PRIMARY CARE IN A NATIONAL HEALTH SERVICE: TIME FOR RADICAL REFORM

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Italy was the first European country dramatically hit by the Covid-19 pandemic [1]. This catastrophic event has put the Italian NHS (INHS) under intense pressure and crudely exposed its structural weaknesses, particularly that of general practitioners (GPs), who are the front-line service in primary care such as their colleagues in the UK NHS. The forthcoming National Programme for Recovery and Resilience (NPRR) [2], funded by the European Union, should support refurbishing the INHS, especially in primary care.

Here we first summarize the main weaknesses of primary care in the INHS, exploiting the UK NHS as comparator to better stress them. Then, we put forward a proposal aimed to consolidate its present fragmentation, potentially useful for other European health systems.

The INHS was born in 1978 in the wake of the UK NHS, historically the first and most widely acknowledged public health care system in the world [3]. In contrast to the UK NHS, the INHS is a three-tiered (central-regional-local) public service institutionally decentralized at regional level [1]. Primary care is delivered at the local level and GPs should be the 'pillar' [4]. Uniquely in Europe, there are two kinds of GPs in Italy, one for adults and one for children. Differently from British GPs, who must undertake at least three years of specialty training after graduation, Italian GPs must undertake post-graduate three-year courses organized by regional authorities but with some variability [5]. These courses are not legally equivalent to those of the other medical specialties and the trainees' pay is much lower, making Italian GPs a kind of second-class doctor compared to their medical colleagues. Citizens are still registered with one GP and this is a major hurdle to them working collectively. Unlike the vast majority of their British colleagues, who now work in large group practices after a seamless policy to deliberately reduce single-handed working [6], many Italian GPs continue to work separately. They remain self-employed physicians mainly paid on a capitation basis under national contracts, although additional financial incentives and fees for service can be agreed at regional and/or local level. According to the current national contract, Italian GPs are formally obliged to open their practice to patients at least 15h per week [7], a minimum which often becomes the maximum in real practice [4]. In fact, rather than 'gate-keepers', many Italian GPs are still 'small private businessmen' [8] mostly remunerated publicly. It challenges credibility that they may really play a crucial role in mitigating redundant procedures in the INHS secondary care, unless there is a substantial change. In addition to GPs, many different facilities provide community health care services in the INHS local tier [7]. Infant vaccinations, population screenings, outpatient consultations, counseling for family planning, home care and rehabilitation services are all delivered in various sites providing unevenly single health and administrative services during the weekdays. Yet, since graduation in nursing was introduced in Italy only in the late 1990s, nurses played an ancillary role until recently in the INHS, primary care included, differently from the large role traditionally played by practice nurses in the UK NHS. In

general, the fragmentation of community health care services makes them hard to manage and their piecemeal delivery still disorients Italian patients and caregivers. Also, limited daily access to general practice has become a generalized issue in this era of aging population, a common issue to the UK NHS too on account of the increasing shortage of GPs [9].

According to the Italian disappointing picture and taking advantage of the opportunities offered by the NPRR, our proposal is to merge all the existing local sites providing different services into single 'community centers' open at least 12h per weekday for reasonably homogeneous urban and rural catchment areas. These facilities should bring together all the health and administrative professionals working in community health care, GPs included, who should become full-time workers, and hopefully first-class medical employees of the INHS in the long-run such as most of their colleagues in public hospitals. With advantages for planning and supervision, these organizations would dramatically extend daily access to services in the community and better filter minor ailments away from emergency departments in hospitals [10]. Thanks to broad consolidation, co-location of a wide range of health and administrative professionals in large-scale organizations should also minimize administrative overlaps, enhance the management of out-of-hours services, and improve the provision of home care for patients unable to travel − especially the older frail patients without relatives. More, co-location should facilitate communication, boost teamwork and eventually better exploit modern information technology tools like telemedicine [11]. The development of hi-tech skills within these organizations should help clinicians recoup time with patients − always their foremost activity − and limit their burnout symptoms. Furthermore, these single facilities could help people better understand community health services and improve working citizens' access, a pressing priority in modern societies. Beyond being potential patients themselves, working people are often caregivers for children and elderly people. So, they are the most penalized social category by the piecemeal delivery of community health and social services in the INHS.

Actually, the outline of our proposal for integrated 'community centres' is basically consistent to the 'community houses' envisaged in the forthcoming NPRR for catchment areas of around 30-50,000 inhabitants [2]. However, the first indications are not encouraging, lacking clear rules on clinical governance of these sites in addition to an expected reluctance by the main Italian general practice associations, with the proposal of GPs frequenting these sites for just 2-6 hours a week as a very disappointing example.

To conclude, the post-pandemic period gives an unexpected opportunity to boost quality of community health care. Once stopped the myth of promoting market competition in healthcare (launched in England in the early 1990s) [3], we are convinced that the Beveridge-style health care system remains the most favorable to enhance integrated care [9,10]. Striving for combining parts to form a whole, the real crux of the matter is to shift from an 'I' to a 'we' mindset for providing primary care [12]. Since timely access to GPs has become a common issue in this era of aging populations [4,13], further amplified by the widespread difficulty of recruiting young GPs among graduates in medicine, the real challenge for European NHSs in primary care is to make it truly patient-centered regardless of underfunding due to the never ending financial crisis. One might hope this will include in the long run bringing all public (including social) services provided in community care closer together in large-scale organizations, which are in our opinion a priority for modern full-access primary care. Our pragmatic proposal to put together all the existing community services goes in this direction.

1 Garattini L, Zanetti M, Freemantle N. The Italian NHS: What Lessons to Draw from COVID-19?. Appl Health Econ Health Policy. 2020;18:463–6.
2 Piano Nazionale di Ripresa e Resilienza. https://www.mef.gov.it/en/focus/The-Recovery-and-Resilience-Plan-Next-Generation-Italia/ (accessed December 3, 2021).
3 Garattini L, Padula A. Competition in health markets: is something rotten? J R Soc Med. 2019;112:6–10.
4 Garattini L, Padula A. English and Italian National Health Services: Time for more patient-centered primary care? Eur J Intern Med. 2018;57:19-21.
5 Badinella Martini M, D'Ascenzio F, Zaninelli A, Garattini L, Mannucci PMM. The dark age of Italian general practice research – An Italian matter. Eur J Intern Med. 2020;73:98-9.
6 McCarthy M. Sustainable general practice: looking across Europe. Br J Gen Pract. 2016;66(642):36.
7 Garattini L, Badinella Martini M, Zanetti M. The Italian NHS at regional level: same in theory, different in practice. Eur J Health Econ. 2021. https://doi.org/10.1007/s10198-021-01322-z
8 Saltman RB . Melting public-private boundaries in European health systems. Eur J Pub Health. 2003;13:24–9.
9 Godlee F. NHS reorganisation: We don't need a big bang. BMJ.2021;372:n464
10 Garattini L, Badinella Martini M, Mannucci PM. Integrated care: easy in theory, harder in practice?. Intern Emerg Med 2022;17:3–6.
11 Garattini L, Badinella Martini M, Zanetti M. More room for telemedicine after COVID-19: lessons for primary care?. Eur J Health Econ. 2021;22:183–6.
12 Ghorob AMPH, Bodenheimer TMD. Sharing the care to improve access to primary care. New Engl J Med. 2012;366:1955-7.
13 Mahase E. GPs are being blamed for government failures in primary care, say doctors. BMJ. 2021 13;374:n2234.