18 ITALY'S RESPONSE TO COVID-19

Michelle Falkenbach and Manuela Caiani

With close to 250,000 confirmed cases and more than 35,000 deaths, as of this writing (World Health Organization [WHO], 2020b), Italy was the first country on the European continent crippled by the coronavirus. Although a state of emergency was declared at the end of January 2020, just few days after the first case was discovered, country leaders as well as medical professionals underestimated the outbreak. Authoritarian public health measures were not promptly implemented; instead regions were initially left to deal with the virus as they saw fit, thereby creating a fragmented approach to containment. Luca Zaia, governor of the Veneto region, stated at the beginning of March 2020 that he remained convinced that a standardized approach "from north to south" should be sought after, "given that the virus knows no boundaries" ("Coronavirus, le Regioni Contro il Governo" ["Coronavirus, the Regions against the Government"], 2020). There was no immediate country lockdown; this came about two weeks after the third confirmed death (Hirsch, 2020). Alternatively, the country took a gradual approach quarantining hard-hit municipalities first, then locking down certain northern regions and culminating in a complete country lockdown by March 9, 2020. Precious time was wasted with miscommunication and a general miscalculation of the severity of the disease, ultimately resulting in a strict and lengthy countrywide lockdown that led to drastic socioeconomic effects.

Although the citizens' trust in Prime Minister Conte was high, there was noticeable disagreement among the parties, resulting in the politicization of the pandemic (Capano, 2020). Populist radical right (PRR) parties such as the Brothers of Italy led by Giorgia Meloni or Matteo Salvini's Lega party regularly criticized the government for its weak leadership and the European Union (EU) for its lack of solidarity. Naturally, this decreased the level of trust in the Italian government for some citizens, often making it difficult to understand the drastic measures that were eventually set. The other pole of citizens showed much solidarity with governmental messaging, launching the initiative *"andrà tutto bene"* [everything will be fine], where banners could be seen from the windows of almost every Italian household from the north to the south. In addition, the musical "flash mobs" on balconies garnered much attention as did the commitment of many popular TV show people and singers in the organization of "educational" entertainment for Italian citizens at home.

In sum, the country's unpreparedness and inexperience coupled with a weak administrative and political capacity cost the country much time and allowed the virus to spread, practically unhindered. Not until Conte's "stay at home" decree was implemented on March 10, 2020, did the government begin to move in a quicker and more efficient way. This democratic regime had a difficult time with communication, coordination, and implementation strategies as some political parties opted to use the pandemic for political gains, leading to the government's decision to take more forceful action (high fines for violations of the strict curfew and drone surveillance to keep people inside and safe) against noncompliant citizens.

This chapter begins by laying out the public health and health systems measures that the country adopted to protect the public and contain the virus. After which, the social policy measures implemented to counterbalance the hard-hit country are discussed, followed by potential explanations as to why Italy was so hard hit. The chapter closes with analysis regarding what was learned from the Italian case and where further research may be necessary in gaining a more holistic understanding of the Italian government's response to the pandemic and its consequences.

Health Policy Measures: Public Health, Health Systems, and Borders

The Italian government played a big role in the implementation of public health and containment measures throughout the coronavirus outbreak. The lockdown of the entire country helped stop the spread of the virus into the far less financially and medically equipped southern Italy, but the initial nonuniform approach adopted allowed some municipalities in the north, such as Brescia, Bergamo, and Piacenza, to opt out of more restrictive lockdown measures, resulting in staggering death rates and legal hassles.

Italian Healthcare System

In 1978 the Italian National Health Service (*Servizio Sanitario Nazionale,* or *SSN*) was created and subsequently ranked as being one of the best in the world (WHO, 2000). The SSN is organized on a regional level and controlled by all three levels of government: national, regional, and local. Article 32 of the Italian constitution ensures that all residents, in any region, have access to services either completely free of cost, even for surgeries, or at a cost that is much lower than the market price (Presidenza della Repubblica, n.d.), whereas Article 117 clarifies the distribution of legal power between the federal government and the regions. The regions are then responsible for organizing and distributing healthcare resources through local healthcare units (Armocida et al., 2020). In addition, the national government, through the Ministry of Health, is also responsible for defining the essential

levels of care and constructing policy and planning frameworks. This role, however, is shifting more and more to the Government Regions Committee (De Belvis et al., 2012). Public health is also interwoven throughout the SNN structure. On the federal level, the Ministry of Health works with various national public health agencies to determine appropriate policies, and the regions are then in charge of implementing them through their health departments (Poscia et al., 2018). Basically, the national government's role is one of guidance and strategy in terms of health policy while also guaranteeing the financial resources to maintain the system. The regions deliver the essential levels of care and are held responsible for any deficit incurred while doing so (see Ferré et al., 2014 for more information on the Italian healthcare system). The implication here is that each region can determine its own healthcare system structure, resulting in essentially twenty different health systems within the same country.

The problem with this type of system in a healthcare crisis is that the Italian government is left with a weak strategic leadership role, which was reflected in the inconsistency of data between different administrative levels during the pandemic (see Berardi et al., 2020). Additional problematic elements in Italy's health system include years of fragmentation (Adinolfi, 2014), decades of financial cuts (De Belvis et al., 2012; Prante et al., 2020), privatization (Quercioli et al., 2013), and deprivation of human and technical resources (Armocida et al., 2020; Rocco & Stievano, 2013). These considerations help explain how a healthcare crisis of such magnitude was possible in Italy.

Coronavirus Pandemic and Public Health Responses

On January 23, 2020, Italy reported its first two coronavirus cases carried into the country by Chinese tourists. By January 25 health checkpoints were erected at all Italian airports for passengers coming from China; five days later, Health Minister Roberto Speranza suspended all flights to and from China ("Misure Profilattiche Contro Il Nuovo Coronavirus" ["Prophylactic Measures against the New Coronavirus"], 2020). On January 31, 2020, shortly after the World Health Organization declared the coronavirus a pandemic, the government and the Council of Ministers declared a six-month state of emergency and appointed Angelo Borrelli, head of the Civil Protection, as special commissioner for the coronavirus emergency (Ministerio della Salute, 2020) whose job it would be to coordinate the interventions necessary to deal with emergency.

By the beginning of February 2020, three cases of the virus had been discovered; all were individuals who had recently returned from China. Not until February 20 was the first case diagnosed, in Lombardy, without possible exposure from abroad (Torri et al., 2020). By February 2020, outbreaks were counted in eleven municipalities (Vo' Euganeo, Codogno, Castiglione d'Adda, Casalpusterlengo, Fombio, Maleo, Somaglia, Bertonico, Terranova dei Passerini, Castelgerundo, and San Fiorano) across the province of Lodi (Lombardy) and the region of Veneto. As a result of these outbreaks, the Ministry of Health ordered a manda-

tory supervised quarantine for anyone that had come into contact with individuals confirmed positive for the virus (Ministero della Salute, 2020). Furthermore, it became mandatory to notify the Department of Prevention, the section of the Local Health Authority in charge of public health, if an individual entered the country from a high risk area (Signorelli et al., 2020); this was followed by mandatory quarantine and surveillance.

Following the municipal outbreaks in the regions of Lombardy and Veneto, the prime minister, with the approval of the Council of Ministers, issued the decree-law 6/2020 (Presidenza della Repubblica, 2020) on February 23, 2020, introducing urgent containment measures and management of the epidemiological emergency. This decree, requiring authorities in the impacted municipalities to take all containment measures necessary to manage the spread of the disease adequately and proportionately, led to the creation of "red zones" in the eleven aforementioned municipalities. On March 2, 2020, there was a proposal to expand the "red zones" to include the heavily impacted municipalities of Brescia, Piacenza, and Bergamo, but this was not adopted. (For an overview of the epidemiological trends see Berardi et al., 2020, Figure 1.)

It was not until March 9, 2020, however, that Prime Minister Conte signed the prime ministerial decree extending the reinforced measures to contain the virus to the entire country and forbidding individuals to gather in public places (Governo Italiano, 2020b), essentially placing the entire country on lockdown. After the decree went into effect on March 10, further ordinances and decrees were passed, prohibiting the access to public parks, play areas, or gardens (March 20), prohibiting individuals from leaving the municipality in which they were located (March 22), and suspending all production (March 25); see Table 18.1. Masses and religious services were forbidden, a difficult decision considering the countries primarily Catholic population, but parishes found alternatives. Pope Francis set the creative tone by livestreaming prayers, and priests created a WhatsApp group for parishioners (Roberts & Stamouli, 2020). The country remained in this state until May 4, 2020, after which a slow reopening of the country, beginning with factories, ensued.

There was an almost two-week gap between the creation of the first red zones and the lockdown of the entire country, allowing the virus to spread throughout the entire region of Lombardy down into the region of Emilia Romagna and west into the regions of Piedmont and Liguria. The daily deaths per 100,000 inhabitants in these four regions were the highest in the country at 5.7, 3.2, 2.3, and 1.9, respectively (Ciminelli & Garcia-Mandicó, 2020). This suggests that the initial step-by-step public health containment measures adapted in Italy were unsuccessful in stopping the spread of the virus in most regions[1] and that the northern regions would have benefited from a general lockdown much sooner.

Health System Responses

From a health systems point of view, measures to combat the pandemic were also characterized by an uneven approach among the Italian regions. Three dominant

TABLE 18.1. Health protection and containment measures

Date	Measure implemented	Place	Authority
January 25	Health checkpoints for passengers coming from China	All Italian airports	Minister of Health
January 30	Air traffic from China banned	All Italian airports	Government
January 31	State of emergency and appointment of Special Commissioner for the coronavirus emergency	All of Italy	Government
February 21	Mandatory notification to health department for those coming from high-risk areas followed by mandatory 14-day quarantine and surveillance	Public Health department	Ministry of Health
February 23	Red zones—containment areas	11 municipalities in the regions of Lombardy and Veneto	Government
March 2	Proposal to expand red zones to include municipalities in Brescia, Piacenza, and Bergamo	3 municipalities in Brescia, Piacenza, and Bergamo	Not adopted
March 10	National lockdown	All of Italy	Government
March 22	Suspension of all commercial activities non-indispensable for production	All of Italy	Government
March 23	Extension of limitations on individual freedom and other business activities not previously mentioned	All of Italy	Government

Sources: Adapted from Signorelli et al. (2020) and Ministerio della Salute (2020).

organizational models crystalized throughout the country: (1) hospital-centered approach, (2) community care approach, and (3) an integrated approach (Ciccetti, 2020). These three approaches and their relation to testing, hospital use, primary and community care involvement, intensive care units, and digital solutions can been seen in Table 18.2. Each of the twenty Italian regions can be placed in one of these organizational models based on the characterization of their health system (Ciccetti, 2020). The Veneto model, with a strong community network, tested both symptomatic and asymptomatic individuals, was characterized by a very limited use of hospitals (less than 20 percent hospitalizations), vigorously traced contacts, and focused on at-home care provisions, proved to be the most successful in combating the virus. The integrated approach minimized collateral damage with its focus on mental health aspects, chronic diseases, as well as testing and collaborative mobile strategies. Although those regions, with a heavily hospital-centered approach (over 40 percent hospital utilization), most notably Lombardy, that tested only symptomatic individuals had a more difficult time managing the virus from a health systems point of view.

TABLE 18.2. Overview of health systems approach for Italy

Dimensions	Hospital-centered approach	Integrated approach	Community-home approach
Regions	Lombardy, Liguria, Lazio, Piemonte, Basilicata, Sicilia and Umbria	Emilia-Romagna, Marche, Toscana, Valle D'Aosta, Calabria, Campania	Veneto, Friuli-Venezia-Giulia, Puglia, Molise, Abruzzo, Sardegna, PA Trento, PA Bolzano
Testing	Used for hospitalized or symptomatic patients only	Diffused in specific territories (symptomatic and asymptomatic patients)	Diffused in the whole region (Symptomatic and asymptomatic patients)
Hospital use	Intensive use > 40%	Intermediate use 20–30%	Limited use < 20%
Primary and community care involvement	General Practitioners active on an individual basis	General Practitioners active in structured mobile teams in collaboration with nurses	General Practitioners active in structured mobile teams in collaboration with nurses
Intensive Care Units	Intensively used and rapidly saturated < 15%	Used to support specific contagion outbreaks 10%	Used to support specific contagion outbreaks > 20%
Digital solutions	Use limited for contract traces	Regional platforms to support COVID-19 patients at home	Local platforms to support COVID-19 patients at home

Source: Adapted from Ciccetti (2020).

Most of the ordinances and decrees passed during the initial phase of the coronavirus pandemic concerned public health and containment measures; two, however, addressed the health system. On March 6, 2020, the Council of Ministers approved a decree law set to reinforce the National Health Service. The aim of the decree was to strengthen the territorial assistance network and the functions of the Ministry of Health by increasing human and instrumental resources. This would include recruiting specialist doctors, bringing retired doctors out of retirement, and increasing the hours of outpatient specialists (Governo Italiano, 2020a). Shortly after the national lockdown, on March 11, 2020, the Council of Ministers approved an additional amendment to further strengthen the support provided for the health system by increasing the financial resources available for civil protection and security (Governo Italiano, 2020a).

National efforts to strengthen the Italian health system as a whole through increased resources (financial, human, and instrumental) proved essential during the crisis; the fact that they were even necessary highlighted the country's years of health budget cuts. The differences in regional health systems made apparent through varying regional characteristics left some regions better off than others. The bottom line was this: public health and health system response in Italy was good, but not fast and good enough for every region.

Boarders

In contrast to many other European countries who closed their borders (i.e., implemented strict controls) to specific countries (i.e., those whose infection rates were high: Italy, France, United Kingdom, Spain), Italy never officially closed its Schengen borders. Initially Prime Minister Conte stated that he was opposed to suspending the Schengen agreement, claiming that the suspension "is a draconian measure that does not meet the needs of Italian citizens in the field of containment of infection" ("Italy Refuses to Suspend Schengen Agreement Amid Coronavirus Outbreak," 2020). There are two reasons the government never had to close the borders: (1) all the neighboring countries had already done so and (2) in Italy after March 10, 2020, you needed an autodeclaration form filled out to leave your home. In fact, leaving home and the municipality in which a person lived was absolutely banned without proof he or she was going to work (medical professionals), had health issues in which case a certificate would be necessary, or could prove that leaving the house was a necessity. Thus, getting across a border was the least of citizens' worries.

Social Policy Measures

Socioeconomic Response to the Crisis

The lockdown implemented by the Italian government to counteract the spread of the coronavirus, and later on adjusted together with the help of the ad hoc appointed Scientific Task Force[2], drastically impacted the Italian economic tissue, making evident the need for stronger (than the ordinary ones) social protection measures. To mitigate the socioeconomic effects of the pandemic the Italian government issued three decree laws in March, April, and May, distributing approximately EUR 80 billion to those sectors of the population most in need. The first, Cura Italia, was published on the March 17, 2020, as a collection of measures foreseeing the distribution of EUR 10 billion not only to further empower the national healthcare service but also to guarantee the economic sustainability of families, workers, and enterprises impacted by the pandemic.

The most important measures foreseen by the decree, including social safety nets, can be summarized as follows:

- Paid layoff was granted to workers from both the private and the public sector.
- Each worker from both private and public sectors with children (max twelve years old) could ask for fifteen days of paid parental leave. No age threshold was given for parents with children who have a severe disability.
- Babysitting vouchers amounting to a maximum of EUR 600 per month were foreseen as an alternative measure to the parental leave.

- Parental leave was extended for those families that had a relative with severe disability.
- EUR 3 billion were allocated to autonomous workers and professionals. Approximately 4,854,000 people received EUR 600 for the month of March.
- An additional EUR 300 million were allocated and specifically dedicated to all people in need who did not qualify for aid in the above-listed categories.

On April 8, 2020, the "liquidity decree" was announced, granting credit and deferring tax obligations for companies as well as extending administrative and procedural terms in the health fields (Liquidity Decree, 2020).

On April 24, 2020, the Italian Parliament converted into law the Italian law decree No. 18 of 2020 ("Cura Italia" decree). The so-called "Cura Italia" law (Cura Italia Law, 2020) was published in the official journal on April 29, 2020, and implemented on April 30, 2020. During the process of converting the decree into law, some of the provisions introduced to address the economic impact of the pandemic (e.g., employment measures, financial measures, taxes, and public law provisions) were amended by Parliament (see "COVID-19: Cura Italia Decree Converted into Law," 2020 for more information).

Reinforcing the Socioeconomic Response

These first measures of government support were not adequate enough to counteract the effects of the crisis and its social repercussions. After a brief period of time, the so-called *Reddito di emergenza* ("Relaunch Decree") was established with the decree n. 34 of May 19, 2020, (Decreto-Legge, 2020). On July 19, 2020, the Relaunch Decree went into effect, thereby leading to the amendment of several provisions introduced to address the economic impact of the pandemic. The law granted a generous two-month income replacement between EUR 400 and 800 to those families mostly heavily exposed to the economic fallouts produced by the crisis (Brocardi, 2020). Moreover, it increased the available resources for the realization of volunteers' association and social promotion association dedicated to face the social and welfare emergencies deriving from the COVID-19 crisis. Similarly, and with the same intention, the government also adopted the prohibition to lay off workers.

Finally, to sustain the supply of adequate nutrition, the government, in close connection with Civil Protection, passed a solidarity-nutrition-measure (Borrelli, 2020), wherein EUR 400 million were collected and distributed among the most impacted municipalities. These three measures had two core objectives: maintaining the country's purchasing power and supporting the country's stability.

What is striking with these measures is that Italy, already heavily in debt and struggling to keep its expenditures under control, wanted to guarantee a very large credit program for companies (32.1 percent of 2019 GDP), while the Italian fiscal stimulus tended to be normal in relation to other EU countries at 3.4 percent of 2019 GDP (Anderson et al., 2020).

Explanation

Limited Public Health Investment

Since the 1990s Italy has implemented reforms attempting to contain costs associated with the healthcare needs of an aging population. The goal was to cut down on the country's debt and public deficits to meet the Maastricht criteria and the requirements of the Stability and Growth Pact (Erber, 2011). Further cuts to the already strained system followed with the global financial crisis (2007–2008) and the euro crisis (2009), resulting in even more restrictions to healthcare spending (Pavolini & Vicarelli, 2013; Figure 18.1). The result of these thirty yearlong cuts to the public health system led to two very important developments discussed in detail by (Prante et al., 2020): (1) The number of acute care hospitals (inpatient hospitals as opposed to outpatient hospitals) were drastically reduced from 2.5 per 100,000 in the 1990s to no more than 1.6 by 2014, falling below the EU average. (2) The number of acute care beds, central in combating the corona virus, in Italy were reduced by a staggering amount. Although in 1990 the country still had seven beds per 1,000 inhabitants, this number was cut to 2.6 per 1,000 by 2017. Because of these reductions, it is not surprising that the number of ICU beds, also fundamental in the treatment of the coronavirus, decreased by 19 percent over a ten-year time period (Prante et al., 2020).

Two concerns presented themselves during the pandemic as direct consequences of these consistent and substantial cuts to the public health system turned into the two main concerns during the pandemic: (1) a lack of medical equipment (e.g. medical masks, protective suits, respirators) and (2) not enough medical staff. The lack of medical equipment must first and foremost be attributed to a poor disaster preparedness strategy, which affected every country (WHO,

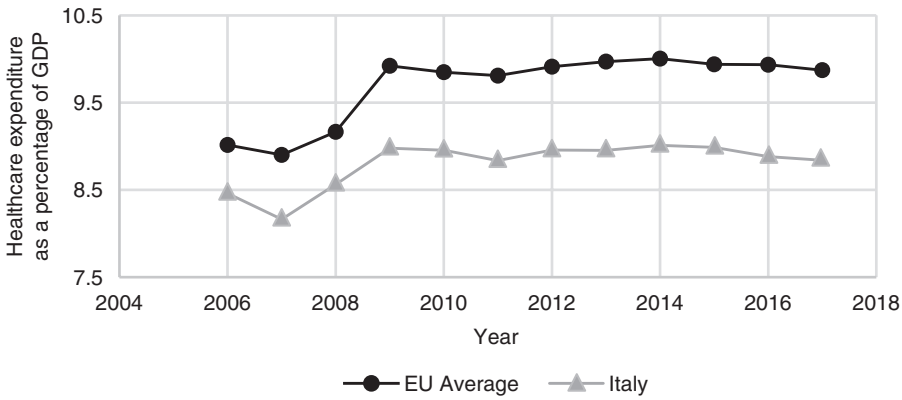

Figure 18.1. Healthcare expenditure as a percentage of gross domestic product (GDP).
Source: World Bank (2020).

2020a). Unfortunately for Italy, it had less time to prepare than other countries, and authorities failed to update the preparedness plan in case of a pandemic (Graziani, 2020). Second, a lack of solidarity among EU countries delayed and downright prevented the transfer of medical supplies to Italy during the initial phases of the pandemic (Sardone, 2020). Finally, because of the fact that Italy had much less medical equipment to begin with, it was especially difficult to make these purchases amid a pandemic in which everyone needed the same supplies. The chief executive, Robert Hamilton, of the world's largest ventilator maker, Hamilton Medical, mentioned that "Italy may have less than a quarter of the breathing machines necessary to help patients" (Miller, 2020).

The Italian problem with doctors is and has been that, although the country has a proportionally high amount of doctors compared to the EU average (European Observatory on Health Systems, 2019), more than 50 percent of these are above the age of fifty, and 15.5 percent are over the age of sixty-five (Figure 18.2). For this reason and because many medical professionals were contracting the disease as a direct result of insufficient protective gear, medical retirees were asked to come back to work and medical students in their last year of education were employed by hospitals.

The long history of financial cuts to the healthcare sector in Italy directly impacted the country's death toll. Without adequate and sufficient medical supplies, the disproportionately older medical staff was contracting the virus, thereby causing a shortage of doctors within the system. This, in turn, reduced the number of human resources the country had to combat the spread of the virus, resulting in a death spiral.

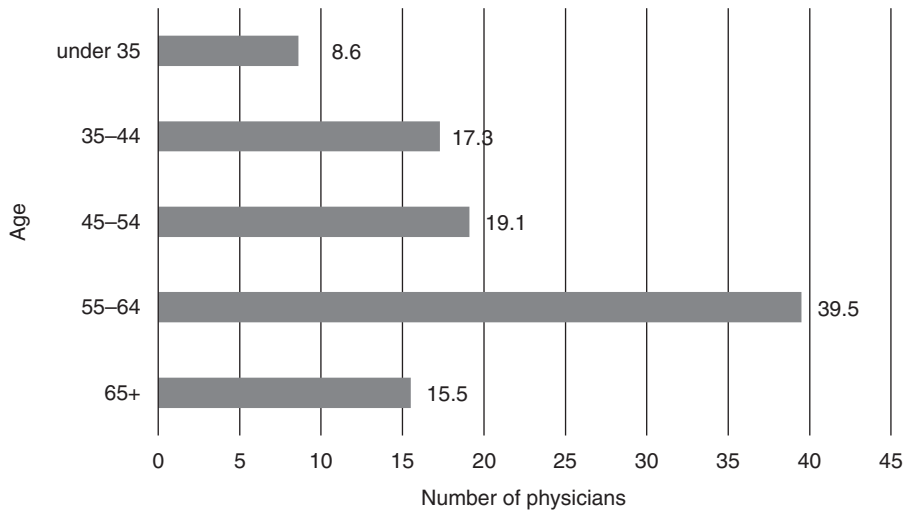

Figure 18.2. Italian physicians by age in 2017.
Source: Adapted from Eurostat (2019).

Political and Administrative Capacity Combined with Inexperience

Three intertwined problems made it difficult for the Italian government to respond efficiently and effectively to the virus and the ensuing social crisis that resulted from the lengthy lockdown period. The first focuses on Italy's fundamental unpreparedness and inexperience. Although a national pandemic plan was present (Italian Ministry of Health, 2002), it was outdated and practically never used, and thus all the procedures had to be reinvented in the midst of the pandemic. The result was, among other things, that overfilled hospitals began transferring infected patients to retirement homes, leading to mass deaths among the elderly (Privitera, 2020). In addition, because there had been no similarly severe outbreaks in recent years, the Italian government was slow to move from a period of "denial" (denying the severity and potential repercussion of the virus) to trying to normalize the threat to actually beginning to recognize that the threat was a real problem that required a solution. What resulted was complete disarray among institutional actors (national and regional governments). The government began creating red zones in certain municipalities, and the opposition leaders requested that these be opened again only to then request that the entire country be closed off (Capano, 2020).

The second problem highlights the country's weak administrative capacity (also problematic in other Western countries). This could most clearly be seen in efforts to supply aid packages to citizens and businesses. At the beginning of May, President Conte apologized on behalf of the government because thousands of Italian workers had not yet received state aid (Good, 2020). Many measures meant to help families, businesses, and individuals were hampered by long administrative delays typical of the inefficient Italian bureaucracy (Bouckaert & Jann, 2020), ultimately resulting in increased inequalities (Brunori et al., 2020; Pavolini, 2020). Simply put, people were not receiving the promised financial support.

The final and biggest problem points to limited political capacity. Recent political developments in the country, including the PRR Lega entering into a governmental coalition with the equally instable 5 Star Movement in 2018 and then leaving the coalition after a failed takeover (see Poli, 2020 for more information), resulted in a "ruling government that was composed of many ministers with a substantial lack of experience and very short political careers" (Capano, 2020, p. 340). This fact produced not only conflictual policy agendas, thereby decreasing the government's consensual ability to design coherent policies, but also a government that did not want to make drastic decisions for which they would then be held accountable. The result was twofold: on the one hand, the political discourse taking place in the country during the pandemic became increasingly unproductive, and on the other, experts and technocrats were called upon to help the government out of its political stalemate as well as share the responsibility and eventual blame that accompanies decision-making (Capano, 2020).

Although the involvement of experts[3] helped convince the public that the government recognized the relevance and importance of the problem and was taking concrete steps to counteract it, the immense number of experts presented two new problems. It showcased the fundamental uncertainty of Italian officials in making decisions, and it risked weakening the democratic accountability of the entire political system. In other words, involving such a high number of experts in the decision-making process impacted the transparency of the process itself. This resulted in questions such as, Who is in charge of making decisions? Are these the best decisions only because experts suggested them? Although it is surely fundamental to establish a technical committee during a pandemic, why were so many experts actually involved, and why were they involved in issues not strictly related to healthcare?

The Pandemic and the Italian Party Politics

What is perhaps most interesting in terms of the pandemic in Italy is not so much how party politics impacted the management of the pandemic, but rather how the pandemic impacted party politics. The pandemic resulted in an increased electoral appeal for certain parties, specifically PRR parties; however, the nature of this effect is still ambiguous and in progress. At the beginning of the pandemic, some commentators argued that the coronavirus would represent the end of populism in Italy ("Italy's Young Doctors Protest Lack of Training Pushing Them to Go Abroad," 2020; Kendall-Taylor & Nietsche, 2020; Rossi & Parodi, 2020); as if the biological virus could counteract the "populist virus." However, the reality turned out partly different.

Both the Radical Right (populist) leader, Salvini, and the representative of the radical right party Fratelli d'Italia, Meloni, initially negated the evidence of the pandemic. Salvini's Facebook posts encouraged followers to continue with their normal lives, while Meloni told her Facebook followers not to believe anything that was being said on TV (Nardelli & D'Urso, 2020a). After the lockdown, they both adapted their rhetoric to the normalization and consequent awareness of the emergency, wherein Salvini argued that the lockdowns were not going far enough and that everything needed to be shut down. Both PRR leaders started attacking the EU's response to the crisis, and they released a video stating that the virus was bioengineered in China (Nardelli & D'Urso, 2020b). At that point, the slowness in the implementation of the above-mentioned measures to counteract the socioeconomic crisis became the substance of the PRRs political discourse and the parties capitalized on the crisis to reinforce their anti-EU stances. In parallel to the evolution of their rhetoric, the consensus for their leadership also changed throughout the course of the pandemic. The PRR flank (represented by the Salvini's Lega and Meloni's Brothers of Italy) blamed the government for not being able to make substantive decisions and implementing them. During times of crisis, Italians, like any other citizens, appeared to look for solemn and stable leaders. Despite still being the strongest part in terms of consensus, Salvini's Lega lost 4 percentage points of support since the end of February and ten points since last summer's peak

(Roberts, 2020), putting it at 27 percent as of July 2020. At first glance, this might confirm the notion that the coronavirus is killing the PRR; however, the decrease in consensus for the Lega made room for the even more right-wing Brothers of Italy under Giorgia Meloni. This party saw a rise in support from approximately 7 to 14 percentage points, the highest level ever reached by the party (Roberts, 2020). To be sure, the (slight) increase of Meloni's success looks like a consequence of the loss of appeal by Salvini.

In addition, as Salvini's favorability decreased, Luca Zaia, the governor of Veneto and more moderate figure within the Lega party, experienced a political boost. Zaia's handling of the crisis in Veneto, one of the regions most affected by the pandemic, garnered him much support, leading to his third term as governor (Pianigiani, 2020) and making him the second most loved politician in Italy (51 percent of the consensus) behind Prime Minister Conte (Roberts, 2020). Although Salvini's light might be fading, there is no shortage of PRR politicians waiting for their chance at center stage.

Furthermore, right-wing forces capitalized on the crisis scapegoating on their traditional targets (i.e., immigrants and minorities). The coronavirus pandemic coupled with the increased support for the PRR shed a new light on the problems associated with the managing of refugees and migrants in the country. To begin with, refugees, asylum seekers, and migrants were among the most severely impacted by the crisis ("Life in Italy Under COVID-19," 2020). Second, the issue of how to provide the basic voluntary and welfare services while also guaranteeing the safety of their personnel and volunteers has been amplified. As the coronavirus makes a reappearance in Italy during the writing of this conclusion (September 2020), migrants are being made into a recurring target for PRR politicians who (continue to) claim, despite official data proving the contrary, that they are transporting the virus into Italy.

Finally, it should be noted that, while the visibility and success of the right-wing forces increased during the first wave of the pandemic, the two political parties in government (i.e., the 5SM and the Democratic Party) did not seem to be able to increase their support. In fact, only support for Prime Minister Conte increased.

However, on a more positive note, the pandemic also gave way to a strong and collective civil society led by activists that created new forms of expressing their grievances (della Porta, 2020). In Italy, for example, "100,000 doctors signed a petition calling for the territorially decentralized organization of healthcare provision," and in Milan "the health care personnel of private hospitals staged 'stay-ins' (keeping social distance) to protest the deterioration of their working conditions" (della Porta, 2020). In this sense, civil society actors were not only suggesting alternative approaches to the management of the crisis, as well as many other economic categories, but also indicating that the path to achieving favorable results would not be through the centralization of political decision-making and even less through technocratic actions, but rather by increasing the participation of the citizens (della Porta, 2020).

Conclusion

The corona pandemic engulfed Italy while it was still trying to recover from decades of strict cost-containment measures, particularly impacting hospital capacity, the healthcare workforce, public expenditure for pharmaceuticals, and out-of-pocket payments for patients. This fact combined with an outdated disaster preparedness plan and an inexperienced government resulted in 35,724 deaths (as of September 2020), second only to the United Kingdom in Europe.

The Italian government's coronavirus approach went from a period of denial to a federal patchwork strategy of containment, to a very rigid and strict lockdown. During the initial containment strategies, certain federal, regional, and municipal officials took the virus more serious than others, leading to confusion and disagreement among some of the Italian public. Statements such as the ones made by Prime Minister Conte and other officials blaming Italy's high number of infections on the aggressive testing of people without symptoms in the north, which they argued only created hysteria and tarnished the country's image abroad (Horowitz, 2020), not only slowed the drive for increased testing in many northern regions but also signaled to the public that the virus was not that dangerous. Similarly, Italy's Foreign Minister Luigi di Maio and Health Minister Roberto Speranza told international journalists at the end of February that Italy had gone from an "epidemic risk to an 'info-demic' of confirmed disinformation, which at this moment is hitting our flow of tourists, our business and our whole economic system" (D'Emilio & Winfield, 2020) certainly did not help the credibility of proposed lockdowns a few weeks later.

The Italian case is one that has and will undoubtedly continue to be studied not only because it was the first country drastically impacted by the virus but also because the virus claimed a disproportionately high number of lives, for which the reasons are still highly debated. Furthermore, the impact of the pandemic on Italy was strong not only from a health standpoint but also from an economic one. Italy entered the pandemic in a less stable economic state than its neighboring countries with a government debt of 132 percent of GDP in 2018 (Gramlich, 2020), never really having recovered from the 2008 economic crisis. The European Commission's projections for the Italian postpandemic economy are a decrease of 11.2 percent of GDP for 2020 and an increase of 6.1 percent of GDP for 2021 (European Commission, 2020). What makes the economic situation in Italy particularly bad is that overdue reforms were held up because of the complex and old-fashioned Italian bureaucracy, the slow judicial system, and outdated infrastructure. Within such a context the social assistance and aid for citizens and business heavily impacted by the crisis was undeniably slow and filled with administrative hurdles.

Subsequent research could investigate the most efficient and effective ways the country could use the EUR 209 billion, a combination of grants and loans from the EU, to stabilize the economy, reinvest in health care and public health, and perhaps, most importantly, take initial steps in simplifying the overly complicated Italian

bureaucracy and reforming the slow judicial system. In addition, eyes should be on the PRR leaders as they continue to polarize society and capitalize on the pandemic, by accusing migrants and minorities as virus spreaders (della Porta, 2020), the EU for their lack of solidarity, and the EU loans as weakening Italian sovereignty, refueling heated *Italexit* debates (see Di Quirico, 2020 for more information). The needs of the Italian citizens and the Italian economy must be addressed, and one might be left wondering whether the substantial weaknesses displayed by the political parties in government vis-à-vis the increased visibility of the radical Right could have negative effects on the Italian political system after the pandemic.

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Notes

1. The region of Veneto is an exception as mass testing, at-home care provision, and contact tracing significantly helped curb the death rate in this region, which was the lowest out of all the Northern regions with 1.1 daily deaths per 100,000 inhabitants (Ciminelli & Garcia-Mandicó, 2020).
2. The term *scientific task force* refers to a group of scientific experts appointed by the Italian government to limit and counteract the effects of the COVID-19 crisis on the population. Lead by Walter Ricciardi, Paolo De Rosa, and Fidelia Cascini, the core objective was to provide regions with guidelines on hospital reorganization, community care networks, and related facilities.
3. Fifteen different taskforces were established at the national level, some of them with curious and interesting roles (see Capano [2020] for more details).

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