Access to primary care in Italy: time for a shake-up?

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Introduction

The combination of an aging population, the growing prevalence of patients with chronic conditions and advances in technology arouse renewed interest but also significant challenges for primary care (PC) [1]. Although a variety of definitions exist [2], PC can be considered ‘first-contact, continuous, comprehensive, and coordinated care’. Thus it is the pivotal level of a health care system, and potentially crucial. Broadly, PC includes a wide range of services such as general practice, home care, prevention, counseling and minor surgery, mid-way between hospital and community care. The next essential levels include secondary care (mainly specialist consultations), tertiary care (for unusual disorders) and emergency care (especially for serious trauma). All these further levels must be integrated with PC to provide rational, consistent care for patients [3].

PC is usually described as basic, first-step care for (1) directing appropriate access to outpatient and inpatient services [4] and (2) improving the consistency and sustainability of non-hospital health care services, often perceived as fragmented, poorly coordinated and centred on health professionals [5]. In particular, access to PC seems to be an important feature in most definitions and is still reported as a key issue in many countries, including Italy

according to the latest reform, in 2012 (National Law 189/2012) [6].

This article assesses the ‘state of play’ for access to PC in the Italian National Health Service (INHS). After a general overview of the main features of the Italian primary health care system and of the above law, we present the findings of our survey in three northern regions and discuss them in the light of ambitious expectations raised by political pledges and notions of economic evaluation.

Primary care in Italy

Local health districts

The INHS is a three-tiered (central-regional-local), highly decentralised public service mainly funded by general taxation, which provides universal coverage and comprehensive health care. The 20 Italian regions (governed by elected politicians) autonomously manage and control the services delivered by their hospital trusts and local health authorities (LHAs) (headed by general managers appointed at the regional level). The territory of each LHA is divided into local health districts (LHDs), operational units that should provide PC services and coordinate general practitioners (GPs). The average number of LHDs within an LHA varies widely, depending on the size, catchment population and geographical characteristics of the area [7].

The services delivered to citizens by LHD facilities can be roughly grouped as health and administrative services. Although the mix of health services can vary a lot at the point of delivery even within the same region, the most important are GP and specialist consultations, prevention (vaccinations and screening), counseling for family planning, home care and rehabilitation services. The

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administrative services delivered at the local level are even more varied, the most frequent being choices of GPs, specialist consultations, home delivery of devices and pathology exemptions.

General practice

General practice should be the ‘pillar’ of primary care in the INHS. Unlike other Western EU countries, there are two kinds of GP in Italy: (1) GPs for adults (1 every 1147 citizens on average) and (2) GP paediatricians (1 every 864 children <14 years on average) [8]. These are self-employed physicians mainly paid on a capitation basis under national contracts, although additional financial incentives and fees for service can be agreed upon at the regional and/or local level, and make up around one-third of their total income [8].

Unlike the majority of their British colleagues, Italian GPs have historically worked single-handedly and are somewhat isolated within the INHS [9]. Although several regional experiences have encouraged group practices since the late 1990s, largely through financial incentives, patients are still registered with one doctor, and this is a major hurdle to working in groups [10]. An aging workforce is becoming a further barrier to cultural change since around half the Italian GPs are over 55 years old [8]. According to the current national contract, a GP should open her/his practice at least 1 h per week for every 100 patients on their own list. So, on the basis of the national mean number of patients, an average single-handed GP is formally obliged to open at least 2/3 h per weekday.

The latest reform on access to PC

The law launched two radical changes in PC: (1) a single role for PC physicians, grouping all together GPs, GP paediatricians, non-hospital and out-of-hours consultants (paid per hour) to facilitate replacement as ‘*locums*’; (2) the reinforcement of GPs’ work in groups rather than as individual practitioners through (a) compulsory clinical commissioning groups of at least 20 GPs to foster clinical guidelines and good prescribing practice; (b) group practices organised into operational and multidisciplinary PC units (comprising all types of health professionals working in LHDs) open 24 h a day, 7 days a week to guarantee citizens full access. These ambitious reforms, which are intended to be achieved without any extra public spending, have been formally incorporated into the national GP contract [8]. However, their implementation will clearly be a challenge and imply radical changes from current practice; therefore, they are hardly likely to be achieved in a cost-neutral manner.

LHD survey

We conducted a web-survey on a small sample of LHDs to investigate the actual level of access to PC services by citizens [11]. Given the well-known gap between the north and south of Italy on the provision and quality of health care services [12], we limited our analysis to three advanced Northern regions in PC organisations [13]: Lombardy (by far the largest Italian region), Emilia-Romagna and Veneto (two big regions with traditionally different political orientations). For each region we selected three LHDs within an LHA of average population in order to compare three urban, rural and mountain settings selected according to their population density [14]. First, we collected information from local websites, then we made telephone calls and personal field inspections to validate them.

Table 1 summarises the main results findings. The number of sites providing health and/or administrative services ranged from one in an urban LHD to five in a rural one (3.3 on average). The weekly opening hours per site of health and administrative services averaged 14.6 and 23.2 (respectively 2.9 and 4.6 h per weekday), ranging from 6.5 and 9.7 to 28.5 and 34.0 at the LHD level. The average weekly timeline of the 731 GP practices surveyed was 17.3 (only 3.5 h per weekday, range 15.3–20.1 at LHD level).

Policy implications

Access to PC is a hot, politically debated issue in some EU countries at present, particularly in those with ‘Beveridgian’ health care systems like the UK [15] and Italy where expectations concerning the ‘gatekeeper’ role of PC for hospital services are high. In addition to GP practices, PC services are provided through various LHD facilities in the INHS, making the Italian system more complex and calling for a higher level of coordination than in the UK.

This small survey in three Italian northern regions was designed to assess the potential access to PC services in Italy on the basis of the weekly opening hours of LHD facilities and GP practices. Although the survey was deliberately unrepresentative of the whole INHS reality, it confirmed that even in advanced regions the catchment populations still have limited access. Broadly, we found widespread but very limited access to both LHD facilities and GPs’ practices. While the former ranged widely (for both health and administrative services) in our sample, the latter was very homogeneous at the local level (for both types of Italian GPs), confirming a previous questionnaire-based survey conducted throughout the country a decade ago [16].

Table 1 Weekly access to PC services and GP practices in nine LHDs in Northern Italy

Region	Type of LHD ^a	Number of LHD sites	Mean weekly hours			
			Health services ^b	Administrative services ^b	GPs for adults	GP paediatricians
Lombardy	u	1	25.4	21.9	17.1	17.8
	r	4	10.9	22.8	17.6	17.1
	m	4	11.5	9.7	16.8	18.9
Emilia Romagna	u	2	28.5	34.0	17.9	16.4
	r	5	12.0	26.0	19.3	15.9
	m	3	14.5	30.0	18.4	20.1
Veneto	u	3	13.0	22.5	14.4	16.7
	r	4	12.0	23.5	17.1	15.3
	m	4	6.5	18.5	17.5	16.5
Total	u	2.0	21.3	26.1	16.8	16.9
	r	4.3	11.6	24.1	18.0	16.3
	m	3.7	10.8	19.4	17.6	18.9
Mean		3.3	14.6	23.2	17.3	16.8

GP general practitioner, LHD local health district, PC primary care, u urban, r rural, m mountainous

^a Population density (inhabitants/square kilometers): (u) 1200–2194; (r) 208–979; (m) 46–72

^b Per site

As already seen from the literature [10], Italian group practices, although quite common now (for instance, only 15 % of GPs in our sample formally worked single-handedly), barely affect the weekly timeline. ‘Sharing the care’ requires a practice shift from an ‘I’ to a ‘we’ mindset [17] that goes beyond ‘sharing the costs’ with colleagues, and both the current ad personam capitation system and the high mean age of Italian GPs seem to make this cultural switch difficult. This situation is likely to disorientate patients (and their caregivers) between the various local sites providing health and administrative services, still often making them feel like ‘errand boys who sew together the various parts of the system’ [9]. In the end, hospitals remain the only easily identifiable health facility to which Italian citizens relate, often inappropriately as a consequence.

Given this disappointing background, the ‘24-h access target’ of the last reform, clearly drawing on the English example [18], is very likely to be—unsurprisingly—unrealistic (albeit in the right direction) and its political promise seems a chimera. Unlike the English NHS, where PC has been centred on large GP practices for decades and the political debate on 7-day full services is advanced and backed by technical information on their benefits and costs [19, 20], the situation of PC services in the INHS is historically mixed and piecemeal throughout the country. At the same time, the (largely predictable) negative reaction to the reform by the Italian GP medical associations [21] and their counterproposal of achieving the target by investing

extra funds in their role appear both simplistic and opportunistic on the basis of historical experience and in the present period of unprecedented economic difficulty.

We are convinced that a more realistic solution could be to start by merging all the existing LHD sites providing different services in a single LHD ‘health centre’ (for instance, from 30 sites down to nine in the sample of our survey), open 12 h per weekday at best and bringing together all the health and administrative professionals who work in PC. Similarly to what has happened with shopping malls in the last decades, nowadays most people are willing to travel to find wide-range facilities open on a daily basis so a large number of sites scattered over a large area has become less relevant even in mountainous zones. A single facility in each LHD could help patients understand PC health services, better improve working citizens’ access to administrative services and filter minor injuries to hospital emergency units. The INHS could offer citizens the choice either to stay with their GPs in the current situation or to opt for funding the new ‘health centres’ through their per capita fee, encouraging competition between tradition and novelty and offering new opportunities not only to young GPs but—more in general—to GPs keen to work in a group. This should enable many GPs to move there from their local practices and facilitate continuous daily medical care. Of course, the GP capitation system and fee-for-service incentives would have to be revised accordingly to give this choice more chance of being ‘cost neutral’, as the present economic situation requires.

To conclude, we firmly believe that a first clear-cut move to make PC services more accessible to the Italian population should be made very soon, then technical details can follow. Merging the existing LHD sites in a single ‘health centre’ could at least ensure that services are similarly effective. These new facilities will very likely be more cost-effective than the current sites, starting from direct savings in estate/building overheads from the INHS viewpoint to indirect gains for workers in a societal perspective. We are putting forward this very general proposal, open to debate for improving access to PC in Italy, in the belief that it is time for really ‘patient-centred’ reforms.

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