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Policy design and state capacity in the COVID-19 emergency in Italy: if you are not prepared for the (un)expected, you can be only what you already are

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ABSTRACT

Italy was the first large epicentre of the COVID-19 pandemic in the Western world. Since the country has not had any serious experience with this kind of disease in recent decades, its response has been indicative of a first reaction to an (un)known and (un)expected event. At the same time, the Italian experience is an emblematic case of how a lack of specific preparedness measures drives a country to deal with this kind of crisis through a process in which the existing characteristics of the policy and political system, with all their pros and cons, prevail. This means that the existing country characteristics that affects policy design, state capacity, institutional arrangements and political games forge the process and content of the response. Based on this observation, this paper analyses the policy dynamics of the first four months of management of the COVID-19 outbreak in Italy, focusing on how the health and economic responses were designed and implemented.

KEYWORDS

COVID-19; Italy; policy design; state capacity; experts; path dependency; policy style

1. Introduction

COVID-19 has been a veritable tsunami that most countries were not prepared to handle. Surely, in the future, there will be dense empirical research to explain why most, if not all, Western countries went through the same problem-recognition process before reacting effectively to the outbreak: denial ('it is not truly happening'), normalisation of the risk ('it will not happen here'), underreaction ('we must do something to show that we are doing something'), recognition and reframing ('it is here, and it is our problem!'), and finally, real and concrete responses in line with prevailing epidemiological orthodoxy.

This process clearly highlights how the level of pandemic preparedness – e.g., pre-existing protocols to isolate hospitals and care facilities, develop testing and tracing capabilities and stockpile personal protective equipment (PPE) – and the presence or absence of recent outbreak experience influenced COVID-19 pandemic management around the globe (see the introduction to this issue). On the one hand, a strict containment path was followed by a few prepared and experienced countries, such as South Korea, Hong Kong, Taiwan, Australia and New Zealand, that were able to minimise the transmission of the virus. On the other hand, countries that were less prepared and less

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capable of containing the virus and that focused instead on trying to slow down its effects on the health system and the mortality rate followed the mitigation path. The latter path was the path taken by most countries in the world, and Italy, as the first country where the outbreak exploded outside Asia, was the frontrunner of this approach. Although ultimately successful in getting a handle on the disease and stopping its spread, it was also one of the worst-hit countries (almost 233,019 cases and 33,425 deaths as of 31 May).

In such cases of unpreparedness and a lack of recent pandemic experience, it is expected that the health response, as well as responses to the socio-economic effects of the pandemic, will be strongly influenced by the most relevant existing political and policy characteristics of the country's governmental system. Although this path dependency could undergo shifts in the case of a specific contingency due to external factors or unexpected agency, such shifts may or may not happen. Thanks to the reconstruction of the policy dynamics of the first four months of the crisis, this paper shows that this shift did not happen in the Italian case and that the actual characteristics of the existing health policy design and state capacity, the existing institutional arrangements and a penchant for political gamesmanship in the Italian system strongly drove the process and content of the country's COVID-19 response. Thus, the Italian case shows how, without preparedness and recent relevant experience, the extant, rooted policy style – intended as “set of political and administrative routines and behaviours, heavily influenced by the rules and the structure of the civil service and political system in which it is located” (Howlett & Tosun, 2019, p. 10) – definitively prevails.

The second section of the paper presents the main policy and political-institutional characteristics of policy design in Italy. In the third section, the response process, the main health emergency interventions and their socio-economic impact are described. The fourth section focuses on the roles and interactions of the main actors and their policy dynamics. The fifth section considers the main initial results of the management of the crisis. The conclusion assesses the overall process and offers possible generalisations from the Italian case regarding how countries might prepare for the (un)expected in the future.

2. The path of the Italian COVID-19 response

2.1. The path to unpreparedness

Italy has a high-risk profile in terms of natural hazards; earthquakes, floods, volcanic eruptions, storms and storm surges and land subsidence have continuously punctuated the history of the country. To deal with these structural problems and develop risk management policies, a national civil protection system was established in 1992. This system is coordinated by the government through a specific bureaucratic structure, the Department of Civil Protection, which has been assessed very positively in terms of its monitoring activities and first response operational capacities, especially related to earthquakes (OECD 2010). The Department of Civil Protection works together with various national and local institutions and is supported by significant volunteer efforts (Lucini, 2012). It was this Department that was charged with managing the COVID-19 outbreak.

In terms of the management of health-related outbreaks, however, Italy had not faced this kind of emergency for half a century. The last pandemic that seriously affected the

country was the H3N2 ('Hong Kong flu') outbreak, which occurred in two waves, in 1968 and in 1969, and killed approximately 20,000 people. Subsequent pandemics only marginally affected Italy; the SARS outbreak in 2003 led to four cases, while the H1N1 outbreak in 2009 killed in Italy 229 people (out of 229,000 cases). Regarding epidemic management strategies in Italy, a national plan against pandemics was issued in 2005. The national plan was very detailed and well done. However, it was never updated, and most of its relevant guidelines (including the provision on stocking up on PPE) were never implemented at either the national or regional level even though the plan assigned very specific pandemic preparation duties to each region.

2.2. The governance arrangements of Italian regionalism and its implications for health policy

The response to any crisis within a nation is rooted in the governance characteristics of that jurisdiction. Unlike Italy's 'national' level coordination of agencies in terms of crisis management (disasters, earthquakes, etc.), in the case of the COVID-19 pandemic, the regional institutional arrangements of the Italian state emerged as a key dimension affecting the nature of the government response. In fact, the outbreak was affected by the dynamics of Italian regionalism in a very critical way; after 2001, constitutional reform gave more concurrent legislative powers to the regions due to the various ambiguities contained in the reform, a jurisdictional conflict between the state and the regions occurred. Furthermore, in recent years, capitalizing on those same constitutional provisions, the northern regions (the richest ones in the country and the ones most affected by the pandemic) continually requested and obtained more autonomous powers (Baldi, 2019; Giovannini & Vampa, 2019). Moreover, the way that Italian regionalism was designed in 2001 has had a relevant impact on health policy because the reform of the Italian health system has been highly decentralised as a result. This means that while the national state is in charge of formulating general guidelines, allocating funding and ensuring essential levels of assistance (LEAs), 20 regions have complete autonomy in organising and managing health care services in their territories (Fiorentini, Lippi Bruni, & Ugolini, 2008; Toth, 2015). The high degree of decentralisation implies that key activities are organised very differently from region to region, and this was exactly the case with the COVID-19 pandemic (Nutti, Vola, Bonini, & Vainieri, 2016).

Another relevant point in terms of the governance arrangements of health policy concerns the role of the central government in a pandemic. From a legal point of view, both the primary legislation and the Constitution guarantee its supremacy. However, the fact that the regions have constitutionally guaranteed powers for organisational and managerial matters makes the concrete exercising of state supremacy in an emergency dependent on the regional legislation for its implementation. This vicious circle of legislation could be a problem during a pandemic (and this indeed happened in the case of Italian response to COVID-19).

Finally, it must be emphasised that Italian regions operate on presidential systems, while national government seats are secured through a parliamentary system. This asymmetry favours the tendency of regional presidents to politicise many issues because of their direct popular legitimation and electoral fortunes.

2.3. Characteristics of policy design and state capacity

When a response to an unexpected crisis is needed – and there is no previously prepared plan that can be followed immediately, or there is one, but it has been neglected or forgotten, as in the Italian case – the government’s governance characteristics clearly matter, as does the state’s capacity to determine what responses are chosen. State capacity can be operationalised in terms of the government’s capacity to implement its decisions. Comparative assessments using worldwide governance indicators all show that Italy has only a moderate-to-low capacity level and has had an evident decrease in this capacity in the last 20 years (World Bank, 2020). Furthermore, in terms of executive capacity, the Italian score is lower than the scores of most other European countries (BertelmansStiftung, 2018). This low score is due to the many ineffective public administration reforms over the last decades that have been unable to overcome the traditional, highly legalistic characteristics of Italian administrative behaviour (Capano, 2003; Di Mascio & Natalini, 2014, 2016).

Furthermore, low state capacity also affects policy design characteristics. Here, we can view the Italian case according to recent policy design studies that propose that good policy design is characterised by the capacity of policy formulators to base their decisions mainly on evidence-based knowledge, learning, clear goals, and consistent and coherent policy tools (Bendor, Kuman, and Siegel, 2009; Howlett, 2014; Howlett, Mukherjee, & Rayner, 2014; Radaelli & Dunlop, 2013; Sidney, 2007) and by the government’s political capacity or will to make or accept decisions in this manner (Capano, 2018; Capano & Mukherjee, 2020; Howlett, Mukherjee, & Woo, 2015).

The Italian case appears particularly problematic in this area. In fact, Italian policies are often incoherently or inconsistently designed (Capano, 2018; Capano & Pritoni, 2016) because an insufficient amount of evidence-based information is gathered and mobilised due to the undeveloped and often politicised nature of the Italian policy advisory system. However, while this gap can vary according to the policy field (and health policy is usually at the higher end of the evidence-based category), the government’s political style is generally uniform and covers all policy fields.

Political capacity herein refers to the strength and effectiveness of a government in its decision-making and policy formulation and implementation processes. This capacity is widely recognised as being dependent upon the nature of institutional arrangements and their interaction with the structure and dynamics of the party system (Capano, Regini, & Turri, 2016; Xun, Howlett, & Ramesh, 2018). This property is both structural and contingent in the sense that it can change across time. This can be seen in recent political developments in Italy that have led to the rupture of the bipolar dynamics of the last three decades and the rise of populist parties, thus creating novel and highly contradictory and conflictual governmental coalitions with very different policy agendas. These events have reduced the government’s political capacity by affecting its ability to find sufficient consensus for coherent policy design.

In addition, the growth of populism has caused a significant shift in Italian political discourses, which have become characterised by the extreme demagogic framing of every policy issue and the prevalence of ‘blaming’ political rivals for any missteps (Blokker and Anselmi 2019). This way of framing policy issues represents an intrinsic barrier to evidence-based policy making and places significant constraints on the policy-making

process. This is very relevant when managing a crisis because, as Boin, ‘T Hart, Stern, and Sundelius (2005, p. 103) point out:

“when efforts to investigate crises turn into blame games, truth finding through dialogue and debate loses out against defensive rationalisation (‘we made no mistakes’), deliberate silences, and factual distortions. As a result, democratic accountability is perverted, and institutional learning capabilities are impaired”.

3. The delayed process of developing a proper response

3.1. Denial and normalisation of the risk: state of emergency without action and political games

The dynamics of the reaction to the COVID-19 crisis in Italy were first influenced by the political and social denial of events in China. This denial was a common characteristic of most Western governments at the time. There is a great deal of research on how and why crisis denial (and its sibling, wishful thinking) can prevail as the first framing mechanism under conditions of uncertainty (Jervis, 1976; Lebow & Stein, 1994; Perrow 1999; Parker & Stern, 2002). Specific organisational characteristics can also favour the activation of this mechanism as a crisis emerges (Boin et al., 2005). In the Italian case, the denial should be contextualised. Specifically, the situation can be characterised by two structural factors and one contingent factor. The two structural factors were as follows:

- The national pandemic plan had been forgotten, so all of the procedures for dealing with the news from China had to be reinvented (unpreparedness).
- Italy had not had a similar serious outbreak in recent years (inexperience).

The contingent factor was the radicalisation of the political discourse due to a very conflictual political situation in which the issue of COVID-19 immediately became caught-up in a blame game between the government and the opposition (Vicentini & Galanti, 2020)

After this initial period of denial, there was a shift to the ‘normalisation’ of the risk. On 27 January, four days after the Chinese authorities implemented a lockdown in Wuhan, the Italian Ministry of Health suggested a low-to-medium-level protocol for monitoring the eventual transmission of the virus (the guideline aimed only to control symptomatic patients who had had some contact with China). This decision was the first signal that ministerial consultants and the National Health Institute (NHI; Istituto Superiore di Sanità) had decided to follow the somewhat ambiguous and ‘normalised’ guidelines issued by the World Health Organisation (WHO) at the beginning of January.

Thus, the Italian government accepted only the notion of a low level of risk, and the situation was officially declared to be under control or ‘normalised’. Even the declaration of the state of emergency (31 January), after the first two cases (Chinese tourists) were detected in Italy, can be considered an action taken to show the public that the government was completely in control (and in compliance with international norms after the World Health Organization (WHO) declared on 30 January that the COVID-19 outbreak was a public emergency of international concern). In declaring the state of emergency,

the Italian government appointed the Chief of the Department of Civil Protection as a commissioner to coordinate the management of the emergency. From 31 January to 20 February, when the first local Italian cases were discovered, only minor bureaucratic actions were taken, along with disruptive actions initiated by political polemics, such as when the centre-right regional presidents asked for the quarantining of Chinese students living in Italy who had recently returned from China. There is no empirical evidence that the regions actually implemented their regional pandemic plans – which had not been updated since 2010 – as requested by the Ministry of Health on 22 January.

3.2. Recognition and reframing

On 20 February, the first local case of COVID-19 was diagnosed in Codogno, a town in Lombardia, thanks to a doctor who decided not to respect the protocol established on 27 January by the Ministry of Health and instead tested a problematic patient, notwithstanding the fact that he had apparently had no contact with China. Between 20 and 21 February, almost 20 cases were diagnosed. On 21 February, the date of the first COVID-19-related death in Italy, the Ministry of Health, acting under the authority of the president of Lombardia, ordered restrictions on movement in 10 municipalities in the region. At this point, however, the number of cases started to increase, and the government soon declared red zones in 10 municipalities in Lombardia and one municipality in Veneto on 23 February. This date can be considered the point when there was official recognition that the virus had taken hold in Italy. However, the process of reframing the problem still took slightly more time.

First, the government started with what can best be defined as an incremental strategy to mitigate the transmission of the virus. Only on 11 March – when the high speed of the transmission was close to overwhelming the hospitals' capacities – was a national lockdown established. It was tightened on 22 March with the closure of all essential productive activities, and on 20 March, a second commissioner was appointed and charged with reinforcing the health care infrastructure. This incremental process was accompanied over the period of 20 February–7 March by another round of political games in which the opposition leaders first requested the reopening of the locked zones in Lombardy and then requested closures throughout the country.

Figure 1 summarises the most relevant national measures aimed at mitigating the outbreak.

Only with the 11 March presidential decree (the stay-at-home decree) was the process of reframing completed. This occurred three weeks after the first local case (40 days from the first so-called imported cases) and the first death and 40 days after the declaration of the state of emergency, emphasising the weak and slow nature of the Italian response to the pandemic. However, by 11 March, the total number of cases was almost 12,550, and the number of deaths was 827. Thus, it was absolutely clear that the curve was rising very quickly and that there was a risk that medical facilities, especially emergency care units, would be dramatically overwhelmed. As a result, the government then moved much more quickly and strongly to deal with the problem.

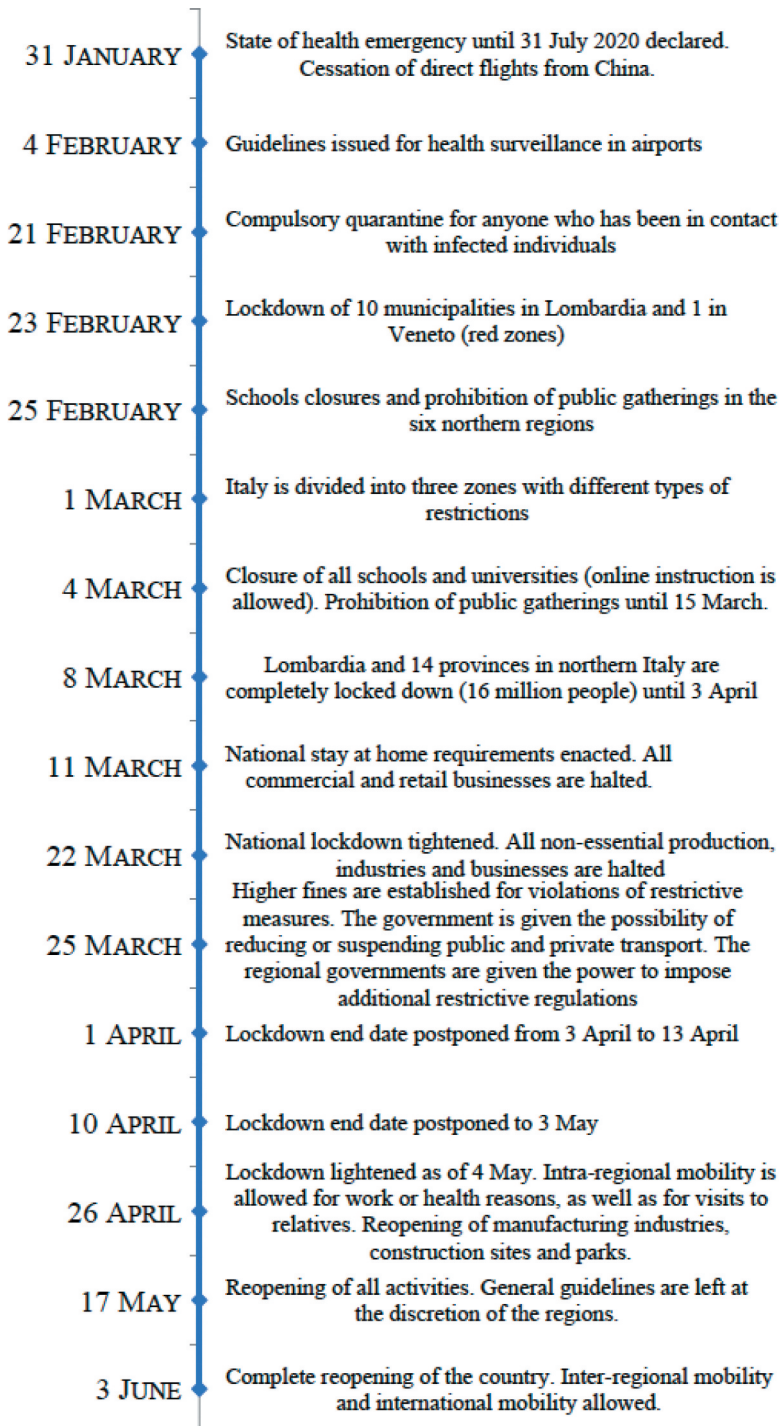


Figure 1. Timing and content of the main mitigation decisions at the national level (lockdown and reopening processes). Source: author's elaboration.

3.3. A flood of measures

The response to COVID-19 has been very dense in terms of decisions at the national level. Between 22 January and 31 May 278 crisis-related regulations were issued by 20 national authorities (see Figure 2). The majority of them were made by the Ministry of Health, the Civil Protection Department, the Ministry of Interior, and, obviously, the President of the Council of Ministers.

Significantly, this flood of national measures was accompanied by another flood of measures from regional governments. Most of these measures were focused on addressing and managing the mitigation effort, while socio-economic recovery measures were the focus of two decrees issued in March and May.

More time is needed to code all of the measures contained in the national decisions. However, it is clear that most of the mitigation measures were adopted via regulatory instruments, exercising government authority to restrict individual behaviours and the working of specific public institutions. The main instruments used included zoning measures, school closures, workplace closures, public event cancellations, public transport limitations/closures, public information campaigns, internal movement restrictions, social and physical distancing, smart working, the use of protective masks, and international travel controls. Furthermore, these tools were accompanied by instruments for data collection, monitoring and preventing the collapse of hospitals (the so-called 3Ts: test, trace and treat). Finally, regulations related to reopening the country began to take effect on 18 May; most of them formally required physical distancing in public venues and on public transport or addressed hygienic actions and the use of masks. Along with these types of authoritative instruments, some financial instruments were also used to reinforce the health system response (e.g., funding to buy ventilators and PPE for health personal and common citizens and for the hiring of additional doctors and nurses).

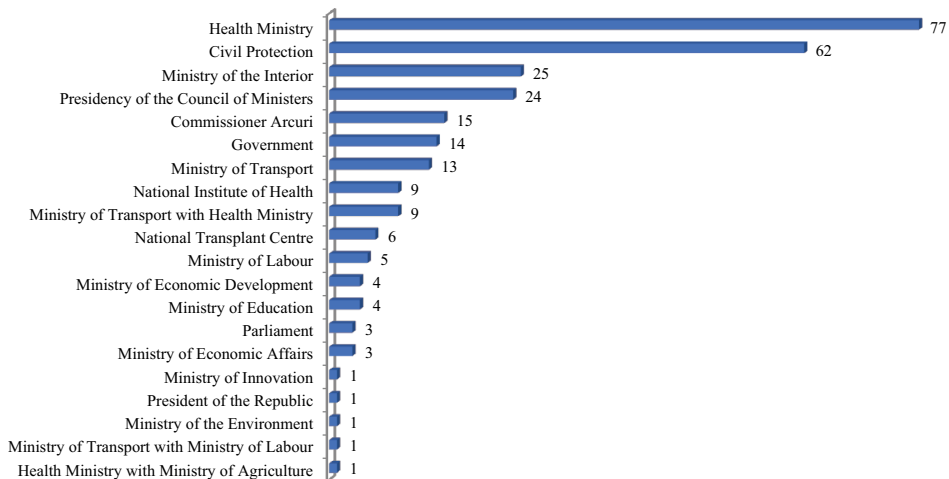


Figure 2. Measures approved by national authorities for mitigating COVID-19 and for recovering from its socio-economic effects.

Source: *OpenPolis* data (www.openpolis.it)

The sequence in which the authoritative instruments were used varied over time. During the acute phase of the pandemic, Italy enacted measures at the national level in the following sequence:

- international travel controls and closures
- bans on public events and gatherings
- school and university closures (with the subsequent decision that they would remain closed until at least the end of August)
- partial lockdown (partial closure of some commercial activities, public transport limitations, severe restrictions on individuals' intra-city movement, restrictions on inter-municipality and inter-regional movements, smart working)
- complete lockdown (everything closed, except for necessary production activities, and a drastic reduction in public transport)
- rules for the 3Ts (to be implemented at the regional level).

All of the restrictions on individual mobility were compulsory; therefore, they were sanctionable. As shown in [Figure 1](#) above, the reopening efforts were then divided into three stages:

- 4 May: construction firms and sites reopened
- 18 May: all activities reopened in accordance with specific rules (physical distancing, hygiene routines, the use of masks, and suggested ambient temperatures as well as, when possible, the adoption of smart working) and intra-regional mobility allowed
- 3 June: international travelling and inter-regional mobility finally allowed.

It must be emphasized, however, that the regions have high levels of autonomy in implementing these reopening measures.

Regarding the lockdown zones, it is interesting that, initially, only the aforementioned small red zones were completely closed. Then a regional lockdown was adopted only a few days before the national lockdown. The former then distinguished among the original small red zones, the regions where they were located, and the rest of Italy (three different types of zones). Thus, the Italian government adopted a very incremental strategy that was disproportionate to the speed of the virus's transmission and a very precautionary approach to reopening the country to reverse the two lockdown types.

Regarding the measures taken to mitigate the socio-economic impact of the pandemic, the government issued two decree laws, one in March and one in May, widely distributing 80 billion euros as subsidies. This included 'helicopter' money; public guarantees for loans; extra funding for health, education, higher education; furloughs; tax credits; and the postponement of fiscal deadlines. All of these were intended to maintain the country's macro-economic purchasing power and stability. Furthermore, a fundamental regulatory instrument, a prohibition on dismissing workers, was adopted with the same intention.

The distributive nature of these economic measures was stigmatised by many observers. Preferring more targeted approaches, they underlined that the content of the measures was based only upon the goal of compensating and supporting every interest and pressure group without any strategic commitments and with a very low capacity to actually relaunch economic activities. Here, the low political capacity of the government was manifestly obvious.

3.4. Timing of the intervention design and problematic implementation: the prevalence of the policy legacy

As the introduction to this issue has noted, timing is very important when designing and implementing interventions to fight pandemics. The most relevant decisions made by the Italian government in relation to the mitigation of the COVID-19 outbreak were characterised by an incremental strategy (as already underlined, several small steps were taken before a complete lockdown of the country was established).

In fact, all of these decisions were characterised by dilatory timing, meaning that the government only informed the public about each next step a few hours before the relevant new regulations entered into force. Furthermore, the final reopening plan was not based on a real design for implementing an effective 3Ts strategy, and the contact-tracing app intended for this was still not at disposal of citizens four weeks after the first reopening measures were enacted. The incremental process towards the complete lockdown and its poor timing are indicators of the low political capacity of the government. The major economic interests of the country exerted much pressure against a complete lockdown, for example, and the government itself displayed only very weak confidence in what should be done.

Many of the response measures also faced numerous implementation problems due to the state's weak administrative capacity. As in other Western countries, for example, for weeks, the purchase of PPE for health workers was very problematic. Many of the economic and financial measures that were approved to support and sustain people also encountered long administrative delays, i.e., subsidies did not reach the people for months. The implementation of the 3Ts (approved at the end of April) also did not effectively start until mid-June (at the time of writing, no one had been hired yet to perform contact tracing, and the app chosen for tracing is set to be working nationally by mid-June at the earliest), except for in a few selected regions (Veneto and, partially, Emilia Romagna). Furthermore, many of socio-economic measures had to follow existing sets of rules and procedures, which are well known to carry a lot of red tape and involve many formal review and approval steps that are not ideal in an urgent situation.

Notably, these 'normal' administrative procedures and processes have represented a structural constraint on the rapid implementation of the socio-economic measures designed in response to the outbreak, as is expected in an epochal emergency such as the COVID-19 pandemic. This is perfectly illustrated by the 'Relaunch' decree law issued on 19 May, which allocated 55 billion euros to start the process of economic recovery. To reach its full potential, 92 additional ministerial regulations need to be approved. As is well known to scholars of Italian public administration, the more regulations that are needed to implement a law, the greater the chance of the implementation being delayed or only partially completed (Capano, 2003; Cassese, 1993; Di Mascio, Natalini, & Ongaro, 2017).

4. Decisional dynamics: inter-institutional conflicts and the massive involvement of experts

The decisional dynamics during the four analysed months of the management of the COVID-19 crisis were characterised by continuous puzzling about what to do and how to do it. This puzzling was, to a certain extent, normal and expected in a catastrophic crisis

but was exacerbated in the Italian case by being persistently punctuated by inter-institutional conflicts between the central and regional governments and by the massive involvement of experts from both levels of government who generated contradictory advice on what courses of action should be followed.

4.1. Inter-institutional conflicts

From the outset of the emergency, it was clear that the Italian institutional system would have serious issues coordinating between the central and regional governments. In fact, notwithstanding the legislative supremacy of the national government in the event of a pandemic, the high degree of organisational autonomy of the regions in health care matters and the institutionalised conflict between state and regional policies were clear sources of coordination problems in both the pre- and post-outbreak periods.

That is, the outbreak occurred in a very complex, even confused, institutional context that has shown all of its shortcomings and gaps when dealing with the pandemic. Importantly, the inherently conflictual characteristics of the institutional arrangements of Italian regionalism were exacerbated by the asymmetric spread of the pandemic in the country; the outbreak primarily hit the northern regions, while it seemed to be contained in the southern ones. This imbalance created friction in the state/regions conference (the institutional body devoted to coordination and negotiation between the national and regional governments). Furthermore, the hardest-hit region, Lombardia, is ruled by opposition political parties and is the real economic motor of the country.

In this context, the weak national government (due to the many cleavages dividing the political parties of the ruling coalition) has behaved in a very erratic way, showing weak or at least varying levels of decisiveness. Initially, the national government made decisions without truly consulting the regions, as seen by the 8 March decree that locked down Lombardia and 14 other provinces in the north. Then, the national government started to negotiate everything with the regions, leading not only to very confused institutional communication but also to many decision-making mistakes in terms of content and timing. For example, the content of the 17 May decree, which established the reopening process, was officially communicated without clear agreement with the regions; after his speech, the premier had to negotiate all night with the presidents of the regions to gain their approval.

Furthermore, this complex and weakly cooperative regionalism forced the government to appeal to the courts regarding a few regions that made decisions against the national guidelines. At the same time, concurrent competences created confusion when the urgent establishment of the red zones was eventually considered necessary.¹

The actual institutional arrangements of Italian regionalism have also been shown to be unfit to deal with dramatic problems, such as an asymmetrically spreading pandemic that, as shown in [Table 1](#), has been particularly destructive in northern regions.

¹The most emblematic case is that of the municipalities of Alzano and Nembro (in the province of Bergamo, Lombardia), which had such a substantial increase in the number of cases that the TSC suggested on 2 March that these areas be locked down. The 'blame game' between the national and regional governments delayed this decision for one week, which had terrible effects in terms of the control of the outbreak at the local level.

Table 1. Distribution of total cases, active cases and deaths in the twenty Italian regions as of 31 May 2010.

Region	Total Cases	Cases/ 100,000 Pop	Active cases	Active/ 100,000 Pop	Deaths	Deaths/ 100,000 Pop
Lombardy	88,968	884	20,996	209	16,112	160
Piedmont	30,637	697	5,161	117	3,867	88
Emilia Romagna	27,790	623	3,163	71	4,114	92
Veneto	19,152	390	1,500	31	1,918	39
Tuscany	10,104	270	1,111	30	1,041	28
Liguria	9,663	617	669	43	1,465	94
Lazio	7,728	131	2,983	51	735	12
Trentino A.A.	7,027	661	371	35	753	71
Marche	6,730	438	1,328	86	997	65
Campania	4,802	82	980	17	412	7
Apulia	4,494	111	1,177	29	504	12
Sicily	3,443	68	986	19	274	5
Friuli V.G.	3,273	269	278	23	333	27
Abruzzo	3,244	245	775	59	405	31
Umbria	1,431	161	31	3	76	9
Sardegna	1,356	82	185	11	130	8
Valle d'Aosta	1,184	933	15	12	143	113
Calabria	1,158	59	144	7	97	5
Molise	436	140	145	47	22	7
Basilicata	399	70	29	5	27	5
Total Italy	233,019	384	42,027	69	33,425	55

Source: Author's elaboration on data of Dipartimento della Protezione Civile

The process and content of the decree on the rules for reopening offers the best and most definitive evidence of this. In fact, the government (following the advice of the NHI and the Technical and Scientific Committee (TSC)), with the support of some regions, initially wanted to design a differentiated reopening process based on the degree of regional impact of the outbreak and wanted to be very restrictive, especially in terms of the minimal distances to be respected in restaurants, bars, shops, etc. However, on both issues, the government's position was defeated. The time-differentiated reopening strategy was substantially vetoed by Lombardia, and the final guidelines established only some common minimal rules for reopening, which each region can ease or strengthen according to its own context. Additionally, the technical proposal on minimal distances was rejected in favour of a proposal presented by the majority of the regions, which halved the distance required in the original proposal. Overall, after four months of continuing conflicts, the national government decided to charge the regions with the main responsibilities involved in future outbreak-related developments and transmission monitoring during the reopening phases.

Surprisingly, however, the fragmentation and chaotic dynamics of Italian regionalism did have some positive effects, as the mitigation strategy chosen by the government had some contradictions. In fact, the organisational autonomy of the regions allowed for the sharing of some best practices, especially in Veneto, which immediately adopted effective mass testing and tracing practices (Lavezzo et al., 2020). In Emilia-Romagna and Tuscany different and more successful strategies were followed respect to those indicated by the national government, as well as in some southern regions that had to deal with massive transfers of people working or studying in northern Italy. Regarding the Northern regions, the more hit from the pandemic, it emerges clearly of the different organization of the regional health system (in terms of level of distribution of the delivery services

within the territory) has been the determinat driver in defending the hospitals from the risk of overwhelming (Pisano, Sadun, & Zanini, 2020).

4.2. Weak governmental confidence: the multiplication of experts and task forces

The absence of real preparation and real enforcement of the national/regional pandemic measures obliged the main institutional actors – the national and regional governments – to behave in a very disoriented way, at least during the first weeks of the outbreak, and to progressively involve different types of experts. In Italy, the NHI is the official governmental advisor on health policy. However, on 5 February, a new committee, the TSC, was established; it was composed of seven people in the top organisational positions in governmental and health institutions (the number of members increased to 25 in the next two months as experts in various medical fields were added). The TSC (including the NHI president) was in charge of advising the Department of the Civic Protection and was the main governmental advisor throughout the COVID-19 outbreak. As such, the committee can be considered the real leader for most of the four months under analysis.

Both the NHI and the TSC closely followed the guidelines of the WHO, which not only delayed its declaration of a pandemic (until 11 March) but also waited until mid-April to underline the relevance of testing and tracing for tracking the progression of the pandemic. In addition, the WHO was very ambiguous for a long time about the role of masks in preventing transmission. Thus, until the end of February, the NHI and the TSC played a major role in normalising the risk and gave suggestions that, in hindsight, have proven to be misleading (especially regarding transmission-monitoring guidelines and the use of masks by citizens). When the outbreak exploded after 20 February, these two national advisory bodies assumed very precautionary roles and were the main actors behind the governmental strategy to incrementally lock down the country. While many observers have indicated that these two bodies were the real leaders during most of the analysed period, it is very clear that many of their suggestions and advice were ignored when the issue at stake was deciding when and how to reopen the country.²

The composition and, above all, the establishment and role of the TSC can be considered to be as expected – because, in a pandemic, it is logical that governments have a committee of experts to help them understand what the situation is and how the so-called enemy should be dealt with. However, surprisingly, the COVID-19 crisis also saw a very unusual explosion in the number of expert committees and task forces. At the national level, 15 task forces were established (comprising more than 450 people). Among them were several very interesting ministerial cases. The Ministry of Education established two task forces, one to manage the emergency and the other to organise the post-emergency situation; the Ministry of Justice also established two task forces, one to manage the COVID-19 problem in prisons and the other to address the impact of the emergency on the judicial system; and the Minister for Innovation and Technology established a 76-person committee to choose a contact-tracing app. Finally, a task force was established to propose a socio-economic strategy for the future recovery and development of the country.

²The TSC has been expressing many doubts about a fast, complete reopening of the country in many official documents.

This flourishing of advisory committees and task forces was unusual and indicates the decision-makers' level of uncertainty about the present and future. It can also be considered a reliable indicator of the weak confidence the government has in managing not only the health side of the emergency but also all of the other real and potential outcomes. It has been well established in the literature that a major crisis leads to significant opportunities for what is perceived as evidence-based policy making; thus, the input of experts is considered a fundamental need in making decisions in the most rational and informed way (Cairney, 2016; Rosenthal & Hart, 1991). Experts can also be a powerful tool for legitimising the decisions made by the government. Meanwhile, there are risks of weakening democratic accountability, because it is no longer clear who is of charge of what, since decision-makers can present some decisions as inescapable based on the recommendations of experts. However, in the Italian case, we can distinguish between the role of the expert committees dealing with the health emergency, i.e., the NHI and the TSC, and those dealing with many other policy issues.

The NHI and the TSC demonstrate all of the characteristics proposed by the literature regarding the role of experts in pandemics: doctors, epidemiologists and virologists have long been the most reliable and trusted actors, and until the government shifted its activity to making decisions about the reopening, their suggestions were transformed directly into decisions. However, as already underlined, these entities were also powerful drivers of the failed strategy of the normalisation of the risk until 20 February. This happened despite the presence of other experts outside the institutional circuit who offered different views and claimed that the virus was not truly under control and that there was the risk of serious damage. This normalising behaviour helped reinforce the natural denial that decision-makers feel about the risk of uncertainty and of encountering into the unknown. Obviously, there is the question of why the NHI and the TSC fell into the trap of normalising the risk. In this case, the usual precautionary clause probably applies, and the two bodies were cautious of the risk of creating a panic about something without sufficient scientific evidence or results from epidemiologic models.

However, at the same time, the NHI and the TSC played a fundamental role in setting the standard for how tests were administered until the end of April (only to those with symptoms). This choice has been criticised by many other experts in the country (as well as based on the experience of the Veneto region, where, following the advice of other experts, testing and tracing has been implemented since the end of February). This dynamic opened a large debate about whether institutionalised experts are more prone to assume incremental positions. In the Italian case, for example, it was well known that it would have been impossible to perform many tests during the first weeks of the outbreak because of a lack of reagents. However, with hindsight, it has been determined that reagents could have been produced internally, such as by university laboratories. What emerges from this analysis is that compared to other expert networks, these two pivotal expert committees operated with a certain degree of impermeability and were, to some extent, controlled by their bureaucratic masters.

However, after reframing the problem, the NHI and the TSC both focused on social/physical distancing as the core of every mitigation strategy and were quite rigid on this position when addressing the reopening issue.

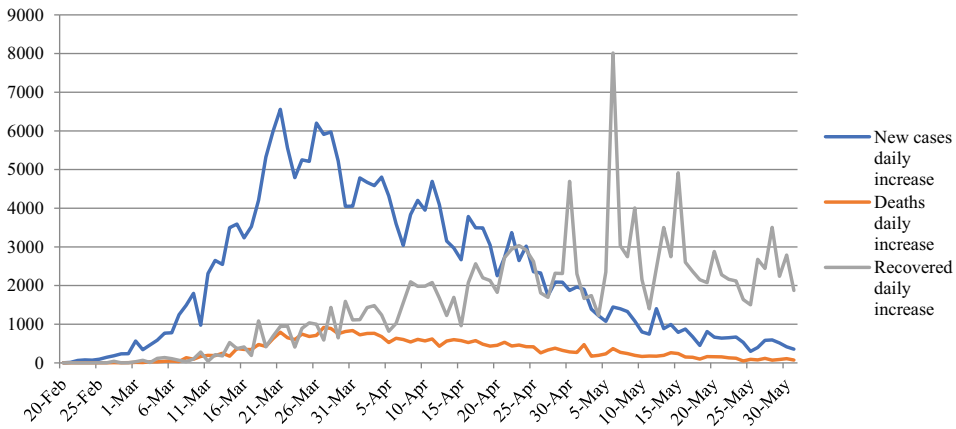


Figure 3. Daily trend of the pandemic in Italy (20 February–31 May 2020).
Source: Author's elaboration on data of Dipartimento della Protezione Civile

Other expert committees have operated very differently; however, this raises questions about the nature of policy advice during an emergency. First, while it may be reasonable to establish a specialised committee on health issues during a pandemic, it is not very clear why so many and such large task forces were formed around so many different issues and topics. What seems to matter in the decision to establish such committees are the characteristics of the decision-makers. The ruling government was composed of many ministers with a substantial lack of experience and very short political careers, thus, they were not used to making either strategic or drastic decisions. Consequently, they preferred to share the responsibility, and the eventual blame, with as many experts as possible.

4.3 Results

Despite all these problems, the pandemic curve slowly started to flatten around the middle of March and it seemed to have been tamed by the end of May as the impact of the lockdown strategy took effect, as shown by Figure 3.

Overall, it is fair to say that the incremental progression towards a complete lockdown reached the desired outcome. However, it is unclear whether the dilatory timing of the response or a faster national lockdown decision would have been more effective in limiting the transmission of the disease, as was the case in many other jurisdictions.

Another positive result is the expectation that the health care system should be more prepared for an eventual second wave not only in terms of developing containment and mitigation procedures but also terms of providing emergency beds. There were 5300 beds at the beginning of the pandemic; this number increased to 8660 during the acute phase of the outbreak, and thanks to the new governmental funding, it should rise to more than 11,000 by the end of the year.

However, problems with designing and implementing policies remain, and serious problems can be expected when implementing the 3Ts (because there is still no national strategy for this, only general guidelines for regional implementation) and during the

period of economic recovery due to the deeply distributive nature of the first two rounds of economic measures.

5. What can we learn from the Italian case?

Italy was the first Western country to face an outbreak of COVID-19. It was unexpected, although it could and should have been anticipated, as experts had been warning about the next major pandemic for the last two decades. Nevertheless, Italy was not prepared and had no recent experience with a mass outbreak of this kind of disease. This lack of experience cognitively favoured denial, while the lack of preparedness required the country to deal with the crisis based on existing rules and fostered the use of incremental responses to the first signs of an outbreak. Thus, the characteristics of the normal Italian way of designing policies prevailed in this case: low state capacities and complex decision-making and implementation procedures and a context complicated by structural political games and inter-institutional conflicts. This routinized and embedded policy style affected the governmental response, which can be characterised as the government having only weak confidence in its capacity to deal with all of the health and socio-economic outcomes of the crisis. The response was driven by the massive involvement of experts, as well as an erratic decision-making process, and it was punctuated by deep conflict with the regions and delayed by various waves of overtly political games. The consequence was a slow, incremental response to a fast-moving crisis, and the response did not anticipate how quickly the virus would spread around the country but instead followed behind the virus's progress. Thus, it took three weeks from the first cases for a stay-at-home regulation to be imposed and five weeks for the complete lockdown to be implemented, even though it is well known that, in the absence of other interventions, such as a quick application of the 3Ts, the faster the introduction of social distancing measures is, the more effective the containment of the transmission will be (as shown by the experience of China and New Zealand, for example, as well as by previous major pandemics such as that of the Spanish flu).

The Italian case is thus emblematic of a low-capacity response, showing that a robust response to an outbreak is not possible without careful preparedness and experienced policy-makers and advisors (Capano & Woo, 2017, 2018). Failing to anticipate future problems (Bali, Capano, & Ramesh, 2019) leaves decision-makers without plans and in a state of cognitive uncertainty (with respect to the problem and its solutions) when a crisis occurs. In such situations, decision-makers are at the mercy of the structural and contingent characteristics of policy making and are subject to path dependence and political gaming. In addition, agility and flexibility, which are fundamental attributes when dealing with pandemics (Lai, 2018), can only exist before the crisis and cannot be invented during the process (unless specific forms of agency emerge, as in the case of Veneto, where, thanks to the immediate choice of its president and his medical advisors, a different and much more successful response was pursued).

The Italian case, like that of Canada and the United States (see elsewhere in this issue), also shows that a decentralised (health care) system needs formal procedures (or institutionalised practices) that push for cooperative coordination or clearly establish who is in charge of which activities if the system is to be effective in a crisis. At the same time, it shows that if the decentralised system lacks a common template, different localised

responses can be offered, providing a variety of solutions that can inspire the eventual redesign of inter-institutional relationships as well as the distribution of tasks between central and regional governments. However, such tendencies and learning processes should be organised and not random or coincidental.

Finally, the Italian case shows that experts and knowledge played a pivotal role even from the first policy-making steps undertaken but that this role was not always positive, thus demonstrating that experts can also have a relevant role in the denial and normalisation of risk, as well as in reframing and designing mitigation strategies.

Overall, however, perhaps the most important lesson from the Italian experience with COVID-19 has been that without preparation and in the absence of a recent lived or learned pandemic experience, the historically rooted characteristics associated with designing and implementing policies – a country's policy style – and the normal political games associated with it will prevail. A country can only be what it is, and its government can only behave according to its routines, known practices and procedures.

Disclosure statement

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Notes on contributor

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