ABSTRACT

Health systems across Europe are under increasing pressure to shift care outside of hospitals and into community settings. The emphasis is on providing high quality, coordinated care for a growing population of older patients and those with long term conditions. Extended primary care is regarded as key means of achieving such a shift. We report learning following exploratory visits to two sites in Italy, each providing an example of a primary care organisation with extended general practices, community health and local resource utilisation responsibilities. We draw out three areas of potential interest - shifting care from hospital to community settings, facilitating localism, and enabling stable leadership – all of which appear to provide a means for local clinicians, managers and their communities to commission care according to local needs. We conclude by recommending that primary care researchers consider undertaking further work in Italy, building on this exploratory work and more systematically exploring the effects of such programmes.

BACKGROUND

Across Europe, increased attention is being given to extending primary care (Atun 2004, Health Council of the Netherlands 2004, Salter, Rico & Boerma 2006, Meads 2009). The aim is to address a growing older population and rising incidence of long term conditions by shifting care from hospital- to community-based settings (Rosen 2011; Smith & Ovenden 2007). The vision is one where services are more efficient and responsive, incorporate a coordinated and multidisciplinary approach to delivering high quality care, and connect firmly with the needs of service users by enabling a growth in the activities devolved to primary care. Primary care professionals are thought to be well-placed to manage demand, provide personalised services, advance quality and use resources efficiently. However, questions remain about whether primary care is capable of taking on the leadership of running a whole health care system.

Little attention has been paid to extended primary care in Italy, where the decision to devolve national powers to regions with their own highly decentralised structures has led to rapid if variable development. We therefore report from exploratory visits to two Italian sites (see Box 1): each in a region with extended primary care at the heart of its healthcare strategy. Our paper is intended as an opinion piece, highlighting areas of potential learning for primary care researchers drawn from our site visits, each of which involved a mix of informal interviews and documentary review.

BOX 1 ABOUT HERE

STRATEGIC DEVELOPMENT OF HEALTH CARE IN ITALY

Like most other European countries, the Italian National Health System (*Servizio Sanitario Nazioanale*) offers universal health-care coverage backed by the state. Primary care is largely provided by GPs and paediatricians who are independent contractors acting as gatekeepers to secondary care.

National reforms promoted cooperation amongst health and social care providers and an integrated framework for delivering care to targeted groups (Donatini et al, 2001). In addition there has been a steady decentralising of power to 20 regions, each having a directly elected government with wide legislative and administrative powers (Maio & Manzoli 2002). Healthcare strategy is therefore largely devolved to the regions with many remaining committed to public provision (Lombardy being a notable exception, see e.g. Stancati 2010). In each region, local healthcare executives undertake population-based health management and purchasing at locality level.

In the regions we visited - *Tuscany* and *Emilia Romagna* - regional reforms focused explicitly on extended primary care. In both regions the term is understood as a concept which embraces both individual and population health requirements and as a service provided from directly accessed, frontline units. In *Tuscany*, the emphasis is on a coordinating health

and social care, implementing the Chronic Care Model (Wagner et al 1996) across group practices, combining budgets and aligning both managerial and financial structures. At locality level six new 'Health Homes' have been jointly commissioned with the aim of reducing acute hospital usage and costs. *St. Andrea's Health Home* was the first to emerge and with a focus on health and social care integration (Box 2).

BOX 2 ABOUT HERE

In *Emilia Romagna*, the emphasis is on increasing the primary care budget and decreasing hospital admissions through shared medical care. The *Max Ivan Chercish Polyambulatoria* is a group general practice in Bologna (Box 3) that has been driving vertical integration with secondary care. Shared care across GPs and specialists is facilitated by locally adapted national guidelines. The quality of clinical relationships and the lack of professional boundaries appear to be the key to developing and maintaining high quality services out of hospital.

BOX 3 ABOUT HERE

SHIFTING CARE FROM HOSPITAL TO COMMUNITY SETTINGS

Since opening in 2008, *St Andrea's* has steadily increased its patient registrations whilst simultaneously reducing hospital referrals and inpatient admissions (now 140 per 1000 patients). This has been achieved by expanding the activities devolved to primary care: *St. Andrea's* now provides specialist outpatient and inpatient services in 14 areas including, for instance, cardiology, dermatology, gastroenterology and ophthalmology.

The shift from secondary to primary care accounted for cost savings in 2008 and 2009 of 6% and 22% respectively. Gain sharing is in place to encourage further change, with budget savings split in equal parts between the local health authority, physicians and St. Andrea's infrastructure account. The result appears to be a new mindset amongst primary care professionals in which demand pressures and claims for additional resources are no longer synonymous and where previously elusive changes in clinical behaviour appear possible. Such changes are facilitated through an employment contract between GPs and the local health authority. This contract outlines six objectives, each having specific targets. In 2010, all six objectives were met meaning that the local authority met the rental costs for the building in which *St Andrea's* is housed and GPs shared €9000 (c. £8000) in financial benefits.

At regional level, the strategic commitment to extending primary care appears to have paid off with Tuscany reducing its complement of hospitals from 90 to 35 in ten years.

In Bologna similar shifts were reported with secondary care expenditure reduced to less than half of the regional budget and a future target of 43%. At a local level this shift appears

to have been achieved by directly employing specialists from the four areas of highest secondary care demand (cardiology, orthodontics, ophthalmology and dermatology) within the *Max Ivan* group general practice. These specialists are integral to the primary care service - not part of a hospital outreach – and see/treat patients in the community or enable the GPs and practice nurses to do so. They have no inpatient beds. Their main purpose is diversion not prevention.

This change in the way services are provided has been achieved with limited use of pay-for-performance incentives. Instead local administrators and political leaders appear to have successfully re-framed senior 'medical status' away from secondary care and towards community-oriented disciplines and settings.

FACILITATING 'LOCALISM'

Political and financial federalism in Italy has allowed a compelling mix of decentralisation, local political structures and cultural engagement. This appears to have facilitated local decision-making incorporating the views of patients/public, managers, clinicians and politicians. For instance, in Bologna all proposals for increasing extended primary care are subject to local discussion with community representatives before being given the go ahead and paving the way for additional regional taxation and income. And in Tuscany, the *St Andrea Health Home* is named after a local saint in an attempt to reinforce local engagement. Participation is the watchword in both sites, with wide-ranging contributions to healthcare planning from elected councillors, cooperatives, voluntary groups, charities and the Church.

The ethos of decentralisation has permeated into a stewardship role for primary care in respect of community resources. Such stewardship is reinforced by locally elected mayors who are responsible for healthcare deficits and endorse local health targets in their manifesto. Critically, we were told that politicians are regarded by clinical leaders as 'inside the organisation'. For instance, provider groups in Bologna are commissioned in conjunction with Bologna's elected *Presidentes* who are responsible for municipal services. They link politically to the regional and provincial mayors who also have a role in drafting and approving the national Italian health strategy and its 'shared medical care' guidelines.

On the face of it having to account to so many stakeholders and their interests may seem an obstacle to reform. However, both sites reported real and sustained local engagement with local political buy-in enabling hard decisions (e.g. regarding hospital closures). The national health plan provides a framework for regional and local approaches to strategic planning and delivery without curtailing the local political and managerial autonomy. Democratic elections at regional, provincial and municipality levels – all of which have an explicit role in planning services - facilitate engagement through planning mechanisms and the ballot box.

STABLE LEADERSHIP

With political leaders tending to move on every few years, system stability comes from the long-term positions occupied by clinical leaders. Public health doctors have occupied senior executive positions for over 20 years in each of the sites, ensuring a long-term steadying influence on strategic planning and change. The approach to clinical leadership is characterised by dialogue and an apparent political astuteness. This appears to foster 'professional organisations' which are characterised by the way in which they reach decisions: automatically sharing data and expertise, naturally interprofessional, working to regional health plans but with a robust capacity to amend and expand these to meet local needs.

In both sites stable leadership appears to filter positively into clinical integration 'on the ground'. The overarching emphasis on cooperation appears to set the tone for coordination of care with clinical networks – rather than financial incentives - the preferred means of achieving this.

DISCUSSION

Our site visits were exploratory and present only a snapshot of extended primary care in Italy. However the strategic focus on extended primary care in both *Tuscany* and *Emilia Romagna* appears to be achieving tangible results. Organisational reform focused on extended primary care has been achieved by forging productive relationships across health and social care and across partisan political interests. Such relationships have provided legitimacy for reforms. Political and fiscal federalism have enabled citizens to contribute to effective-decision making and allowed clinicians, managers and politicians to trust them to do so. A deliberate reliance on senior clinicians and stable executive roles to implement service changes appears to have provided both impetus and sustainability.

Typically, primary care in Italy has not featured strongly in published primary care research. However, it appears that there is potential learning. Further review is needed to examine and endorse the substantial resource shift away from hospital-based care; to explore value for money, affordability and the cost-effectiveness of extended primary care initiatives; and to understand if and how the partnerships underpinning extended primary care can operate effectively elsewhere (and particularly in the context of competitive, market-driven systems and the continent-wide economic downturn which has particularly affected Italy). Primary care researchers would therefore do well to turn their attention to Italy, build on this exploratory work and more systematically explore the effects of such programmes on specialty service utilisation and cost of care.

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Box 1: Overview of case study sites

Case study	Approach to extending primary care	Organisational model	Registered population	Service focus
Max Ivan Chercish Poly- ambulatoria Bologna, Emilia Romana	Shared medical care across GPs and specialists	Group general practice	7,100	Registered patient list
*Sant' Andrea Health Hom*e Empoli, Tuscany	Coordinated health and social care focused on reducing acute hospital usage	Health Home / cooperative	7,500	Local community

Box 2: Overview of St Andrea Health Home

St. Andrea Health Home is in Empoli, one of the 11 municipalities of the 'Health Society of Empoli' which is being developed through six new 'Health Homes' commissioned at provincial level jointly with the municipality.

St Andrea's opened in November 2008. It has 7500 registered patients and is open seven days a week, 24 hours a day. There are five GPs (all regional employees), four practice nurses, five administrators, one social worker and additional attached staff. Mental health is kept strictly separate. Nurses focus on prevention and are, as yet, barred from prescribing.

There are fourteen other specialities working within St. Andrea's on a fee-for-service basis. In addition, St. Andrea's is the home for the Diabetes Association, a fitness gym, Alcoholics Anonymous and the Drugs Advisory Service, some local charities and the statutory social work function. Much has achieved much in a short space of time with, for instance, use of social care facilities rising by 63% from 2008 to 2009.

Out-of-hours services are located within the Health Home and provided by *Guardia Medica,* an organisation covering 85,000 people and involving local GPs on a rota basis.

Box 3: *Max Ivan Chercish Polyambulatoria*, Bologna, Italy

The *Max Ivan Chercish Polyambulatoria is a* group general practice in the Emilia Romagna region. The region consists of 900,000 people and is divided into six health districts for primary care provision and public health planning. These districts are known as Primary Care Groups (*Nucleos delle Cure Primarie)*, each comprising geographic groupings of up to 20 GPs, ten community nurses, three paediatricians, two physiotherapists, two social workers and 0.5 community pharmacists, as well as auxiliaries.

Established in 2000, the *Max Ivan Chercish Polyambulatoria* is open six days per week with a separate out-of-hours service agency on the ground floor. It has five GPs and a community pharmacist. Four consulting rooms accommodate a half-time cardiologist, dermatologist, orthodontist and ophthalmologist. There is a range of diagnostic, nursing and AHP services within the centre. Shared information is facilitated by electronic records.

Joint working is evident in the extended role of the community pharmacist who has a dispensing role and holds the doctors' prescribing budget. This financial relationship is welcomed by all team members as part and parcel of vertical integration.