The Crisis of Universalist Health Services
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There are signs of a crisis in public health services in several European countries. These signs are particularly evident in Italy where the value of the National Health Fund, based on general taxation, is significantly lower than the percentage of GDP invested in most European health systems that are based on the principles of solidarity and distributive justice. Exacerbating the situation is the fact that Italy has the highest prevalence of elderly people in Europe (24 percent of the population is over 65 years old), resulting in increased costs, related to the health needs of the elderly. The distressed situation of the public health service is associated with private spending accounting for 25 percent of the total. It amounts to 41 billion a year for health care (to which 25 billion a year should be added for long-term care of the elderly): this sum should be compared to 136 billion for public health care. Such a ratio of public to private spending can pose a threat to the principle of universalism, equality and equity that are the founding pillars of the National Health Services (NHS). Exacerbating the situation is highly uneven private health care spending among Italian regions (for example, 800 euros per person in northern regions such as Lombardy and Emilia-Romagna versus 300 euros per person in southern regions such as Calabria).

The gap between available resources in the NHS and the growing needs, due to the increasing incidence of elderly people and chronic patients, results in the extension of waiting lists and a certain degree of avoidance of response to health problems especially of the less affluent. There is an increasing number of citizens who give up care due to excessively long waits and the inability to cope with their problems in the private market due to limited funds. The results of the OECD's Patient Reported Indicator Survey (PaRIS) on the performance of health care systems from the perspective of patients underscore a below-average quality of health care perceived by Italian patients, even in comparison with countries with per capita spending similar to Italy. For example, patients with chronic diseases complain of shortcomings in their relationship with their general practitioner, both with respect to the continuity of that relationship over time and the generally very short duration of GP consultations. The increase in waiting lists is not unique to Italy but common to several post COVID-19 European countries. In England, more than three million patients wait between four and 12 months for hospitalization. Patients on waiting lists have a median time of twelve weeks.

Inappropriateness of health care services contributes significantly to generating long waiting lists, with significant and unjustified variability in health care use by inhabitants with similar diseases; this has a major impact on public budgets, with an estimated 20 to 40 percent of services provided in high-income countries having low or no health value. The causes of inappropriateness are diverse and include cognitive biases, lack of clear diagnostic-therapeutic pathways especially in cases of multi-morbidity, sociocultural factors, expectations, market pressures, and defensive medicine. A systemic approach is needed to address demand-side governance, fostering public awareness and involvement, development of a scientific and health culture, control of market dynamics, improvement of the relationship between health services and citizens (as well as between professionals in different fields), limiting the effects of defensive medicine, and systematization of programs for Guidelines and “Health Technology Assessment.”

It is often said that there is a shortage of doctors in Italy, but this statement is not true. Italy's medical density (4 doctors per 1,000 inhabitants) is higher than that of the United Kingdom (3 doctors per 1,000 inhabitants) or France (3.3 doctors per 1,000 inhabitants). The number of

new graduates in our country is also higher than the European average; increasing their share without careful planning risks creating in a few years a population of physicians with significant employment issues. Nevertheless, there are large gaps in specialist training, particularly in disciplines such as emergency and emergency medicine, community medicine and primary care, microbiology and virology, pathological anatomy, radiation therapy, general surgery and others. The problem is not the shortage of physicians in general, but the shortage of specialists in some disciplines, which can be attributed to the lack of attractiveness of these specialties. In contrast, disciplines that offer opportunities in the private sector, such as dermatology, ophthalmology, pediatrics and cardiology, show no signs of crisis; in essence, there are distortions in the allocation of personnel resources due to the incentives of the private health care market. Indeed, there is a hemorrhage of health workers from the public to the private sector. This is attributable to a lack of attractiveness of the health professions in the public sector, not only because of relatively low salaries, but also because of management, organizational and administrative aspects. The shortage is particularly important for the nursing sector, and this is a chronic problem in our country, albeit one that has been markedly exacerbated over the past few years (partly as a result of the pension curve and early discharge), and for which comprehensive strategies must be activated both to boost the attractiveness of the profession and to retain nurses in service.

Health research is an integral part of a complex system such as the NHS. To strengthen the role of research in the NHS, we need to act on several fronts. It is necessary to simplify bureaucracy, making the approval procedures for clinical trials and funding faster. Increase investment to ensure consistent and accessible and therefore sustainable resources, as well as improve data interoperability by developing secure and efficient digital infrastructures. We also cannot neglect the training and enhancement of health personnel, so that they are always up-to-date on new technologies and research methodologies, nor ignore the need to reduce territorial inequalities by strengthening research even in areas with fewer resources. Finally, it is crucial to promote a culture of innovation, raising awareness among all stakeholders in the system of the importance of research for the continuous improvement of the health system. Addressing these challenges with targeted policies and adequate investment is the key to a modern, efficient and evidence-based NHS. Only through an ongoing commitment to research can we ensure better care, equitable access to innovation, and greater resilience of our health system in the face of future challenges.

Biotechnological advancement now offers treatment opportunities for diseases, including rare diseases, that only a few years ago appeared without concrete possibility of effective treatment. But the most innovative drugs and treatments have costs that run a real risk of being unsustainable for an NHS like ours. We need, therefore, investment in academic research, perhaps even through coordinated actions at the European level, to ensure better sustainability, and we need new models for setting reimbursements that are based not only on reasonable profit margins but also on real benefits for patients, development, validation and production costs.

Prevention in our country has so far been neglected. This is also evidenced by data from the Ministry of Health's New Guarantee System, which measures the level of attainment of the LEAs (Essential Levels of Carer) in the regions: although the overall (national) indicator reaches the sufficiency value in 2023 (but decreasing from 2022), there are still significant distances between regions with values ranging from 40 to 98 on a scale of 100. Less and less is being spent on prevention interventions, and most indicators on individual (e.g., smoking habit, alcohol, physical activity, obesity etc.) and environmental (e.g., air pollution) risk factors

show stability in recent years or even worsening. There is an urgent need for legislative interventions that increase taxation on some products (tobacco, sugar) and restore the environment, and a major communication effort for health education that can start from compulsory schooling. Prevention is a cultural revolution that has the great merit of opposing the medical market, which, like all markets, can only want to grow. Increasing the culture of prevention requires a coordinated effort, which could be facilitated by the creation of a Higher School of Public Health to train leaders in the NHS.

Conclusions

Medical sciences serve society, and the mutualization of tax contribution according to income has been a pillar of our coexistence in order to have high quality public health care in much of Italy, excellent university training and adequate, though certainly not enough capillary distribution in the different areas of the nation. Now public spending is no longer sufficient to meet the needs for health care personnel and adequate healthcare facilities to cover the needs of the population.

We are moving toward the weakening of the NHS, that was an extraordinary achievement of the welfare state: the distance between resources in the field and needs is growing, the heterogeneity of treatment among homogeneous patients is clearly detectable, private health care is gaining market share, and it is surprising how we are becoming accustomed to resorting to private health care in order to be able to have specialist visits or interventions in time compatible with health needs. District health services are lacking, and territorial reform related to PNRR (Recovery Funds) mission 6 is being implemented with gaps, inconsistencies and delays. The function of primary care medicine and the relationship of general practitioners with the National Health Service is unresolved.

The situation is becoming increasingly pervasive, fueling the inequality between rich and poor. These dynamics are not unique to Italy. Several European countries, including the British NHS, face similar problems. A European-level dialogue can be a source of inspiration for identifying solutions

Remediating this situation can be done; there are moral reasons for doing so, and it is primarily a cultural problem: to be taken care of when you get sick is the essence of a just society and the very foundation of being free. Taking charge of citizens' health implies an enormous responsibility, which cannot be delegated to private organizations built around numbers and profits. It must be a true “service,” inspired by the right of all to adequate care and the desire to relieve the pain of others, with attention to detail and the quality of services provided.

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