Developments in the Italian primary care sector

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1 - Introduction

The regulation and organisation of Italian primary care services is influenced, on one side, by the nature of the National Health System (NHS) which has become a “multi-tier” public system articulated in national, regional and local entities (namely Local Health Authorities - LHA's - and Hospital Trusts - HTs) and, on the other, by a comprehensive and universal coverage of health needs (ensured by the constitutional principle of “solidarity and freedom of choice” about provider and settings of care). From 1978 to 1993 the Government was then in charge of financing and administration, Regions managed funds allocation, and LHAs were responsible for providing or paying care on a territorial basis. After the major reforms of the 1990s, Regions acquired more power over healthcare; legislation, planning, a partial fiscal autonomy, the freedom to shape models for delivery of care. Concerning LHAs, they were pushed to better respond to local needs by developing a full range of services, from prevention to primary care, to community services (nursing, residential and day care), up to secondary general hospitals, or by reimbursing care provided by external providers such as HTs or APPs (Accredited private providers).

In this scenario primary care services are framed within Health Districts (sub-articulations of LHAs, ranging on average from 50,000 to 200,000 residents), involving different professionals such as: GPs (on average 1 every 1,000 patients), Paediatricians (1 every 800 patients under age of 14), the so-called Ambulatory Specialists (such as gynaecologists, psychologists, psychiatrists, cardiologists, orthopaedists, oculists, lung specialists, etc.), Nurses (also obstetricians), Care continuity physicians (for out-of-hours services), Therapists, and Social care workers. Some of these professionals work physically within Health District facilities (e.g. all the Specialists and Care continuity physicians), others are independent contractors with their own ambulatories (e.g. GPs, Paediatricians), while social workers usually depend from local Municipalities. Consequently primary care services can range from “in-house services” provided in Health Districts, such as vaccinations, consultations (e.g. families, pregnancy, disabilities, etc.) education and screening programs, specialist consultation, medical certifications, exemptions (e.g. elderly, chronic diseases, handicaps, etc.), to “out-of-house services” such as home-care assistance (e.g. with GPs, Specialists, nurses, etc.), ambulatory services (e.g. GPs, Paediatricians), public assistance and transportation.

Factors such as the variety of geographical areas, with more fragmentation and isolation in southern and insulated regions, the distribution of hospitals, with more structures in the northern-central area, and finally the concentration of big tourist flows in the summer season, explain also the role of care continuity physicians, which are intended to replace GPs and Paediatricians by working at nights, on week-ends and holidays, along with emergency services (ambulance services and emergencies departments at hospitals). Therefore care continuity is ensured with the contribution of different professionals according to work schedules, but with relevant limitations in terms of coordination, quality of care and sharing of information.

2 – Regulation of primary care services

Supply of primary care services in Italy is regulated by laws and contracts. The main regulation is enforced by a National Agreement (the last ones in 1996, 2000, 2005), which is negotiated between Government and GPs trade unions, and defines the principles of primary care services in terms of general objectives, requirements and payment schemes. Regions are autonomous in establishing further agreements aimed mainly at identifying the most appropriate organizational arrangements for the provision of services, but they might also define additional services to be ensured locally.

All patients in Italy are registered with a GP or a Paediatrician who is in charge for providing most primary care, referring to specialists, and prescribing diagnostic interventions and drugs. The citizen can
freely choose his or her own GP, given the limit of maximum number of enrolled patients (1,500 for GPs, 800 for Paediatricians). Primary care physicians may provide their services under public coverage only to patients on their list. Occasional visits to patients not included in the list are paid directly by the patient, as for foreign patients who temporarily reside in Italy. The categories of services that primary care physicians must ensure are broadly defined as: (1) essential services: acute and chronic disease management, in line with best practice indications and in agreement with the patient; (2) health promotion activities; (3) patient management within home-care programs coordinated with providers of specialist and rehabilitative care services; and (4) community services defined on the basis of regional agreements. GPs are not free to set-up practices, but according to geographical vacancies are admitted to a post through open competition, taking up residence in the assigned area and opening a suitable ambulatory. Concerning the daily activity, the National Contract requires minimum standards in terms of working hours, according to the number of patients, for five days a week, and a minimum list of patients (e.g. 300 after 3 years of practice).

In this perspective, Italian GPs and Paediatricians work as independent contractors, mainly paid on a capitation basis, set at national level and uniform across the country. Their remuneration derives from a combination of different elements:

- “capitation-based share” (ranging from 65 to 75% of total payment) for each patient registered in the GP closed list, balanced according to the GP seniority and also to the age and sex distribution of the patients (since 2005, ranging from 40 to 60€ per patient a year);
- “fee-for-service share” (5-10% of total) for additional services such as vaccinations, home-care visits, minor surgery, certifications, etc.;
- “variable share” (approximately 10% of total) for the achievement of regional or local health programs and other integrated activities or for control of expenses generated by patients (e.g. drugs, diagnostics, hospitalisations, etc.);
- “investment share” (approximately 10-15% of total) in terms of economic incentives for medical association, ITC integration, support staff (e.g. secretary), medical staff (e.g. physician’s assistant, nurses, etc.), availability in out of practice hours, biomedical equipment, etc.;

Just as an informal reference, the average Italian GP aged 50 with 1,000 patients, working 15-20 hours a week in its ambulatory, but also performing home-care visits and other services (then up to a total of 35-40 hours a week) receives a gross yearly remuneration of about €50,000, which can grow up to €75,000 contemplating additional services, variable and investment incentives. In any case, practice costs (e.g. rent, general expenses, staff, ITC, etc.) have to be absorbed, thus reducing the final net income. Values can grow more in case of patients with a full list of 1,500 patients.

Moving forward, in order to improve services, to ensure care continuity and flexibility, since 1996 GPs, Paediatricians and Care continuity physicians can set-up voluntary associative practices. The main forms of primary care associations are regulated as follows:

- “associative practice”: from 3 to 10 GPs with their own ambulatory, ensuring access in rotation at least 6 hours for 5 days a week, until 7 p.m.; GPs are to share clinical and diagnostic guidelines, participate to common projects, but they are not forced to share resources while they can be asked to hold a joint responsibility on prescriptions, expenses, hospital admissions;
- “network practice”: same rationale of the previous form but with an obligation to own a common information system and network in order to be able to share patient records and consequently substitute a colleague, especially in case of urgencies;
- “group practice”: from 3 to 8 GPs operating in a same ambulatory with a number of clinical rooms equal to half of the professionals. The group is incentivated to use support staff and advanced IT services.

In 2004, according to the Ministry of Health, 36% of Italian GPs were experiencing the associative practice, 9% the network practice, 13% the group practice. Such national models coexisted with regional or local organisations delivering primary care (e.g. country hospitals managed by GPs) and other initiatives providing services to Physicians (e.g. Cooperatives, Foundations, Service companies). Regions can indeed define other forms of group practice and set up additional economic incentives on top of the National Agreement.
3 – Issues affecting primary care services

Despite the reforms in the 1990’s, the Italian NHS is still facing new challenges (Torbica and Fattore 2005): further decentralisation (e.g. funding collected at regional level), a review of public health services in terms of LEAs = Essential Levels of Services to ensured nationally (complemented by co-payments for additional services), pressure from experimental regional or local models (e.g. competition between public and private providers, the “privatisation” of major hospitals, etc.), and finally, an increasing demand of “opting-out” from the NHS (shifting from a public universal coverage to private insurance or public integrative insurance).

Nevertheless Italian GPs still represent the front-end of health services, the first point of contact for patients; they are valued for using a person-focused rather than disease-focused approach, caring for most common diseases. For these reasons, the integration with other levels of care appears to be fundamental in order to achieve proper management of all services. In addition primary care professionals face nowadays patients who value increasingly things such as improvements in the health status of local communities (e.g. health promotion and education, GPs engagement and integration of service delivery), provision of comprehensive services (e.g. family health needs such as medical, dental, pharmaceutical and optical), and not just mere traditional services (e.g. prescriptions and general counselling).

In this perspective primary care in Italy can play a significant role as it involves about a fifth of the entire public healthcare workforce (e.g. 47,000 General Practitioners, 7,500 Paediatricians, 14,000 Out-of-hours Physicians). Such professions are generally framed within different institutions and organizations; they also experience the effects of a peculiar workforce imbalance as, in general terms, Italy experiences an excessive number of doctors, underemployment, progressive aging of occupied physicians, increasing percentage of female personnel, low salaries, inadequate post-graduate educational training.

Moreover the lack of integration between hospital-based services and community-based health care poses a significant threat to the evolution of the Italian NHS, which is also struggling with expectations for targeted services on specific health needs (e.g. disabilities, frailties, elderliness). Italian GPs are traditionally not accountable in managing local needs, mainly because of their historic organizational model (solo practice, without any shadow budget). Under such circumstances, provision of integrated services between hospital and primary care requires managerial approaches, new information systems, combined health-care processes; the increase of elderly population will determine also a reallocation of resources between the secondary and primary level of care (e.g. rehabilitation services, long-term care) and, not to mention, the emerging role of the patient as a consumer which requires more attention in addressing preferences and choices (e.g. integration between health and local Authorities to address complex demand for chronic diseases, with both social and health issues).

Rising health costs, pressure on public finances, increasing expectations from the demand side, are therefore questioning current organisational settings and rules for Italian primary care (Tedeschi and Tozzi 2005); this will involve a shift in the role of GPs and other professionals, giving them the opportunity to think and work differently to solve old problems in new ways. Such pressures probably imply a different way of managing primary care through empowerment of frontline professionals (higher operational freedom as they are best placed to understand the needs of patients), patients education (by giving them more information and more influence in resolving issues before they escalate into greater problems), professional enhancement (performance measurement, targeted incentives, accountability on results), service integration and innovation (investments in infrastructure and technologies, decentralisation of specialist or diagnostic services, provision of new services such as prevention and proactive disease management).

4 – The slow but moving evolution of Italian primary care

Starting from 2000 Italy observes a progressive reorganisation of primary care with the objective to both improve quality and possibly reach a more cost-effective delivery of care. Some Regions and LHAs have been addressing the issue of integration within primary care services, and among different levels of care, especially researching a methodology based on bottom-up involvement and entrepreneurship of professionals. In other words, the current challenge is searching the right combination between traditional
features of primary care (e.g. listing of patients, accessibility, gatekeeping, long term care, orientation to local needs) and more structured settings, such as primary care organisations or networks ensuring preventive care, integrated care, and new services such as long term care, local specialist consultations, diagnostic treatments. For example, a main target would be shifting from a scenario of different professionals providing continuity of care, each one at its own time and according to different rules, to a network of professionals taking care of patients according to organised processes, sharing resources and responsibilities. Some observers would argue “nothing really new”, especially looking at the international arena; but the challenge is delivering tangible value to patients (e.g. first-aid, out-of-hours assistance, ambulatory surgery, first-level diagnostics, proactive medicine for early recognition of diseases, etc.), and not just announcements!

In this perspective, the last years have seen a significant share of Italian Regions elaborating their own primary care settings, adding on previous forms of medical associations; usually such organisational models are based on the idea of concentrating professionals in the same facilities, with GPs leaving their ancient ambulatory or maintaining it as a peripheral access to networked services (also because of the peculiar geographical conditions of Italy, with a few plains mainly in the north, a prevalence of mountains and coasts, and besides 10-15 large cities, a population dispersed mostly in small-medium villages). Translating from Italian, “Primary care nucleuses” have been activated in the region of Emilia Romagna, “Primary care groups” in Lombardia, “Primary care units” in Toscana e Lazio, “Primary care territorial units” in Veneto, “Territorial Equipes” in Piemonte, Marche, Puglia e Umbria, private “primary care networks” in Liguria. Italian primary care professionals are increasingly pushed and rewarded to experiment local models, to work in group, to use technologies, to be part of the health system. The approach seems to be somehow different form adopting a unique solution defined at a national level, but potentially unfit to local needs (e.g. as it is likely to be for UTAPs - Primary Care Territorial Units announced by the Ministry of Health, serving at least 10.000 patients through a physical facility concentrating all services, personnel, resources, which is likely to work in the cities, but not elsewhere, unless flexible and customisable to local contexts). In addition, partnering for Italian GPs is not evident, both inside the profession and with hospital physicians, because of different traditions, professional competition, economic conveniences. Besides the different nuances of each regional model, Italian GPs are asked to engage actively on healthcare networks. But this could be only a first step as, in order to ensure clinical governance and control of resources, Italy probably needs networking both “horizontally” (e.g. between GPs, Paediatricians, Nurses), but also “vertically” across the different organisational layers of a same regional healthcare model (e.g. networks between primary care, health districts, and hospitals for managing the different stages of chronic diseases).

Even with a delay of some years, the Italian primary care sector seems to be finally caught in a slow-moving process of structural transition based on wider ranges of services and new supporting conditions. In particular overcoming the challenge of coordination means evolving from the concept of “generic gatekeeping” into a “diversifying primary care world” with large group practices, flexible staff, multiprofessional teams and primary care triage nurses, thus enhancing accountability, quality and new working arrangements. However, as it is for other numerous western countries, primary care has not yet become what it needs to be as there is uncertainty over the final organizational model, as credibility of GPs within the medical world and to patients is sometimes under discussion, as “putting primary’s care in the driver’s seat” of health systems (Saltman et al. 2004) is an interesting but debatable solution which should be experimented and assessed before becoming an irreversible dogma.

Nevertheless, the regional models being introduced will help to test a new framework for Italian primary care based also on managerial tools and organizational support. Indeed if a new culture does not come along with models and rules, then it will be hard for GPs to sustain new challenges and to play a role in the health system: training is required to avoid underestimation of workloads and to use new information systems, project management techniques, practice analysis tools. Additional financial resources for structural investments, economic and fiscal incentives, procedures for staff hiring, legal recognition of primary care organizations, are also probably required in order to pursue integration of dispersed services, to reach some breakthroughs such as the combination between “small is beautiful” (meaning the success factors of primary care such as local context, personal services, economic medical treatments) with “big is powerful” (meaning back office capabilities such as bargaining power, group organisation, administrative, technical, housing, and ITC support services, quality assurance management and standardised care processes, pooling of social and
health care financial resources). Such elements can foster the coordination between Specialists and GPs, pushing hospitals to be accountable not just for “production efficiency”, but also for quality, degree of specialisation, integration with primary care services, health gains and cost savings. In the end, as it is for other countries, success of the evolution of Italian primary care, probably depends from the capability of keeping, on one hand, primary health care “personal”, and on the other, developing operational capabilities enhanced by organisational models, involvement of professionals such as nurse practitioners and physician’s assistants, activation of formal or informal local caregivers networks, targeted services at home, or by telephone, email or websites (Schrijvers and Freeman 2005).

Though such a scenario seems to be highly attractive, integration is not easy to reach in primary care; larger organisational settings and capabilities have indeed to complement, and not substitute, the need to deliver services on a small scale, preserving human relations based on trust as the founding asset which justifies the value and future of primary care. This means that organisational paradigms, clinical and managerial tools, professional behaviours and knowledge about primary care still require a different mind-set from specialists and hospitals, though more integrated with them. In particular, concerning Italy, the challenge for primary care professionals is both clinical and managerial; on the first issue, the request is to become case managers for chronic diseases, able to manage increasing workloads (if hospital emergencies were to be used more properly and inpatient discharges to be coordinated with follow-up services), on the second one, to create conditions for adopting and spreading innovation, for cost and quality control, for proper conflict management between private interests and public goals. The future of Italian primary care is not gained, but at least things are turning “back to future” beyond the traditional divide between GPs and the NHS, finally implying for primary care professionals that being contractors does not exclude active integration in the provision of care (Borgonovi 2004).

BIBLIOGRAPHY


