



Health Reform Monitor

The 2022 community-based integrated care reform in Italy: From *desiderata* to implementation

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ABSTRACT

The Italian National Recovery and Resilience Plan allocated € 7 Bn for community care. In May 2022, the Italian government issued a Decree to define the strategy for the development of community-based integrated care. The reform aims to create uniformly a network of services close to where patients live, thus overcoming geographical disparities between regions. The strategy is based on a strong role of the central government in community care, but still leaves autonomy to regions. Levelling availability of services across territories, setting uniform targets with a short period horizon and disregarding starting points may create important implementation problems. Financial constraints will also hamper the implementation of the reform. Ultimately the development of Italian community care will depend on the institutional and managerial capabilities of regions and local health authorities. Firstly, they should shape the actual implementation of community care services by defining organizational arrangements, priority targets and models of care delivery. Secondly, they should develop strategies to face the lack of financial resources and the shortage of healthcare workforce. This contribution informs international readers about a major policy in a European country and its implementation challenges. It offers insights into inter-government relations in NHS-type healthcare systems (Nordic countries and Spain), showcasing the complexity of policymaking involving multiple political actors and resulting indeterminacy of policies and their implementation.

1. Introduction

Major Italian health policy reforms correspond to critical junctures in the history of the country. The National Health Service (NHS) was established in 1978 when the country was destabilized by terrorism and a large political alliance faced the emergency. That political convergence created an opportunity window to introduce the NHS [1]. On the basis of a strong vision and a preparatory work lasting decades, the Parliament approved the most radical welfare reform of the Italian Republic. In the second juncture the Italian political system collapsed due to corruption investigations of all main political parties and a monetary crisis. In 1992/93, the NHS was reformed along three main lines; Regions were empowered as the pivotal institutional actor, elements of competition were introduced and the repertoire of the New Public Management doctrine were endorsed to improve efficiency and accountability [1,2]. Since then, a difficult balance between national and regional powers have dominated Italian health policy making, with the Central State gaining ground on financial matters and the regions

maintaining organizational prerogatives in their jurisdictions [3].

The third juncture was the Covid-19 pandemic. Italy was one of the first countries to detect cases and by the end of February 2022 registered 154,767 deaths. In 2020 life expectancy fell by 1.2 years, compared to OECD average of 0.6 years [4]. While the country was not prepared to face such an emergency [5,6] the NHS was successful in rapidly increasing intensive care capacity, enhancing community and domiciliary services and launching a massive vaccination program. At the same time, the crisis made also clear the deficiencies of the NHS and particularly the frailty of the healthcare system of Lombardy (the region of Milan) where community care is underdeveloped [7]. The Covid-19 epidemic also briefly ended a very long period of austerity. While government healthcare expenditure was stable in nominal terms from 2010 to 2019, it increased by 6.4 % and 4.5 % in 2020 and 2021, respectively [8].

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2. Next-Generation EU community care in policy-making

To cope with the economic crisis due to the pandemic, in 2021 the European Commission launched a fiscal and policy package of € 750 Bn [9]. Italy is the main beneficiary of the program and, while obtaining funds for € 191 Bn, it also committed itself to make important reforms. In April 2021, the Italian government issued the National Recovery and Resilience Plan (henceforth, NRRP) which includes a specific investment programme of € 15.6 Bn dedicated to health (Mission 6) [10]. The Component 1 of Mission 6 “*Proximity networks, structures and telemedicine for community healthcare*” includes € 7 Bn for the establishment of a network of community care facilities and the enhancement of domiciliary care and telemedicine. The investment programme stipulates that regions may obtain funds only upon establishment of community care facilities. As a consequence, the regions have a strong incentive to achieve the centrally set objectives. The Italian government also committed to develop a major reform to transform community care, aiming to overcome geographical disparities and achieve greater effectiveness of services.

In May 2022, the Italian government issued the Ministerial Decree nr. 77/2022 (henceforth, “Decree”) “*models and standards for the development of community care in the National Health Service*”. The reform aims to encourage the development of community-based integrated care (henceforth, “CBIC”) across all regions [11]. The Decree follows the reorganisation of hospital care that had started in 2015 with the Ministerial Decree nr. 70/2015. The overall aim of the strategy is to uniformly create a network of facilities and services in the Italian territory close to where patients live, so to complement hospital care that is increasingly concentrated in high volume settings [12]. Domiciliary care and the integration between health and social services are set as priorities of the strategy as well as citizens’ co-production and the spread of telemedicine.

The reform revamps the role of districts as organizational units of Local Health Authorities (henceforth, “LHAs”). According to the Decree, Districts are in charge of the coordination of all community healthcare services in their territories, including primary health services and social care with relevant healthcare components (e.g., integrated domiciliary care). They both deliver and purchase services with a defined budget and are the place of needs assessment and service planning according to population health management and chronic care models. They are accountable to the General Director of the LHA.

The reform defines a common organizational model for the districts. Each district should serve 100,000 inhabitants and provide services in different facilities. They are required to organize a transitional care unit (*Centrali Operative Territoriali – COT*). Its function is to coordinate the transfer of patients across settings, including those transferred home and supported by domiciliary care. It is mainly staffed by nurses; it collects placement requests from clinicians and matches demand and supply through the use of an electronic platform.

The Decree also mandates to have a community care centre (*Case della Comunità – CDC*) every 50,000 inhabitants. Services offered by hub community care centres include primary care, prevention, maternity care, laboratory pick-up points, common specialist services and basic diagnostics. These centres should be staffed with doctors 24 h a day 7 days a week and nurses 12 h a day 7 days a week and should be the access point for all non-emergency services offered by the NHS. In addition, smaller community care centres (spokes) are expected to be the physical sites for the delivery of primary care by hosting GPs’ activities, nursing care and basic specialist services. They are expected to be open 12 h a day 6/7 days a week.

To strengthen community care and allow hospital care to focus on acute conditions, the Decree plans to introduce community hospitals (*Ospedali di Comunità – ODC*) that are small inpatient centres of one or maximum two units of 20 beds each. Overall, each District needs to have one community hospital every 100,000 inhabitants (0.2 beds per 1000 inhabitants). Each community hospital unit of 20 beds needs to be

staffed with 7–9 nurses, 5–6 health workers, 1–2 rehabilitation professionals and 1 physician for 4.5 h 6 days a week. Clinical responsibility is taken by a medical doctor while organizational responsibility is assigned to a community nurse.

Other provisions included in the Decree concern the use of the European number (116,117) as first contact for healthcare services, standards for continuity of care (non-emergency services at night and during week-ends when GPs are not on duty), the deployment of community nurses (one every 3000 patients over 65) and the development of home care through telemedicine and other digital tools.

3. National direction and regional autonomy

The development of CBIC is generally welcomed and addresses social, demographic and epidemiological changes of the Italian society [13]. The overall national strategy tries to establish a strong role of the central government in community care. The development of CBIC has been promoted by setting national models and standards. The central government set a common organizational model of the district by defining both the type of facilities – community centres, community hospitals, transitional care units – and the service they should offer. Moreover, it established organizational standards for the homogenous distribution of facilities across territories as well as the number of personnel and beds per facility. These national organizational standards are a substantial novelty for community care. Indeed, while the central government set homogeneous standards for hospital care starting in 2015, the development of community care was mainly left to the autonomy of the regions. Prior to 2022 Decree, the role of the central government had been mainly limited to the definition of the benefit package (Essential Levels of Care – LEAs), while granting substantial autonomy to the regions in the organization of services [2].

While expanding the power of the central government, the Italian reform of CBIC still grants autonomy to regions and LHAs. The Decree has not fully defined organizational arrangements, priority targets and service models of care delivery. For example, for what concerns organizational arrangements, the reform prescribes that community centres and community hospitals have to be managed by a coordinator. However, it has not been defined whether the coordinator has to be a doctor employed by the NHS, a GP, or a nurse, nor whether they will report hierarchically to the Director of the District or the General Director of the LHA. With regards to priority targets, according to the Decree the aim of transitional care units is to coordinate the transfer of all patients between settings through the use of an electronic platform. However, the digitalization of transitional care will probably take years, given that it requires the development of operating systems for each setting and a specific matching algorithm for each patient condition. As a consequence, the implementation will start for selective group of patients and for settings chosen autonomously by local and regional authorities. The same considerations can be made to service models, where regions have substantial autonomy in defining how to digitalize CBIC services.

The national government *de facto* granted a certain degree of discretion to the regions and LHAs, allowing them to adapt the national framework on the basis of the health needs, values and beliefs, and capabilities of healthcare professionals across diverse contexts. As a consequence, the role of regions extends beyond the mere implementation to encompass the definition of the content of the reform. The policy-making process is thus shaped by the interplay between the national government and regional and local authorities.

4. The challenge of implementation

The development of CBIC in Italy faces several challenges. Regional supply of community care services largely varies [14]. Some regions, like Emilia-Romagna and Tuscany, have heavily invested in community care in the past and are already close to the standards set by the central government while others start from little more than zero. For instance,

Emilia-Romagna already had 29 community hospitals prior to the reform while the standard required it to have 27 facilities. On the other, Campania started with 1 community hospital and is required to have 48 facilities [15]. While the objective to even availability of services across territories is largely agreed upon, setting uniform targets for a short period horizon and disregarding starting points may create important implementation problems. A group of academics from 6 universities active in health policy research suggested to keep a more decentralized approach to let regions to have more freedom to design how to develop CBIC. The group also recommended to invest heavily in institutional capacity at regional and national level, as the development of community care requires a major injection of professional capabilities which are often lacking in the NHS [16].

The development of CBIC is also hampered by financial constraints. The size of the investment has been set before the start of the inflationary period that occurred in Europe since autumn 2021. A group of regions requested to reduce the number of community care facilities to be established with the resources of the NRRP due to the increase in the construction prices. Moreover, the package almost exclusively funds capital expenditure, that is for buildings and technologies. The introduction of community care facilities and services entails an increase in current expenditures, such as personnel, pharmaceuticals and medical devices and support services. However, financial planning does not envisage an increase in current expenditure. Indeed, the last government document set NHS funding at € 129.4 Bn for 2025, € 4.5 Bn less than in 2022 [17].

The greatest challenge lies in staffing the new community care facilities and services because of the shortage of healthcare workforce. However, the potential to significantly increase the healthcare workforce is limited by financial constraints. To cope with this challenge, regions and LHAs may employ different managerial tools and incentive schemas in accordance with the contractual nature of healthcare professionals. Theoretically the new facilities could be staffed with three different categories of workers: NHS professionals, contracted professionals or personnel from private healthcare organizations. The only possibility to staff community care with NHS professionals is to take resources from hospital care, but the road is very narrow. It requires efficiency gains and a substantial reduction in hospital admissions. Whether expanded community care eases such reduction is not proven. In addition, transferring resources from hospitals to community care might meet resistance from the NHS personnel. For what concerns the second category, private practitioners who have collective contracts with the NHS play a significant role in community care. In Italy, GPs are contracted professionals that typically working in individual private facilities. GPs fear that moving to community centres will reduce their autonomy and are thus resisting change in some regions. Staffing needs in the new facilities have thus opened a debate about the possibility to have GPs joining the NHS as its employees. More pragmatically, LHA managers are working on incentives such as nursing support or digital tools that are difficult for contracted professionals to access individually. Lastly, a different public-private mix could reduce the staffing needs of community care centres. A part of the community care centres could be leased to private healthcare organizations which in turn would provide services such as basic diagnostics, sport medicine and prevention. There are already examples of this public-private collaboration in regions such as Emilia Romagna where a private accredited facility provides diagnostic services within a community care centre [18].

5. Conclusion

The COVID-19 pandemic has revealed that lack of coordination amongst care systems and fragmented delivery of care can result in high system vulnerability in the face of health emergencies. Numerous countries in the European Region planned or implemented reforms to promote integration and coordination in delivery of care as a response to the pandemic [19]. Following this path, the Italian government

promoted the development of community-based integrated care with an investment package addressed in the Italian NRRP and a substantial reform issued with a specific decree. However, the implementation of CBIC will presumably vary across different regions. Policy outcomes will depend on the action of the central government as well as the institutional capabilities (quality of politics and regional public administration) of regions and LHAs. A right balance between the national government and regional and local authorities will positively impact an effective implementation of CBIC. On one hand, having common standards and targets as well as national databases and programs to support backward regions will facilitate a homogenous development of CBIC. On the other hand, it will be important to leave regions the autonomy to promote innovations at the local level and adapt community services to the specific needs of very different contexts. Furthermore, the central government will presumably have to provide support to tackle specific issues such as the severe challenges related to the shortage of health personnel and staffing of new facilities. Ultimately, the development of Italian community care will depend on the managerial capabilities of regions and LHAs. Firstly, they will shape the actual implementation of community care services by defining organizational arrangements, priority targets and service models. Secondly, regions and LHAs will develop strategies to face the financial constraints related to the expected decrease in current expenditures and in particular the shortage of healthcare workforce.

In addition to inform international readers about a new major policy in a large European country, this contribution offers insights on inter-government relation in NHS-type of healthcare systems (Nordic countries and Spain). It shows the complexity of policy making when two or more political actors are involved and the indeterminacy that results from the interaction of different level of government. It also shows the complexity of implementation in such context.

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Declaration of Competing Interest

Both authors have no conflict of interest related to the content of the manuscript

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