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RESEARCH

Lessons Learned from Italian Nursing Homes during the COVID-19 Outbreak: A Tale of Long-Term Care Fragility and Policy Failure

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The paper critically discusses policy implications and policy lessons from COVID-19 management in the Italian LTC sector. The aim of the paper is to highlight strengths and weaknesses of measures promoted to support nursing homes during the pandemic and after, so to discuss possible routes for future reforms in Italy and comparable countries. After having described the features of Italian LTC sector, the paper discusses 2020 pandemic events both by presenting administrative data and a policy analysis conducted in 9 out of 21 Italian regions so to assess policy interventions. The paper shows that the intrinsic features of Italian LTC sector played a major role in COVID-19 crisis and new policies enacted in 2020 were insufficient to manage the situation. Possible routes for policy reforms are presented in conclusion. Limitations of the analysis relies in the time frame, since COVID-19 effects are still ongoing, while the analysis ended in November 2020.

Keywords: Italy; Nursing homes; Reforms; Integrated Care

Introduction

The COVID-19 outbreak in Italy has exposed the fragility of its long-term care (LTC) sector, particularly with reference to nursing homes. Italy is one of the countries most severely affected by the current pandemic, possibly because 23% of its population is over 65 years (Istat, 2019), meaning that almost one out of every four citizens is severely exposed to virus lethality (Mallapaty, 2020). As of 27 January 2021, 96% of the officially reported COVID-19-related deaths were of people aged 60 years and above (81,703 out of 85,418) (Istituto Superiore di Sanità, 2021). During the first pandemic peak (spring 2020), major Italian newspapers published figures and accounts of unusually high numbers of deaths in nursing homes and drew attention to the inadequacy of guidelines, medical procedures, and, more importantly, COVID-19 tests (Arlotti and Ranci, 2020). Some nursing homes registered mortality peaks among their patients (Arons *et al.*, 2020) that were double the rate recorded during the corresponding months of the previous years (ATS Milano Città Metropolitana, 2020). The experiences of the Italian LTC sector and the management of the crisis, particularly in nursing homes, can serve to provide other countries with useful directives.

The aim of the paper is thus twofold, to use the Italian case of COVID-19 impact on LTC sector so to provide insights about managerial issues (during the pandemic) and to discuss lessons for future reforms (after the pandemic).

Concerning the first, at least four topic relating to the management of the COVID-19 crisis have been highlighted during 2020. In brief, (1) the implementation of homogeneous operational guidelines to support crisis management in LTC services; (2) allocation of resources (such as Personal protective equipment, PPE) as fundamental to the safety of LTC workers and their older adult patients; (3) workers training and (4) effective links between public policies and managerial actions (e.g. governments expected to be coherent and transparent in their decisions regarding the testing of LTC nursing home personnel and residents so that they have sufficient information based on which policy and operational decisions can be made). All these issues are rooted in LTC sector specificities and should be challenged through a general rethinking of its functioning. These elements pave the way to the second objective of the article, that is providing evidence of an urgent need to reform the LTC sector. Directions for the future of LTC are presented in the concluding section of this article.

To enrich this body of evidence, this study examined how the COVID-19 outbreak exacerbated pre-existing weaknesses within the Italian LTC sector and contingent issues that emerged during the outbreak. The article is structured as follows: first, we describe the method adopted for the study; second, we describe our research setting; and third, we present the results of our analysis. In the concluding section, we present the main contributions this

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study makes to the recovery of the LTC sector in light of the challenges that lie ahead.

Method

To achieve our objectives, we adopted a qualitative case study research design. We conducted this study in Italy because of the major weaknesses its LTC system had experienced prior to the COVID-19 crisis. Further, its aging population made it a good case study for comparisons with countries facing similar challenges. As concerns selection criteria, we chose to focus on regions in Italy that had registered more than 5,000 positive cases by 15 June, 2020, and that had the greatest concentration of LTC facilities for older adults (Berloto *et al.*, 2019). Nine regions met these criteria: Emilia-Romagna, Lazio, Liguria, Lombardy, Marche, Piedmont, Provincia Autonoma (PA) of Trento, Tuscany, and Veneto. The results of this study will be presented by accounting for the distinction between the first phase of the pandemic (late February, 2020, to 3 May, 2020, when the first national lockdown ended) and the second phase (4 May, 2020, to 3 June, 2020, when the regional borders were reopened). This timeframe was selected because it represents the true emergency phase of the pandemic, during which the whole world had to come up with new solutions to ensure the safety of its citizens. Data collection was based on two archival sources. First, we collected official administrative data on the spread of COVID-19 in the LTC sector published by the Ministry of Health on its institutional website. Second, we performed a web-based research on the selected regions' institutional websites to gather regulations enacted between late February and June 2020, finding 22 acts. To allow for comparisons, the 22 regulations that were read by two authors, who confronted and categorised them into the following five areas according to their policy objectives.

1. Management of LTC services (all interventions related to the management of COVID-19 in LTC services).
2. Coordination between LTC services and the healthcare system to detect whether and how policy makers ensured proper linkages among different care settings.
3. Management of positive cases, particularly with respect to testing policies, screening, isolation of suspected cases, safety measures, etc.
4. Workforce management, in terms of testing and safety measures for LTC staff and training to be updated with measures to ensure safety within services.
5. Changes in the regulation of LTC services to align new COVID-19 requirements with higher public payment, etc.

This analysis allowed us to identify the priorities identified by regional legislators and the guidelines they enacted to guarantee the safety of staff and users of LTC services.

The research setting: the Italian LTC system before COVID-19—a fragile ecosystem

The Italian LTC sector has historically been characterised by complexity and a fragmentation of competencies and resources among institutional and non-institutional stakeholders (most importantly, families), together with blurry borders between different welfare initiatives and funding (Fosti *et al.*, 2018). This fragmentation originates from the fact that, in contrast to the Italian National Healthcare Service (NHS, in Italian Servizio Sanitario Nazionale), the LTC sector did not originate from a clearly defined and comprehensive model but rather from multiple legislative interventions promulgated over a period of more than 30 years (Rotolo, 2014). **Figure 1** represents the institutional fragmentation of the LTC sector and the functions that each actor oversees.

The key premise is that, as with the NHS, the LTC sector is a regional competence, with the central government only promoting guidelines for the system. In particular, the Ministry of Labour and Social Policy and the Ministry of Health are responsible for defining the national

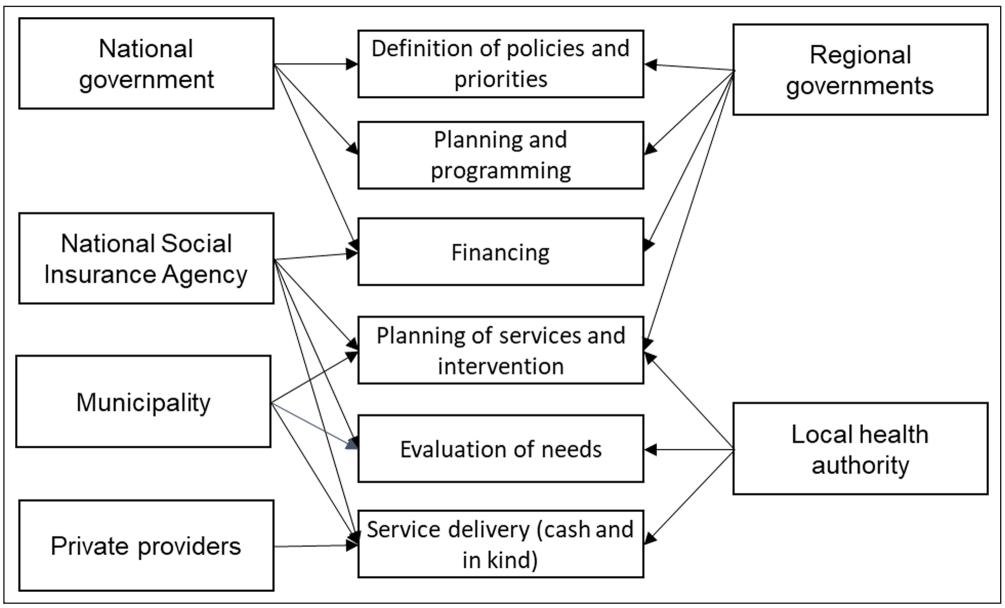

Figure 1: Institutional fragmentation of the Italian LTC sector. Adapted from Rotolo (2014).

framework, producing general guidelines, and funding specific interventions to ensure regional equity. Further, at the central level, the National Social Insurance Agency (Istituto Nazionale Previdenza Sociale, INPS) is in charge of monetary contributions and cash allowances (Indennità di Accompagnamento) that are paid directly to citizens. At the next level, the regions are the key actors because they regulate and fund in-kind services (Berloto and Notarnicola, 2019). Local health authorities (LHAs) and municipalities step into action when it comes to programming services and interventions that are delivered through care providers. The system is highly reliant on publicly funded services, which account, on average, for 85% of providers' revenues (Fosti *et al.*, 2021). Coordination between different LTC responses is absent or left to local best practices and efforts at innovation. Citizens who access the LTC system can go through three different need evaluation systems (LHAs, municipalities, and INPS) to access the in-kind and cash services they are eligible for, without any kind of guidance or coordination between the different interventions (Berloto *et al.*, 2019). **Table 1** presents the main components of the Italian LTC system; it distinguishes between cash benefits and in-kind services and clarifies the actors involved.

Moreover, at present, there is no widespread coordination to ensure continuity between LTC settings and hospital care (Network Non Autosufficienza, 2021). **Table 2** summarises the potential target market for LTC services among people aged 65 years and above, the current public offering,[1] the actual users, and the resulting public LTC coverage rate. Data refer to 2016, which is the latest available data (Berloto *et al.*, 2020b). It is worth noting that the most widespread LTC service is home care provided by local health authorities, which reaches more than 600,000 users per year; however, every older person receives, on average, 17 hours of care per year, which raises the question of whether it reflects adequate provision of services to people in need.

These figures show that the public system can only respond to approximately one-third of those who need LTC services. Moreover, it is unlikely that this rate will increase in the coming years because of the absence of adequate public investments. It is also important to specify that large regional differences exist, which have an impact on equity and access to care. As a consequence of the low public coverage rate, other phenomena have come to characterise the Italian LTC system (Perobelli and Notarnicola, 2018); for example, **Table 3** describes how families cope with the poor public response to the needs of older adults.

In this landscape, nursing homes play a crucial role because they represent the only LTC response available to older adults (Berloto *et al.*, 2020a). It is the only in-kind service that guarantees intensive care and 24-hour caregiving services. However, territorial disparities and a shortage of availability have had a negative impact on their potential to respond to citizen needs.

The structure of the LTC described in the preceding section gave rise to four major weaknesses, which played a role in the pandemic crisis. The four weaknesses are discussed below.

1. Absence of coordination between and within care sectors

The LTC system is fragmented and lacks coordination and integration between the healthcare, social care, and community care sectors (Network Non Autosufficienza, 2021). Nursing homes are also affected by the absence of coordination and are often left to independently manage specific cases and provide care pathways. The relationship between care settings (in particular, hospital inpatient care and community care) is often antagonistic, with strong competition for public funding. Families and older persons are, thus, left alone to create connections between public service and to play the role of care managers themselves.

2. Investments focused on acute care and neglect of LTC

For many years, official attention has been paid to acute care, and poor or absent policy interventions

Table 1: The Italian LTC system: initiatives and actors involved.

Typology	Service/Intervention	Actors involved
Cash transfer	Indennità di Accompagnamento	National Social Insurance Agency
	Monetary vouchers to finance informal caregiving or care services	Municipalities Regions Local Health Authorities
In-kind services	Home care	Local Health Authorities and Municipalities
	Nursing homes	Municipalities and regions; providers (public, private, or not for profit)
	Day care	
	Informal caregiving	Relatives or so-called '*badanti*'.

Table 2: Italian LTC system at a glance: potential target market, public offering, users in charge, public LTC coverage rate (2016).

Potential target population	Public offering (residential beds + day care slots)	Public offering (home care, in hours)	Users in charge2	Public LTC coverage rate
2,907,438	300,913	12,467,620	1,075,152	37%

Table 3: Family solutions to LTC needs (based on Perobelli and Notarnicola, 2018).

Family solution	Key facts and data
Informal care provision by family members	· Family caregivers amount to 8 million (Censis, 2015). · 1 caregiver out of 5 is an older person (65–74 years). · Care provision is mostly undertaken by women aged 25–54 years.
Professional private services	· Approximately 92% of families who care for older persons at home do so through services and care facilities that are organized privately. · €3,4 billion of LTC expenditure is out of pocket. · In public services, the share of co-payment required from families can be exorbitant.
NHS services	· National data on hospitalisation and multiple hospitalisations show that, often, there is a need for constant care that is not met by hospitals. · 57% of hospitalisations are pursued and required by families, usually after admission to the emergency room. · 90% of hospitalisations of older persons end without the activation of any public service.
Care workers (regular or irregular, not professionals)	· In 2018, there were 1 005 303 care workers in Italy, 60% of whom were irregular. · There were 14.2 care workers for every 100 citizens aged above 75 years. · Care workers are more prominent in the northern regions, where the service network is more widespread.

for LTC are apparent. The same holds true for data gathering and evidence-based interventions. On the one hand, Italian administrative health records are among the best-organised in the world; however, on the other hand, information regarding LTC is absent and poorly structured (Motta, 2021). For example, figures regarding care services and care needs are outdated (those cited in this article are from 2016), and no information system has been put in place, not even during the COVID-19 crisis.

3. The management of care personnel and lack of a dedicated workforce

The caregiving workforce in the Italian LTC sector is small, and it suffers from the absence of clear national guidelines concerning training and staff requirements. Care workers operating in nursing homes do not have specific medical training and focus on personal assistance and social interventions. Even before the current crisis, this had resulted in inadequate caregiving given that the health conditions of older persons living in nursing homes tend to deteriorate. In fact, all over the country, the average age of older adults in nursing homes has increased (Notarnicola *et al.*, 2020) as has the number of older adults with chronic medical conditions and dementia. This underscores the need for more specialised medically trained personnel. From another perspective, it can be argued that the shortage of professionals has put the existing staff under pressure and at risk for burnout—a situation that is made worse by the fact that contractual guarantees are often weak and vary across the country.

4. Mission assigned to LTC services and connections with other care settings

As mentioned earlier, Italian nursing homes are increasingly hosting older adults with highly complex health conditions, including a range of chronic and neurological diseases. Such cases require high-intensity and specialised care that is beyond the capabilities of nursing home staff, both in terms of the number of working hours and professional competencies (Cappuccio, 2020). Thus, nursing homes operate as acute care settings, but they are neither recognised nor funded as they should be in this case.

Evidence: COVID-19 and LTC in Italy

The following paragraph delineates the impact of COVID-19 on the LTC sector in Italy. This analysis is based on official administrative data regarding the spread of COVID-19 in the LTC sector in 2020 published by the Ministry of Health and on the analysis of regional regulations.

The Italian LTC system during COVID-19: a mismanaged crisis

Following the COVID-19 outbreak, no official data on the spread of COVID-19 in LTC settings were published. The first available dataset was drawn from a survey conducted by the Italian Institute for Health (ISS)[3] across 3,292 of the 4,629 nursing homes operating nationally. A total of 1,356 nursing homes (41.2%) responded and reported an overall mortality rate of 9.1% between 1 February, 2020, and 5 May, 2020. Among the 9,154 deaths, only 680 individuals had officially tested positive, although 3,092 more reportedly had flu-like and COVID-19-related symptoms. The ISS stated that these two numbers should be analysed jointly (Istituto Superiore di Sanità, 2020). Thus, 41% of the deaths (3,772 out of 9,154) recorded during this period were COVID-19 related. These initial figures are similar to those reported in the press by nursing home managing directors, which alarmed the public. Risk underestimation and a lack of coordination and guidelines for the care sector continued, and multiple factors contributed to the failure to control the spread of the disease, especially in nursing homes (Zhou *et al.*, 2020). This exacerbated the aforementioned problems embedded within the Italian LTC system (Razetti, 2020). What happened in Italian nursing homes during the first peak of the pandemic in the spring of 2020 has to be interpreted as a blatant neglect of the LTC system from at least three perspectives: timing, resource management, and the absence of data (Kruse *et al.*, 2020). First, with regard to timing, the first opera-

tional guidelines for nursing homes, which were released after the country's total lockdown began on 9 March,[4] required only that residential services suspend visitations (Arlotti and Ranci, 2020; Cuppini, 2020). This implies that, because of the absence of restrictions or social distancing guidelines, vulnerable older persons had been exposed to visitors who were possibly positive and asymptomatic for at least three weeks. At the national level, updated operational guidelines specific to nursing homes were released by the Ministry of Health only on 25 March, whereas the first measures geared towards the general population were enacted on 22 February. In accordance with what was being implemented at the national level, most of the regions (who are responsible for LTC sector operational regulations) enforced the first set of guidelines for COVID-19 management more than a month after the outbreak. Lombardy was the only region that acted earlier. On 8 March, local health authorities were asked to identify nursing homes that met 'adequate' structural specifications (i.e. they had independent pavilions) and organisational requirements to host low-intensity COVID-19-positive cases. This disposition was highly contested by both care providers and their representatives because of the high risk that such exposure would pose to both workers and patients. Therefore, this measure was implemented in only a few cases. Second, the lack of PPE for LTC services negatively impacted the management of the crisis. Italy faced an overwhelming shortage of masks, tests, and gowns, which deeply affected the social and healthcare sector personnel. New PPE supplies were primarily directed to hospitals, and nursing homes struggled to find adequate equipment to protect their workers and residents. In Lombardy, the first supply of masks for nursing homes arrived on 12 March but proved to be insufficient to meet their needs.[5] The third shortcoming was the inability to track and control the spread of COVID-19 in nursing homes by failing to test suspected cases among older adults and staff. Even at present (early 2021), current procedures do not accommodate the testing of older people in nursing homes or those who pass away after presenting with symptoms.[6]

Policy response during the COVID-19 crisis

As noted earlier, the organisation of LTC services is a regional responsibility. **Tables 4** and **5** summarise the results of an in-depth analysis of the 22 regulations enacted by the nine Italian regions where the effects of

Table 4: Synthesis of regional responses in Phase 1 (21 February, 2020, to 3 May, 2020).

	Phase 1				
	Measures for the management of services	**Linking measures between the health and social health sectors**	**Measures for the management of residents in home care and positive cases**	**Workforce management (safety and training)**	**Service review measures**
Lazio	✓	X	✓	✓	X
Liguria	✓	X	✓	✓	X
Lombardy	✓	X	✓	✓	X
Marche	✓	X			X
PA Trento	✓	X			X
Piedmont	✓	X	✓	✓	X
Emilia-Romagna	✓	X	✓	✓	X
Tuscany	✓	X	✓	✓	X
Veneto	✓	X	✓	✓	X

Table 5: Synthesis of regional responses in Phase 2 (4 May, 2020, to 3 June, 2020).

	Phase 2				
	Measures for the management of services	**Linking measures between the health and social health sectors**	**Measures for the management of residents in home care and positive cases**	**Workforce management (safety and training)**	**Service review measures**
Lazio	X	X	✓	✓	✓
Liguria	X	X	✓	✓	✓
Lombardia	✓	X	X	X	X
Marche	✓	X	✓	✓	✓
PA Trento	✓	X	✓	✓	X
Piemonte	✓	X	✓	✓	X
Emilia-Romagna	✓	X	✓	✓	✓
Toscana	✓	X	✓		X
Veneto	✓	X	✓	✓	X

the COVID-19 crisis were the most severe. They were analysed in accordance with the five categories based on policy objectives described earlier (see the Methods section).

With respect to guidelines for managing COVID-19 in nursing homes, the regions initially focused on arranging the closure of services (both in terms of suspending multiple activities and limiting physical access) and regulating the methods of entry to facilities in a timely manner. The focus was on the 'physical' containment of already existing situations and on the prevention of new outbreaks. Thus, regulations regarding PPE use and the safety procedures to be followed were emphasised. This was done by indicating standards and mandatory constraints, but little attention was paid to the operational and management methods of implementation. The Marche region, which provided checklists and operational guidelines designed for nursing homes, was an exception. Nevertheless, with regard to the operational management issue, it is interesting to note how some regions (e.g. Liguria and Tuscany) activated ad hoc task forces or operational units specifically dedicated to the management of COVID-19 cases to determine what had occurred in the individual structures. In some regions (Lazio, Lombardy, Piedmont), structural and operational requirements have also been envisaged for the creation of a 'COVID-nucleus' or, in other words, a centre for the management of symptomatic or positive guests.

None of the examined regions had adopted measures specifically aimed at coordinating the activities of hospital and nursing homes. Even in the case of Liguria and Tuscany, the operational units that they had created, which were responsible for coordinating between care settings, did not include the organisational supervision of the network as a whole in their primary objective. Therefore, this function was indirectly delegated to the local level. The management of the flow of patients and professionals between the network nodes was, in some cases, hindered, if not blocked by, for example, the prohibition of transfers to emergency rooms or hospitals. The objective was, therefore, the opposite of the one we investigated: instead of reinforcing coordination between settings, the aim was to isolate settings from one another.

With regard to the management of residents in home care and positive cases, there was a certain degree of homogeneity among the actions undertaken by each region. The first measures were aimed at blocking new entrances; subsequently (but not always promptly), guidelines and recommendations were implemented to identify COVID-19 cases and secure other guests in the facility. As a last resort, in places where access has been granted for specific purposes, triage and user profiling mechanisms have been introduced. The initiation of screening and swab use as a preventive practice started only at the very end of Phase 1. Among all the regions analysed, the Tuscan case was interesting: dedicated information flow was ensured to precisely regulate the procedure for responding to a suspected case.

With respect to specific measures directed towards personnel, the regions mainly focused on providing strictly operational and peremptory indications on the use of PPE without providing enough opportunity for training and preparation for emergency management. In this regard, there was variability between the more general information provided to the entire staff of the facility (e.g. Piedmont) and cases in which detailed information was provided to individual professionals (e.g. Tuscany). In this case, attention was paid to the issues of isolation and containment of cases, both by limiting movement and by using devices, without paying attention to how active the staff of the structures could and should be during the emergency.

With respect to measures aimed at the revision of specific standards (care standards, pricing methods, etc.), no initiative was recorded by any of the nine regions under investigation. During Phase 1, nursing homes were asked to practice the standard rules enforced prior to the COVID-19 pandemic, and no effort was taken to adapt them to the changed and extraordinary context.

In Phase 2 (from 4 May to 3 June), attempts were made to overcome the emergency containment phase and move towards preventative mechanisms and a gradual return to pre-outbreak functioning of services. This also happened in the LTC sector and was the subject of analysis for the same nine regions for which the measures adopted in Phase 1 were examined and discussed.

The primary focus has been on restoring 'normality' (i.e. pre-COVID-19), with dedicated regulations and indications for the reopening of spaces, the reactivation of visits, and the control and prevention of potential new cases in nursing homes. This was managed by reviewing structural requirements in terms of the number of guests (e.g. in Emilia-Romagna) or by working procedures for screening and swab testing. The case of Lazio is interesting. It adopted a process of reviewing care models for nursing homes and combining other health and social services to promote an integrated approach to service provision to older adults. Despite what had been experienced in the Lazio region, especially in Phase 2, no specific guidelines or indications were identified with respect to the connection between health sectors. Further, in Phase 2, this issue was not put on the legislative agenda of the regions. With respect to the definition of measures for the management of older residents in care and registered positive cases, various regions had adopted the reference standards adopted at national level. With reference to the measures targeted at personnel, a wide differentiation was evident in Phase 2. Generally, more attention was paid to training, albeit with different trends. Some regions (e.g., Veneto and PA of Trento) provided specific indications regarding the training of social and health sector personnel, thereby equating the training of social sector staff with that of health sector personnel and making the content and number of hours mandatory. Others, such as Lombardy, have instead assigned the responsibility of training to individual structures. In addition to training, numerous guidelines regarding the correct use of PPE and internal procedures for identifying suspected cases among staff members have been provided, in continuity with Phase 1.

With respect to possible service review measures for care standards, pricing methods, and related aspects, there was only one region that actively promoted a structured

initiative. Indeed, Emilia-Romagna implemented an extraordinary and temporary remuneration mechanism for all costs incurred from 20 March onwards for for vacancies resulting from the lack of recruitment of new residents. This guarantees structures and companies to cover part of the fixed costs incurred during the emergency period.

Discussion

The relationship between COVID-19 and the LTC sector and future challenges

COVID-19 had a significant impact on an already fragile LTC system. The main weaknesses of the LTC system (namely, fragmentation, challenges regarding coordination with the healthcare sector, questioning the vocation of the services, and inadequate allocation of resources, as described in the first section of this paper) appeared to be even more relevant during Phase 1. Extreme fragmentation had occurred. Specifically, facilities for older adults were completely isolated from a physical point of view (by virtue of the need to contain the disease) and with respect to access to information and support from the health and social health service network. The various nodes of the NHS found themselves operating in isolation without any attempts at coordination being institutionalised or formalised. Resources (PPE and personnel) dedicated to the sector were scarce, and no supportive investments were foreseen. The mission of the services, which were already weak, was further exaggerated: some structures for older adults found themselves operating as real COVID-19 hospitals, having to manage numerous cases within them but without being able to count on specific professional skills or the support of hospitals or specialised centres. Even in Phase 2, the inherent weaknesses of the sector persisted, and no efforts to cope with these were recorded. However, some positive signs were identified. They were related to specific issues such as coordination with the healthcare sector, the first attempts to connect different care settings (as promoted by Lazio), the attempt to adopt a systemic approach to overcome fragmentation, and the issue of the sustainability and management of funding, as promoted by Emilia-Romagna, which had introduced measures to correct the LTC funding system.

The COVID-19 outbreak also made policy shortcomings and the absence of a clear political discourse on the topic rather apparent. Phase 1 of the COVID-19 outbreak (late February 2020, to 4 May, 2020) was characterised by an emphasis on the containment of the emergency across different legislative levels (local, regional, and national). Initially, efforts were directed towards avoiding deaths and containing the spread of the virus, disregarding the effects of the pandemic on the LTC sector. The delay in intervention in LTC settings underscores the lack of attention paid to the LTC sector. Indeed, this temporal dynamic is emblematic: the initial priority was catalysed by the healthcare sector, and the issue of coordination with the LTC sector was not raised at all or was addressed at a much later time. What happened in Italy during the first pandemic peak in the spring of 2020 has to be interpreted as blatant neglect of the LTC system in terms of resource allocation. Workers were dangerously exposed to the severe acute respiratory syndrome coronavirus 2, and many had contracted COVID-19. Infected individuals were forced to quarantine at home, while others refused to work to protect themselves and their families. Failure to implement social distancing measures and a lack of PPE for workers dramatically increased patient risk of contracting COVID-19. This issue was confirmed by a previously recalled survey submitted by the ISS, wherein 86.8% of nursing homes had cited a lack of PPE as the most critical problem encountered during the crisis. Other issues were related to poor guidelines implemented to limit the spread of the disease, a lack of medical supplies, the absence of care workers, and the difficulty of promptly transferring positive patients to hospitals. All these factors contributed to the spread of COVID-19 in LTC facilities, thereby resulting in an inordinately high number of infected older persons and caregiving personnel and a high mortality rate (Bell *et al.*, 2020).

Nursing homes were (and continue to be) deeply affected by the pandemic. This happened as a consequence of the combination of systemic sectorial weaknesses and the impact of COVID-19. Funding mechanisms (based on occupancy rate and number of permanent residents) were not revised during the pandemic; consequently, variations in the number of guests in 2020 resulted in significant losses. Care providers are facing financial distress, and regional policies do not include recovery plans for them. The 'island effect' that nursing homes experienced during the COVID-19 outbreak was the result of the fragmentation of the Italian LTC system, wherein coordination between nursing homes and other healthcare settings is absent. This should be promoted at various institutional levels and not left to the initiative of individual nursing homes, which is what had happened. This is especially true for coordination between nursing homes and hospital care to manage complex patients and guarantee collaboration between health professionals and LTC staff. The COVID-19 pandemic exposed the actual profile of older nursing home residents and showed that they present with complex health conditions. Therefore, nursing homes should be perceived as being closer to the healthcare sector than to community centres, depending on the characteristics of their residents. In addition, the pandemic raised awareness about care-related workforce problems, specifically contractual conditions, inadequate training, and increased emotional distress. Shortages within the care-related workforce need to be tackled in the future to support the revival of nursing homes and ensure service quality.

Finally, as in other countries, in Italy, there has been a lack of data concerning the relationship between the LTC sector and COVID-19. This is rooted in the systemic absence of data for this sector. Therefore, to facilitate effective policy-making in the future, improvements to evidence-based data-collection systems are needed.

Conclusion

It is often said that every crisis brings new opportunities, and this might be the case for the LTC sector, as a result of the COVID-19 outbreak. This article focused on the case of

the Italian LTC sector to delineate how pre-existing weaknesses were exacerbated by the pandemic. The visibility and relevance of the LTC sector in the public and policy discourse, the funding crisis, fragmentation at different levels of the government, challenges in coordinating between the LTC sector and other health care settings, the evolution of nursing homes into systems with different typologies of care services and caregiving workforce shortages, are all issues that are common to LTC sectors in many Western countries and will be core elements for future development in this sector (Lapré *et al*., 2019). The Italian experience of the COVID-19 pandemic described in this article shows that the underestimation of LTC challenges can lead to significant losses (both in terms of the quality of care and the sustainability of the system). At the same time, this article has also demonstrated that the pandemic per se is not the only source of criticalities and that systemic failures need to be addressed. Hopefully, 2021 will be the year in which important reforms are enacted, and these need to be oriented towards the middle term.

Amid the ongoing pandemic, it is crucial for Italy and other countries to reflect upon the challenges that should be considered to guarantee the functioning of the LTC sector in the future so that it is able to face the next global emergency that threatens older persons.

Notes

[1] Data on monetary transfers have been excluded to minimise double counts of service users (e.g. a person benefitting from both municipal home care service and pocket money).

[2] Data concerning users include home care services, which were not represented in the column 'public offer' as the supply is quantified in the number of hours of care provided. See the text for further details.

[3] https://www.epicentro.iss.it/coronavirus/pdf/sars-cov-2-survey-rsa-rapporto-finale.pdf.

[4] DPCM 14/2020. https://www.gazzettaufficiale.it/eli/id/2020/03/09/20A01558/sg. Disposizioni urgenti per il potenziamento del Servizio sanitario nazionale in relazione all'emergenza COVID-19.

[5] https://www.ecodibergamo.it/stories/bergamo-citta/carnevali-arrivate-mascherine-nella-notteaiuto-alle-strutture-andiamo-avanti_1344722_11/.

[6] https://it.reuters.com/article/idITKBN2161IV.

Competing Interests

The authors have no competing interests to declare.

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