy is processing and manufacturing goods, primarily in small and medium-sized firms. Micro firms, many family-owned, are particularly important, providing 44.9 per cent of the employment compared to the EU average of 29.7 per cent (OECD Trento, 2020).

Since the end of the Second World War, Italy's economic structure has changed from being agriculturally-based to industrially-based. Italy experienced its 'economic miracle' in the 1960s. However, the country suffered from several economic crises in the last quarter of the twentieth century. The rate of Gross Domestic Product's (GDP) growth decreased and unemployment rose (Ferrè et al., 2014). The 2008 global financial crisis and the fiscal consolidation measures worsened the condition of a country already in crisis (Di Quirico, 2010). Exports and private consumption were the main drivers of a recovery that, however, has been weaker than in other countries (OECD, 2019). In 2019 the real GDP per capita was still below its pre-crisis peak, and economic wounds inflicted by the crisis had not yet healed. Regional disparities have been one of the long-standing challenges. Four northern regions (Lombardy, Emilia-Romagna, Veneto and Piedmont) account for 48.2 per cent of Italy's GDP (OECD Trento, 2020). Another weakness since decades is the labour market, with a high rate of unemployment among the young generation. In 2019, Italy's unemployment rate reached 9.9 per cent, with the largest regional disparities among OECD countries (OECD Trento, 2020). Notwithstanding a small improvement in recent years, youth unemployment rates above 50 per cent are observed in the South of Italy, while the province of Bolzano-Bozen in the North shows the lowest rate in the country (10% in 2017).

Public debt has worsened after the 2008 crisis, reaching 134.8 per cent of GDP in 2019 (Italy government debt, 2020). The debt burden poses serious constraints on government public spending and on the implementation of expansionary fiscal reforms. The number of families and people living below the poverty line grew. The number of poor individuals in 2018 equalled to 5 million, an increase by almost 1 million compared to 2014 (Statista, 2020b).

Italy has a sizable underground economy, which by some estimates accounts for 17 per cent of GDP (Index Mundi, 2020). These activities are most common within the agriculture, construction and service sectors, and include many nominally unemployed people, as well as undocumented immigrants.

Italy is often referred to as a 'regionalised country' (OECD Trento, 2020), particularly since the constitutional reform of 2001 and a 2009 law on fiscal federalism. Regions have played an increasingly important role, which provided

them with exclusive legislative power in a wide range of fields (healthcare, transport, social services and housing, economic development, environmental protection, culture, agriculture, education, etc.). However, some of these areas are managed jointly with the central government.

The Services to Cure and to Care

The Italian health system, National Health Service (NHS) is based on principles of universal coverage, solidarity and human dignity (Law 833/1978). The NHS provides preventive services, primary and specialist care, and hospital care to all citizens and legal foreign residents. The central government controls the distribution of tax revenue for publicly financed health care and defines a national statutory benefits package, the 'essential levels of care' (*Livelli Essenziali di Assistenza*). The 20 regions have the responsibility to organise and deliver health services and are allowed to generate their own additional revenue. According to the analysis provided by the OECD/European Observatory on Health Systems and Policies (2019, p. 3), 'the Italian health care system is generally efficient and performs well in providing good access to high-quality care at a relatively low cost, although there are significant variations across regions'. Unmet needs for medical care in Italy are generally low. However, the data suggest there are sizeable disparities in access to care across regions, with citizens from the South almost twice as likely to report unmet medical care needs (Van Doorslaer & Koolman, 2004).

A number of cost-containment measures have been taken in the wake of the economic crisis to reduce public spending. As a share of the economy, health spending accounted for 8.8 per cent of the GDP in 2017, one percentage point below the EU average of 9.8 per cent. Between 2000 and 2017 the number of hospital beds per capita in Italy decreased by about 30 per cent to 3.2 beds per 1,000 population, a number below the EU average (OECD, 2019). International comparisons, which consider different parameters, report Italy to spend 2.9 per cent of total health expenditure on prevention, which is in line with the OECD countries average. Expenditure for preventive services targeting individuals (i.e., immunisation and screening) has increased over time, while public hygiene services and veterinary expenditure has decreased (Signorelli et al., 2016).

In Italy, residential care facilities active in 2016 were 12,828, with 390,689 beds (6.4 for every 1,000 residents) (ISTAT, 2018). The majority of the residential care facilities provide both social and health care services. Of all residential care beds, 64 per cent were located in the northern regions (ISTAT, 2018).

Italian social policies and social services are a paradigmatic example of the southern welfare model (Ferrera, 1996). Care for dependent people's needs is mainly provided by family and intergenerational solidarities, while social services are structurally lacking, especially in the South. In particular, there is a high reliance on women to act as informal carers for children and people with long-term-care needs. Law 328/2000 introduced the essential levels for social services. However, its implementation has been vaguely defined and not supported by

guaranteed resources (Leon & Pavolini, 2014). Social services are provided by municipalities and strongly affected by discretion and budgetary constraints. Another characteristic is a strong territorial differentiation, with a higher care coverage of social and educational services in the Center-North of Italy than in the South.

The citizenship income scheme has replaced the previous income support scheme, keeping an active inclusion approach subject to specific conditions. Social policies remain poorly integrated. Measures to promote equal opportunities and a work-life balance are fragmented and limited in scope, negatively affecting women's participation in the labour market (European Commission, 2020).

The Crisis Management Stages in Italy

This section reviews the government's response to the pandemic, distinguishing actions taken in two different stages of the crisis management cycle: disaster mitigation (risk assessment, prevention, preparedness) and disaster response (relief, rehabilitation, reconstruction).

Disaster Mitigation Stage

The mitigation stage includes plans designed to save lives, minimise damage and provide the best response possible if an emergency occurs. The aim is to assess risks and vulnerabilities and build the necessary capabilities needed to tackle the emergency.

Italy is frequently exposed to natural risks, especially earthquakes and flooding. The dramatic delay of rescue and relief operations and the lack of coordination experienced during the Irpinia earthquake in 1980, highlighted the urgency to establish a structure to deal with civil protection on a permanent basis. The Civil Protection Department (Italian Civil Protection, 2020a) (Law 225/1992) promotes activities of risk forecasting and coordinates the interventions in case of national emergencies. The National Service, governed by the Civil Protection Code since 2018, is constituted by all levels of government: the State, the Regions, the Autonomous Provinces of Trento and Bolzano and the Local Authorities.

In 2006, following the WHO's recommendations issued in the light of changes to the world epidemic situation, a new plan (Ministry of Health, 2020a) updated the previous Italian Multiphase Plan for Pandemic Influenza, published in 2002. In 2009 the A(H1N1) influenza was faced with an integrated response mainly based on this plan. The A(H1N1) pandemic did not have consequences on the structural functioning of the Italian society (Di Camillo et al., 2014). Moreover, the weakness of the contagion, combined with the apparent enormity of international mobilisation might have led to an outcome bias. Governments and international institutions were accused of exaggerating the danger, and the WHO

of colluding with drug companies. In Italy, the government was blamed for signing contracts for millions of doses of vaccines that remained unused (Alfani & Melegaro, 2010).

On 30 January 2020, the first people identified as COVID-19 cases in Italy were two Chinese tourists in Rome. Also in view of the declaration of 'International Public Health Emergency' by the WHO, the Italian Council of Ministers on 31 January 2020 declared the state of emergency (Italian Civil protection, 2020b) for a period of six months, and decided to allocate the necessary funds for precautionary measures to adopt. Recommendations for travellers and citizens to reduce exposure and transmission were issued by the Ministry of Health together with a 24/7 toll-free number available to citizens for information about the infection. The Civil Protection started collaborating with the government and the Ministry of Health to prepare operational measures to reduce the risk of coronavirus transmission. The measures were mainly related to air and sea traffic, such as the increase in health checks in ports, and the use of thermal scanners in airports. The direct flights from China were stopped. On 12 February 2020, a confidential report, made by the Scientific Committee, based on the available data, analysed possible scenarios related to the spread of the virus. At that time information was unclear about the possible spread of the virus and the best response to tackle a possible pandemic.

The 'Outbreak' in Italy

The first cases of Italian residents were detected in a hospital near Milan and in a small town in Veneto on 21 February. It took two weeks to reach 3,916 detected cases, among which 2,612 were in Lombardy, 870 in Emilia Romagna and 488 in Veneto.

On 11 March, the WHO declared the COVID-19 pandemic. At that time, there were 118,000 reported cases spanning 114 countries around the world, with over 4,000 fatalities. On the same date, the total number of cases in Italy was already 12,462, with 827 deaths (Ministry of Health, 2020b).

Disaster Response Stage

The response stage includes the activities implemented when an emergency occurs, with the aim to save lives, reduce the suffering, assess the emergent needs, limit the spread of the consequences and open the way to rehabilitation. The quality of the response is influenced by the level of preparedness and surge capacity that territories have available or can quickly implement. It is not known if Italy had an accurate risk and vulnerability assessment related to this specific biological hazard (the document of the ISS is not public). It is very likely that the spread of the virus started many weeks before (Cereda, 2020), so when the first

case was detected it was already late to contain the virus in its infancy. However, what has been immediately evident was that the availability of resources was not adequate to face the health crisis.

The First Government Response: A Gradual Lockdown

The first government response (Italian Civic Protection, 2020) focused mainly on the sanitary crisis, given the available resources. On 23 February, in order to contain the spread of the virus, 11 Municipalities of Lombardy and 1 in Veneto were identified as 'red zones' by the first Decree Law. The government established a series of strict containment measures for these territories: prohibition of leaving, suspension of all events, educational services and schools of all levels, museums and public offices, commercial and work/business activities with the exception of those that provide essential services.

It took one week to realise that the 'outbreak' was spread in several areas, mainly in three northern regions: Lombardy, Emilia Romagna and Veneto. All universities were closed and on 8 March, a second Decree created two levels of 'protection zones'. More strict measures applied to the residents of the Region of Lombardy and other 14 Provinces in the northern regions. For unknown reasons, the news about the extended lockdown was spread by the media the night before the official announcement. This caused panic and many people, working or studying in the North, decided to leave to reach their families in the Southern regions. The high number of people that moved to the South and the awareness of a weaker health system in these regions may have influenced the decision to extend the lockdown to the overall country, through a series of subsequent decrees. On 9 March, a new decree established the creation of one single 'protection zone' for the entire national territory. On 11 March, all non-essential businesses were closed. On 17 March, a shared protocol was signed, providing that production activities may continue only if adequate levels of protection were guaranteed to the workers. The agreement indicates the adoption of 'smart working' (working remotely), as much as possible. On 22 March, a new decree established the interruption of all industrial or commercial production activities, except those listed in an attached list. The government also banned the movement or relocation of persons to a municipality other than the one in which they were located, except for justified work needs, extreme urgency or for health reasons.

The Response of the Health System(s)

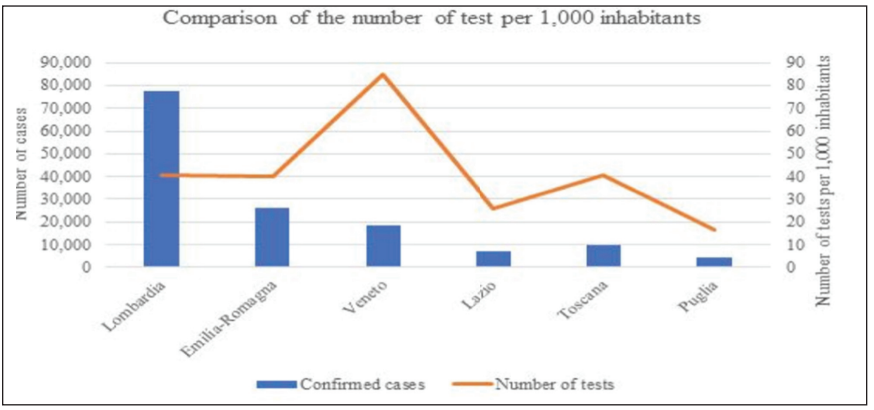
Starting in March, hospitals in the North of Italy reported system saturation, due to very high patient loads requiring intensive care. One of the most afflicted areas was in the city of Bergamo. The shortage of hospital beds, ventilators and health professionals became a concrete threat (Nacoti et al., 2020). Health professionals from different disciplines were converted to COVID-19 patient care. An issue all over the country was that tests were not available for the majority of the health workers and sometimes not even adequate personal protection equipment. By 22

March, a total number of 4,824 healthcare workers had been infected (9% of total cases), and 24 doctors were dead. By 4 May, 154 medical doctors died from a COVID-19 infection.

The spread of the virus varied across areas, with the vast majority of cases concentrated in some of the richest and most industrialised regions of the North, those with the most advanced health systems. Within the broader national guidelines, each region developed its own response plan, with different strategies. The differences between spread trends, response approaches and outcomes suggest that the impact of the COVID-19 is better explained at a regional level. Binkin et al. (2020) compared different strategies adopted in Lombardy and Veneto, the two regions where the outbreak has started. As of 1 April 2020, Lombardy experienced 44,733 cases and 7,539 deaths. In Veneto, the corresponding values were 9,625 and 499. The cumulative case rate was 445/100,000 for Lombardy and 196/100,000 for Veneto, a 2.3-fold difference (Binkin et al., 2020). Mortality rates were 7.5 times higher in Lombardy than in Veneto (75/100,000 and 10/100,000, respectively). Indicators for these two regions are very similar for all 11 OECD-indicators of well-being. Both are heavily involved in international commerce and are tourist destinations. One of the reasons that justifies these differences may be related to the fact that the epidemic in Lombardy started much earlier than 20 February, when the first case was detected (Cereda et al., 2020). Another difference between the two territories is related to the density of the population, higher in Lombardy (420/km square), compared to Veneto (270/km square). Binkin et al. (2020) highlighted how the outcome might have been influenced by the different response strategies also. A community-based approach in Veneto, with extensive contact tracing and more rapid testing appears to be associated with substantially reduced rates of cases, hospitalizations, deaths, and infection compared with the hospital-centred approach in Lombardy (Binkin et al., 2020). In Veneto, at the request of the microbiologist Andrea Crisanti of the University of Padua, the regional government took action to strengthen its ability to trace the contagion, by starting to independently produce the chemical reagents needed to process thousands of swabs. Moreover, the region adopted a bio-surveillance system that allows the integration of data from different sources. It provides information to general practitioners and allows the regional crisis units to monitor the epidemic and identify cluster that require an activation of outreach services. There are 8 public health prevention departments in Lombardy (1 per 1.2 million), compared with 9 in Veneto (1 per 0.5 million). Cumulative rates of testing were nearly twice as high in Veneto, and they were 2.7 times higher in the first week of the epidemic (Binkin et al., 2020). In Lombardy, 51.5 per cent of the patients were admitted, including 5.2 per cent to intensive care units. In Veneto, the corresponding figures were 25.1 per cent and 4.3 per cent, respectively.

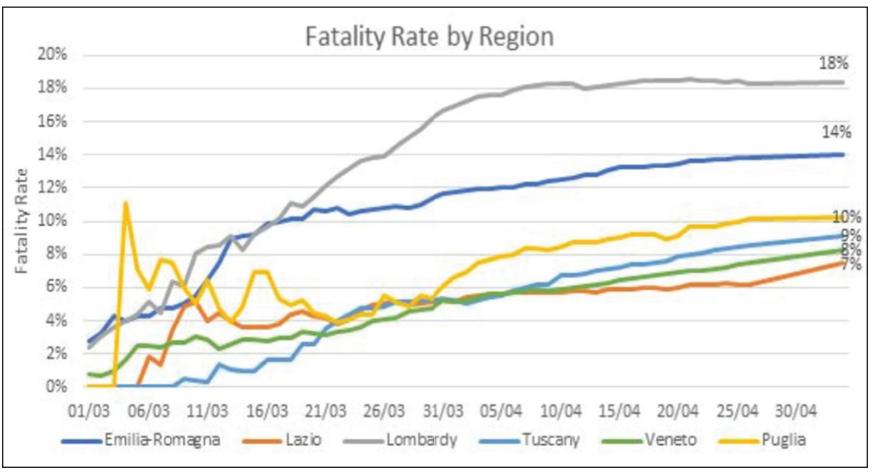
Figures 1 and 2 (Antonini et al., 2020) compare the number of tests and the fatality rates in the most affected regions.

Figure 1.



Source: Antonini et al. (2020) [Colour online].

Figure 2.



Source: Antonini et al. (2020).

A Second Set of Measures to Tackle the Health and the Economic Crisis

The national and regional governments started turning their attention to the costs of the outbreak and looking for a compromise between the necessary sanitary rules and the urgency of a broader set of policy interventions, that could help mitigate such costs. On 17 March, a new Decree Law, *Il Decreto Cura Italia*, has introduced measures to strengthen the health system and economic supports for families, workers and businesses affected by the emergency.

Measures to Strengthen the Health System

Starting from March, the civil medical volunteers and other health care workers started to operate in the most affected regions. New hospitals were built and many

had been converted into COVID-19 hospitals, with the help of NGOs and thousands of volunteers. At the beginning of April, the emergency response commissioner announced (Invitalia, 2020) that the intensive care beds almost doubled, and those in departments for infection and respiratory diseases were four times more and €13 million were invested to start new production of personal protective equipment. The national government approved the introduction of USCA (Special Continuity Assistance Units), to offer more specialised treatment for patients with no severe symptoms at home as soon as possible. The Ministry of Health has announced that measures to enhance the capacity of testing and tracing, as well as to potentiate the health services at the territorial level, will be included in the next decree, that will be issued in the second half of May. The Ministry also announced the recruitment of 'community' nurses and social workers to provide integrated care on the territory.

Measures to Support Families at Risk of Poverty, Workers and Enterprises

A set of measures had the aim to support in particular micro, small and medium-sized enterprises through the banking system, for access to credit and support for liquidity (OECD Trento, 2020). Difficulties have been experienced in having access to this money, mainly due to the length of bank and public administration's procedures. Suspension of payment obligations for taxes and fees and other fiscal obligations, incentives for workplace sanitation and rewards for employees that remain in service have been issued (OECD Trento, 2020).

The National Institute of Social Security (INPS) had approved Ordinary Wage Guarantee Fund (Cassa Integrazione) for 7,139,048 workers (INPS, 2020). Another 70,000 applications were issued for an Extraordinary Wage Guarantee (Cassa Integrazione in Deroga) for those who were excluded by the ordinary one. These workers experienced more problems, since the applications have been approved by INPS, but still need to be processed by the regions. A one-off €600 bonus was issued to self-employed and professional workers. Absence from quarantine has been considered as sick leave, with the costs paid by the state. A set of measures for the workers' safety on the workplaces have been negotiated with the unions at the national and the regional levels.

Parents of children younger than 12 were allowed to take a leave for up to 15 days while receiving 50 per cent of the salary paid by the state. A package of €25 billion included funds to private-sector workers to pay for babysitters via a childcare voucher of up to €600 for workers with children below the age of 12, who decided not to take parental leave (Gentilini et al., 2020). The voucher could reach up to €1,000 for workers in the health sector.

On 29 March, the National Civil Protection transferred €400 million to all the municipalities to purchase food vouchers and/or basic food necessities based on population and income criteria. Local governments were free to decide how to purchase products and how to select beneficiaries. Some issued the money directly to the residents, some other involved social workers with the aim to assess the applicants' needs or their disposable income, with high variability among territories. No implementation of resources has been announced for the social work sector in the municipalities.

The 'March decree' suspended all conditionalities related to the Guaranteed Minimum Income programme for two months. The Ministry of Economy announced the introduction of an Emergency Guaranteed Minimum Income for all the workers that will be excluded from the ordinary measures.

A toll-free number for psychological support has been available since the end of April. It is addressed to people, including deaf people, suffering from anxiety, fears, stress due to mourning, economic difficulties, loneliness and the sudden change of daily habits related to the COVID-19.

The Minister of Education and the Minister of University and Research approved a new decree, with measures to guarantee the regular conclusion of the current school year. The teaching staff had to ensure the continuity of the lessons through remote teaching, using computers or technological tools.

The Impact of the COVID-19 Crisis

The Impact on the Population Health

On 30 April, out of 2 million tests, the total number of detected cases was 205,463, mostly concentrated in the Northern Regions. Among those,1,694 were in intensive care, 18,149 hospitalised with symptoms, 81,708 in self-isolation at home, 75,945 healed and 27,967 dead (Ministry of Health, 2020c). The National Institute of Health (ISS) provided an analysis of the characteristics of patients who died in Italy. Mean age of patients was 79 years, and among them 38.0 per cent were women. Most common comorbidities observed were hypertension and cardiovascular diseases. The ISS analysed a subsample of 8,200 out of 88,517 cases to understand where the virus was more likely to be transmitted. Half of the cases (48.6%) were living in an old age home or in other residential services for people with disabilities. About 22 per cent of people became infected at home, 9.9 per cent in a hospital or in a medical office and 3.7 per cent at work (excluding health services workers) (National Institute of Health, 2020b).

Since the real number of total infections and deaths depends on the actual possibility of testing, the National Institute of Statistic analysed the number of deaths, compared to the previous years. The most affected provinces by the epidemic recorded a three-digit percentage increase in deaths in March 2020, compared to 2015–2019 average (ISTAT, 2020e).

Many people died alone, because visitors were banned from coronavirus wards to help stop the disease from spreading. In Bergamo, the most affected city in Italy, the military had been transporting coffins to other cities to be cremated, because the local funeral services were overwhelmed.

The Impact on the Economy and Employment

ISTAT (2020c) reports that in the first quarter of 2020, in Italy the seasonally and calendar adjusted, chained volume measure of GDP, decreased by 4.7 per cent with

respect to the previous quarter, and by 4.8 per cent over the same quarter of the previous year. The lockdown in Italy and in the main trading partners affected Italian trade negatively, with the exception of sanitary products imports. In March, retail trade of non-food items dropped, while e-commerce increased sharply. In March 2020, exports to non-EU27 countries decreased by 12.7 per cent, and imports decreased by 19.8 per cent compared with the same month of the previous year (ISTAT, 2020b). In Italy, the vast majority of companies are small and medium enterprises, that may have less resilience and flexibility in dealing with the costs these crisis shocks entail. In addition, given the fewer resources of SMEs and existing obstacles in accessing capital, the period over which SMEs can survive the shock, may be more limited than for larger firms (OECD Trento, 2020).

Following the decree-law of 22 March, closing all non-core or strategic production activities, an estimated 7.8 million workers became temporarily unemployed (on layoff). About 60 per cent would be affected in manufacturing and 26.7 per cent in services (OECD Trento, 2020). ISTAT (2020a) reports that in March 2020, in comparison with the previous month, employment slightly decreased and unemployment sharply fell, together with a relevant increase of inactivity. In March, the considerable growth of inactive people aged between 15 and 64 years (+ 2.3%, +301 thousand), led the inactivity rate to 35.7 per cent (+ 0.8 percentage points). With respect to the previous quarter, in the period January–March 2020 employment decreased (–0.4%, 94 thousand) for both men and women. The more vulnerable workers, at least in the short-run, are more likely to be self-employed, engaged in the informal sector or people with precarious labour contracts.

The Impact on Vulnerable Populations

Older persons are at a significantly higher risk of mortality and severe diseases following COVID-19 infection, with those over 80 years old dying at five times the average rate. As in other countries, the most affected people were those in long-stay residential care homes (LSRCHs). A survey on COVID-19 infection in LSRCHs (National Institute of Health, 2020a) reports that, in the two most affected regions of Lombardy and Emilia Romagna, 50 per cent of people who died in LSRCHs were found positive to COVID or with symptoms. The measure taken to contain the spread of the virus had consequences on access to health and care services. Social centres and semi-residential facilities were closed during the lockdown, with a lack of home care alternative services and large differences between municipalities.

Children are being affected, in particular by the socio-economic impacts and, in some cases, by mitigation measures that may inadvertently do more harm than good. The school closure was the first measure taken by the Italian government, starting from 5 March. It is difficult to estimate now the potential losses that may accrue in learning for today's young generation, and for the development of their human capital. What is known is that harmful effects of the crisis are not distributed equally. ISTAT (2020d) reports that 12.3 per cent of the children aged between 6

and 17 years, do not have a computer or a tablet. Teachers in more poor areas in the South reported to be able to stay connected with 60 per cent of the children only (Ferrario, 2020). Economic hardship experienced by the families, as a result of the economic downturn, is affecting a higher number of children in a country in which even before the crisis, 1.2 million of minors (ISTAT, 2019b) were already living in poverty. Lockdown measures come with heightened risk of children witnessing or suffering violence and abuse. The absence of a national data collection system on child abuse in Italy will make it difficult to estimate the impact of this crisis. Children in conflict settings, as well as those living in unsanitary and crowded conditions such as refugees, are also at considerable risk. ISTAT (2020d) reports that 41.9 per cent of the minors live in overcrowded houses. A total number of 6,054 unaccompanied minors are living mainly in first and second level facilities, some of them providing basic services only.

Gender inequalities were evident also before the crisis. Women perform the vast majority of unpaid care work (ILO, 2018), they are paid less than their male counterparts and less likely to be in a management position. If the measures introduced to tackle the crisis are gender-neutral, they may produce other indirect negative effects on women. The first evidence in Italy was that in May, when some sectors reopened, 72 per cent of the people back to work were men (Casarico & Lattanzio, 2020). Considering that the schools are still closed, this is having a large impact on working mothers. Decision-making bodies established specifically for COVID-19 do not reflect a gender balance between women and men. For example, 100 per cent of the original Scientific Committee to tackle the crisis were male (Openpolis, 2020). Only after some women have been included, also in response to associations advocating for their right to participate. In addition, there is a high risk that all forms of gender-based violence will increase. In March 2020, a network of centres (Violenza-Covid19, 2020) that help women victims of violence, recorded an increase of phone calls from women already known, and a worrying decrease of new reports.

Lessons (Hopefully) Learned and Possible Future Directions

Converging Crises

At the beginning of the COVID-19 pandemic, Italy was a country still recovering from the 2008 financial crisis. The adoption of harsh austerity policies has led to substantial cut in public expenditure (Pavolinia et al., 2015). A longer time frame and research efforts are needed to assess the links between welfare retrenchment and its consequences on all public infrastructure, critical to counter the impact of the COVID-19 crisis, for example: the NHS, the educational system and the social service sector. At the state level, low productivity growth, high public debt, strong social inequalities among groups and territories, and poorly integrated social policies were issues still not addressed (European Commission, 2020). Moreover,

both locally and globally, environmental issues, ranging from pollution to anthropogenic climate change, may have played a role in the actual crisis (Wu et al., 2020). Some aspects of the COVID-19 crisis have been attributed to *sfortuna* (bad luck), such as its timing and a lack of scientific knowledge about the virus. In any disaster many variables are not under the full control of policymakers. Nevertheless, decades of studies on disaster management help to develop a more complex analysis, highlighting the importance of actions for prevention and preparedness. The analysis of the 'Italian case' highlights several areas of rapid response to the crisis, but few actions in the mitigation stage, both at the national and at the global level (Djalante et al., 2020). The WHO's Health EDRM model and the Sendai framework stress the importance of a cultural shift in disaster management, that should be risk-based, proactive instead of reactive, inclusive and community-centred.

Towards a Proactive and Community-centred Model of Health Care

Expenditure for public hygiene services underwent the most significant budget cuts (Signorelli et al., 2016). The primary care sector has been only modestly addressed by reforms and policy initiatives (Ferrè et al., 2014). However, these sectors turned out to be essential in the response stage. In particular, in the territories where a community-centred approach to health care was more developed, health services seemed to have performed better in responding to the pandemic (Nacoti et al., 2020). In Veneto, the regional governments have invested in integrated health care at the territorial level and several prehospital facilities (Antonini et al., 2020). Its response to the pandemic has been based on more extensive testing of symptomatic and asymptomatic cases, proactive tracing of potential positives and a stronger emphasis on home diagnosis and care. The set of policies enacted in Veneto are thought to have considerably reduced the burden on hospitals and minimised the risk of COVID-19 spreading in medical facilities, a problem that has impacted hospitals in Lombardy, where a more hospital-centred approach was adopted (Nacoti et al., 2020).

To date it seems clear that early case-finding, testing, tracing and care are essential to stop transmission. Physical distancing restrictions are just one of many other measures needed. The availability of human and material resources is the base to avoid decision-making based on priorities dictated by budget restrictions. Epidemiological capabilities are fundamental to systematically record anomalous infection peaks and to prevent the uncontrolled spread of the disease. It requires adequate ICT and multi-professional staff able to follow and support people in the community.

The introduction of the Special Continuity Assistance Units helped to offer more specialised treatment for patients at home, preventing their arrival at hospitals in unrecoverable conditions. The integration of these units with community nurses and social workers (Sanita Informazione, 2020) can help to build confident and connected communities as part of efforts to improve health and reduce inequalities.

Toward a Sustainable, Inclusive and Community-centred Approach to Reconstruction

Experts from various disciplines in the task forces are helping governments to design responses at the national and regional level, interviewing representatives from the civil society. One of the critiques (Carlini, 2020) that is emerging, is the capacity to actually involve communities in the design of the plans for the next stages, with the risk that groups with less power will be unheard and left behind.

On the one hand, the consequences of the crisis do not have the same costs for everybody. Children and young people still do not know when they can restart going to school and see their peers. Thousands of children have been excluded from education opportunities, also due to the digital divide. Older people and people with disabilities still do not know when services will re-open and isolation for them will end. Physical distancing and its consequences on ordinary life may risk deepening social inequalities. Taking a train or a flight, going to a restaurant, a theatre or visiting other places, and doing it in a safe way, is likely to become a question of who can afford it. Companies are already raising the prices for those who want to travel with the 'privilege' of being at a safe distance. A private railway company, that many people use for commuting to work, has already cut 50 per cent of its trains. Again, budget, more than safety, is a priority. Many of these are middle class worries in one of the most privileged countries, worries of people who could afford to go to restaurants and bars, to work and pay the time of other people who were planting crops and taking care of cleaning their houses, offices and hotels.

On the other hand, the crisis has created the opportunity to make structural problems more visible. It has become evident that many workers who are providing essential services are underpaid 'working-poor' and, in some cases, they are irregular and exploited migrants. Posts on social networks, highlighting how much we were paying football players compared to farmers, went viral. There seems to be the opportunity to re-orient the market's offer towards needs and productions that are more sustainable. The safety and the rights of the workers who structurally contribute to our common wealth has become a matter of major interest. In the public debate, poverty seems to be perceived more as an issue that can involve many people, rather than a problem of a few undeserving poor. The concern about the hypothesis of an association between the areas more affected by the pandemic and the level of air pollution is raising more awareness about the need of action to tackle environmental issues.

There are several experiments on the territory that are going in the direction of a more inclusive approach. In Bologna and other cities entrepreneurs, unions and workers are discussing and negotiating locally what to do for a safe restart, in relation to the characteristics of their specific territories. The municipality of Milan is using a platform to collect ideas about different topics (reorganisation of public spaces and public transport, schemes reallocating street space to cycling and walking, etc.). Some schools and universities are including students in deciding how to reorganise the internal and external spaces. Many associations and movements are gaining more voice in the effort to raise awareness about the

rights of more vulnerable people. For example, *Forum Disuguaglianze e Diversità* (Forum Inequalities and Diversity) started three years ago an action to put together civil society organisations, trade unions and researchers from different disciplines to work on shared interpretation and solutions to fight inequalities. The forum is now contributing through this coalition in designing proposals of public policies and collective actions.

What is still missing is the capacity at the government level, both national and local, to be able to include and systematise these proposals and innovations, building new possibilities for social development.

The Need to Translate Theory into Practice through a Community Social Development Approach

The year 2020 should have marked the beginning of a decade of actions towards the Sustainable Development Goals (SDGs). With the ongoing crisis, the global context for development has fundamentally changed. The world is facing one of the greatest socio-economic crisis, coming at a time of acute inequality, ecological fragility and growing distrust within and amongst societies (UNDP, 2020).

The analysis carried out in this paper highlights the importance of accelerating the application of global policy frameworks, already indicated in the 2030 Agenda (Djalante et al., 2020). They can help to guide an integrated action to build strong institutions, create jobs, ensure education and healthcare for all. However, these principles need to be translated into practice, within a cultural frame that actually allows them to guide action.

Several authors (Ozerdem, 2003) argue that disasters and their impact are the result of unresolved development challenges, but they can also provide new opportunities. The analysis in this paper had highlighted how the crisis has led to a growing awareness of links between disaster and social development. A community social development approach can help to see possible paths toward a cultural shift. The aim is to overcome a residual model of intervention in crisis management, recognising that social and institutional change need to accompany economic development. Community development considers community members to be experts in their lives, and values their capacity to implement actions before and during a crisis. The knowledge gained through community involvement is needed in the design of public policies and collective actions to reduce social inequalities.

This crisis has highlighted the importance of the state and public services to protect and care for citizens. The professionals in the public administration have the opportunity to play a new role, helping to minimise the negative and optimise the positive aspects of the crisis in the direction of social development, involving communities in practice. In particular, social workers and other professionals in the social services can work on community engagement and development at different levels. First, they can involve people to analyse social vulnerabilities and emerging needs. Second, by empowering social networks, they help to avoid that

physical distancing will transform into social distancing and isolation. Third, they can promote actions for the political empowerment of more marginalised people, advocating for rights of vulnerable groups and raising awareness about structural causes of inequalities. Participatory action-research has been used by social workers to connect people, groups and organisations, in the effort to think and design shared solutions for common problems, valuing capacities and training new skills. As for the health sector, also this kind of intervention requires adequate investment and specialised competencies. In Italy social services, especially in more recent times, as well as during the first stage of the Covid crisis, have been mainly focused on providing services and interventions. While healing and service provisions are essential in the context of disasters, such activities do not necessarily address social change (Pyles, 2007). Though providing services is essential, an exclusive focus on this, risks leading social workers to perpetuate injustice by ignoring the larger social development issues (Pyles, 2007). Social workers have the opportunity to play a new role, overcoming a market oriented approach to services, and focus on post-crisis organisation and community social development. The announcement of the Ministry of Health to hire 'community' nurses and social workers to focus on integrated care in the community is an important step in this direction. More efforts should be made to strengthen social work education in order to train policy advocacy skills and specialised competencies in community development and macro-practice.

I hope that this contribution has shown how the COVID-19 crisis could be 'used' to make 2020 a year that marks a new direction towards action for translating into practice the principles of social change and social justice.

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