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**THE MANAGEMENT OF CHRONICITY BETWEEN EQUITY AND
SUSTAINABILITY: FROM EMPOWERMENT TO ENGAGEMENT.**

The case study of MGI in Trebaseleghe.

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LIST OF ACRONYMS

- **A-ULSS**: Health Local Authority
- **AFT**: Territorial Functional Aggregation
- **AZIENDA ZERO**: Local Health Authority in the Region
- **BPCO**: Bronco-pulmonary chronic and obstructive disease
- **CCM**: Chronic Care Model
- **CDCD**: Centres for Cognitive Decay and Dementias
- **CdE**: Exercise Contract (Contratto d’esercizio)
- **COT**: Territorial Operative Centre
- **DGR**: Regional Decision
- **EHR**: Electronic Health Record
- **GDP**: Gross Domestic Product
- **GP**: General Practitioners
- **HLY**: Healthy Life Years
- **HIA**: Health Impact Assessment
- **HTA**: Health Technological Assessment
- **ITC**: Information and Communication Technologies
- **LEA**: Essential Assistance Level
- **LTC**: Long Term Care
- **MAP**: Matching Aid and Person
- **MG**: Medicine Group
- **MGI**: Multiprofessional Team of General Practitioner
- **MGG**: General Practitioner
- **MIUR**: Ministry of University and Research
- **NCA**: National Collective Agreement
- **NCD**: Non Communicable Disease
- **NHS**: National Health System
- **NIHS**: New Information Health System
- **OECD**: Organization for Economic Co-operation and Development
- **P4P**: Pay for Performance
- **PCMH**: Patient Centred Medical Home
- **PDL**: Paediatricians of Free Choice

- **PDTA:** Therapeutic care diagnostic pathways
- **SHI:** Social Health Insurance
- **SSSN:** Health National System
- **SSSR:** Regional Health System
- **TRU:** Territorial Rehabilitative Unit
- **UCCP:** Unit of Primary Care Centre
- **UTAP:** Primary Care Territorial Unit
- **WHO:** World Health Organization

ABSTRACT

Improving human health and providing access to cheap and high quality health care is a key concern of all countries. It is not only an ethical and social imperative but it is a necessary ingredient for the sustainable long-term development of our economies and societies. In many OECD (Organization for Economic Co-operation and Development) countries, health care is one of the most important and dynamic growth sectors in the economy and for this reason it is one of its priorities.

In the OECD countries, health status has improved dramatically over past decades. Life expectancy at birth has increase from 68 to 78 years on average since 1960. Infant mortality, today, is seven times lower than it was then. The successful implementations of childhood vaccination programmes in OECD countries have largely eliminated certain targeted diseases. We have also seen major breakthroughs in prevention and treatment for conditions like hearts disease, cancer, stroke and premature birth, etc. but there are still big differences both across and within countries in life expectancy and other health indicators. Quality services are also uneven and cost pressure is increasing. This means that more needs to be done. The first challenge, faced by health systems, is to provide universal coverage and equal access to medical services for all. Without effective health coverage, people have to pay for care out of their pockets and OECD countries are addressing this problem in different ways. A large majority of OECD countries grant universal access to publicly financed health services but this is not the only model. Switzerland and the Netherlands have a universal mandatory private health insurance system with regulated competition across multiple insurers. Mexico encourages the uninsured population to take up voluntary insurance with an improved package of services: a mix of individual premium and government subsidies to the poorest population groups finances this. Universal coverage offers health but also financial protection. It promotes equitable use of health services, helps tackle poverty and, also, promotes access to treatments and preventive services. But there are still inequities that must be eliminated. Only three OECD countries have not attained universal health coverage yet. In the United States, 14% of the population has neither public or private health coverage. In Turkey the health system was available for only two thirds of the population in 2003. And half of the Mexican population is not part of the social securities and this uninsured population relies on poorer-quality medical services provided by state health facilities. The second challenge that should receive more attention is prevention. Many preventive services have the potential for improving health and longevity at least as much as curative services, at

lower costs. Today, the 15% of the adult population in the OECD countries is obese, which raises the risk of chronic disease, all the ways, from diabetes to dementia. Yet, only a negligible proportion of health spending in OECD countries is explicitly directed towards prevention and the providers, as doctors and hospital are often not rewarded for successes in preventive services and treatments, even if these would reduce the need for expensive treatment later on. Even if we know what works to improve the performance of health system, this is not an easy task to achieve for policy makers. Health policy decisions have considerable economic consequences and reforming the system can be extremely difficult. Given the speed of developments in medicine and the evolution of health care goals, reform of health system is necessarily an on going iterative process.

The focus of the work is the reform of the health system. The need to change rise according to the new demographic conditions that the world must face (as the population ageing) and the new consciousness about the need of universal access to the health services and equity in the distribution of the resources. These are the two main motors pushing for a new healthcare system. Every country in the world present different organizational model but every one must follow the directive expressed by the WHO (World Health Organization) that exhorts toward a model closer to the community and that grant more continuity and comprehensiveness of the cure pathway. These features are some of the five health indicators that the health system must have in order to achieve the goals fixed by the world community and they are the bases of the primary care. The primary care, hence, is the structure on which the nations found the actions to overcome the new issues and challenges coming from the population ageing. The population ageing is due to several factors: the increase in the healthy life condition, medical innovation, the disappearance of infectious due to vaccines and the lower rate of nativity, after a boom of birth in the years '50. This demographic condition affect large part of the policy decision and the social structure, and the health system is one of them. In fact, the ageing of the population leads to an increase in the chronic degenerative disease, that present high health costs to be sustained and the old hospital centre model is not efficient to face the matters. Chapter 1 presents a deeply analysis of all these aspects and explain the world demographic situation, giving more attention to the developed countries.

Chapter 2, starting from the previous analysis, try to describe what are the main solution that the nations can take. The best one is the implementation of the primary care model, which gives more importance to the people and their needs. The primary care is based on the *Chronic Care Model*, proposed by Wagner in 1968, which reorganize the health structure on the territory, giving more attention to some particular features, as: the new health organization, delivering system, the self-management of the patients, informatics system and

the community. Start to raise the idea that, if the health system wants to grant and offer high quality services, it must rethink the providing system with the decentralization from the hospital and giving more power to the territorial structure and implement the resources distributed on it. Hence, thanks the *Expanded Chronic Care Model* the dimension of the community gain a key role and the organization becomes more patient centred. In the *Patient Centred Care* patients are the heart of the cure and the system is created around their needs. To ensure a totally taking care of the person, it is required the collaboration between professional in working team. Group the GP (General Practitioners), distributed in the territory, in team gives the possibility to increase the coverture of the community, giving continuity and comprehensiveness of the cure. However, the concept of continuity it is not only linked to doctor and patients but also to territory and hospital. For this, it is require the empowerment of the informatics system, which facilitates communications and the transfer of patient information in short time. Give more importance to the people allows the health system to gain important information about the epidemiological situation of the society and to implement the most appropriate preventive programs, that play an important role for increase the health of the people but also for reduce the waste of resources. In fact, with the population ageing and the high incidence of chronic degenerative disease, the old hospital centred system it is not efficient to deliver the needed services and reduce the bad fiscal impact of these disease. Hence, the prevention activities are real interesting aspects of the reform because them consent to have a control of the chronic diseases distribution and its effects over the people and community and to reduce the health expenditure with the decline of unnecessary access in hospital and emergency (especially with a control of the white codes).

However, for activating these world's directives, every nation must have a legislation base that support the reorganization. The chapter 3 is focused on the main national and regional law that allow the reform. From 1950 until now, the Italian health system has always changed the organization to better deliver services in relation to the social needs. The National Health Plan, from 2006 showed the want to reorganize the health system with the realisation of the primary care team. In the last year, with the latter regional decision, there was the development of the model that allow the pre-existent UTAP (Primary Care Territorial Unit), MG (Medicine Group) and all the doctors to activate the Multiprofessional Team of General Practitioners (MGI): this integrate group medicine can reflect all the main aspects presented in the WHO declaration and, also, give the possibility to gain a reduction in the health expenditure. In fact, the model is based on the creation of team of doctors that work together and grant a high coverture of a given area. The patients of all the general practitioners can easily have access to the principal ambulatory that offers different services:

simple clinical intervention, medication, control, continuity of care for particular disease, taking care in urgency and prevention activities. The plan was implemented from 2015 and it is, actually, in developing phase. All the regions present different states of the work, but here it is analysed what is happening in Veneto. In order to implement the reform, the first step in Veneto region was to reduce the number of A-Ulss (Local Health Authorities), from 21 to 9, and in each of these is started the programming and the implementation of the MGI. The regional decrees and declarations said that, at the end of 2018, the 80% of the GPs in the territory should be organized in MGI and, in this chapter, it is described the actual state of actuation of the plan.

In this macro-context is introduced the MGI of Trebaseleghe (PD) and, in the last chapter, is taken into analysis this practical case study. This is a completely new reorganization of the surgery's systems in the community and, from it, can raise the positive aspects and the main issues. If we add the experience of this team to the all other actually implemented, it is possible understand if it is a good way to grant better services with high quality and reduce the health spending.

1. EVOLUTION OF HEALTHCARE SYSTEM: AN INTERNATIONAL OVERVIEW

Balancing health care accessibility, quality, financial sustainability and equity is one of the most difficult challenges facing the modern governments. Health is a uniquely complex intersection of cutting-edge science, constantly developing technology, acute political sensitivity and practical complexity and profound importance for patients and their families. During the last decades, the health system gains more value and it becomes a fundamental part of the economic growth. It means that the structure of the health system changes over time according to the cultural tradition, to the historical background and to the new needs that rise from the modern society. However, today the health system must face several issues and new challenges.

1.1: HEALTHCARE SYSTEM IN THE OECD COUNTRIES

For the policy makers of the OECD countries it is very interesting understand the level of the health of the people and, also, how good is the health system and how is the quality of the services that it delivers. In fact, the attention on health became an integral part of the economic development and many countries are investing a lot in it. The clear result of the increasing interest on the health system is the drastic changes in the life expectancy: people in OECD countries are living longer than ever before, with life exceeding 80 years on average.

Health services will always reflect not just the evidence about best policies and practices but also local and national contexts or circumstances. It means that, according to the cultural base, the historical background and the main interest of the administration, the health structure and the delivery of services changes across the states. In most countries, universal health coverage provides financial protection against the cost of illness and promotes access to care for the whole population but, in some other countries, the health access is not so easy and guaranteed. Broadly speaking, it is possible to identify three main general contracting models in the health care that ensured the possibility to benefit of the health services:

1. *Integrated model*: the funding and ownership of services are under the same public or private responsibility. The best-known example of this model is the original British National Health Service (NHS) of 1948. The NHS provided tax-funded health care for all, largely paid out of general taxation. A modern-day example of an integrated private model is the health maintenance

organization (HMO) in the United States.

2. *Contracting model*: where governments or other third party payers (the administrative agencies of social health insurance or private health insurers) negotiate long-term contracts with health care providers.
3. *Payment model*: common in private insurance, is that of reimbursement, where the patient first pays his provider and then seeks reimbursement from his insurance agency.

Found that the countries can have different health system, that affect the health coverage and the degree of access to the services, the key challenges facing from all the National Health Systems (NHS) are the same:

- Financing the health care to ensure equity of access and provision;
- Demographic trends pointing to ageing populations and the rapid rise of chronic and non-communicable diseases;
- The pandemic of disease of affluence and lifestyle, notably obesity, alcohol misuse, mental ill-health and sexually transmitted infections;
- The shifting balance between primary and secondary care to give greater priority to the former;
- Health inequality and the widening health gap between rich and poor, which is occurring at a faster rate in some countries (especially in USA).

Thus, in the modern society the health system covers a really important role and it is essential implement it according to the new issues and difficulties that arise from the change in the life expectancy, demographic composition and the new disease and health problem. To do this, it is necessary to analyse how works the actual health system and, also, determine the general key elements that are useful to study in order to assess the strength of the health structure. The OECD finds several indicator of the well being of the health arrangement and five dimension that the health organization must achieve in order to have an effective and high quality system.

1.1.1: THE FIVE DIMENSIONS OF THE HEALTHCARE SYSTEM

As showed by the research and the collection of the data of the OECD countries, the quality of care has generally improved. The reduction in deaths after hearth attacks and strokes, and earlier detection and improved treatments for serious diseases, such as diabetes

and cancer, are a clear evidence of increase in quality. But this improvement is translated in an increase of the costs: the health spending is 9% of Gross Domestic Product (GDP) on average in OECD countries, and exceeds 10% in many countries. Higher health spending is not always turn in a good management of the resources and in an efficient service delivery, but there is ample evidence of inequities and inefficiencies in health systems. The nations have some key indicator to analyse the well being of the health system and to use to understand if the policies in action will be the good one to achieve best results. The analysis is made along five dimensions:

1. Health status;
2. Risk factors to health;
3. Access to care;
4. Quality of care;
5. Health care resources.

The *health status* is the life expectancy at various ages, that is not only related to health spending and the performance of the health system, but also to a wide range of non-medical determinants of health, as the lifestyle and behavioural factors. The countries that have a good performance in this indicator, typically, have lower rates of mortality from, for example, cardiovascular diseases. Usually higher health spending per capita is associated to higher life expectancy, but is not always true. Some countries as Japan, Spain and Korea have relatively high life expectancy with a high level of financing but the United States, instead the elevated investment, have relatively low life expectancies. In USA, the health system is predominantly in the hand of private insurance agency and for receiving medical services the patients must have signed a policy of insurance. In addition to this service, there are *Medicare*, the unique public care program addressed to people older than sixty and independent from the income, and *Medicaid*, which helps the population below the poverty level. But, in the USA the life expectancy is lower than the most other OECD countries¹. This low level of health system performance is due for several reasons: the fragmentation of the USA health system, with relatively little investment in the public health and in the primary care; the life style of the people, as the increasing in the consumption of alcohol, smoking and the increasing in the obesity rates among adult (35%), and in the last years, of the child; higher mortality rates from various health-related behaviours; adverse socio-economic conditions; and poor access and co-ordination of care for certain level of people². In the USA

¹ Health at a Glance, 2015

² Matthias Wismar and all, 2011

health system the acute care, which is managed by the hospital, is excellent, with a great quality in the services related to the heart attack or for the diagnosis for different types of cancer, like breast cancer or colorectal cancer. But it is not enough to ensure a good service despite funding. In fact, it is very important to reduce the hospital admissions for people with chronic conditions, such as asthma, chronic obstructive pulmonary disease or diabetes and managed these syndromes in the territory, with the implementation of the primary care, through regular monitoring and surveillance, involving patient it-self care, and providing them with counselling about dietary habits and the importance of regular physical exercise. This highlights the importance that countries putt on health promotion and disease prevention policies to reduce modifiable risk factors to health and mortality from related diseases.

Despite remarkable progress in health status and life expectancy in OECD countries over the past decades, there remain large inequalities not only across countries, but also across population groups within each country. These inequalities in health status are linked to many factors, including differences in exposure to *risk factors* to health and in *access to health care*. Inequalities in health status are due to many factors, including differences in living and working conditions and in behavioural factors. Lifestyle behaviours (such as nutrition habits, physical inactivity, obesity, smoking and alcohol drinking) are important risk factors for many diseases including diabetes, cardiovascular diseases and cancers. People in lower socioeconomic groups are more likely to smoke, be obese and be exposed to other environmental risk factors. Greater efforts targeting modifiable behavioural risk factors, among disadvantaged groups, can play an important role in promoting healthier lifestyles, offering individuals better choices and reducing health inequalities. In order to reduce the incidence of these different risks, it is necessary to create a prevention program and to improve the information and the education of the people. The other features governs must consider to moderate the inequality is the *access of care*. Most of the OECD countries have achieved universal coverage of health care costs for a core set of services, with the exception of Greece, the United States and Poland. In the United States, for example, the percentage of the population uninsured has started to decrease significantly in 2014³, following the implementation of the “*Affordable Care Act*”, which is designed to expand health insurance coverage and Obama, with his “*Obama Care*”, the reform of the health system, tried to reduce the inequality in the access of the health performance. In Greece, due to the economic crisis, the health insurance coverage among people is drastically reduced, and many self-employed workers have also not renewed their health insurance plans because of reduced disposable income. The access to the health system may not depend only on the financial protection, but

³ Health at a Glance, 2015

also on the range of goods and services covered and the extent to which these goods and services are comprised. In countries like France and the United Kingdom, the amount that households have to pay directly for health services and goods, as share of their total consumption, is relatively low, because most such goods and services are provided free or are fully covered by public and private insurance, with only small additional payments required. Some other countries, such as Korea and Mexico, have achieved universal health coverage, but a relatively small share of the cost of different health services goods are included, leaving a significant amount to be paid by households. The health access may be restricted, also, because of the geographic barriers, waiting times and other reasons⁴.

Linked to the health access there is the *quality of care* and the improvement of this has a high priority in most of the OECD countries. The United States is an excellence in acute care, with a good and efficient management of the activities in the hospital, but has a lack in the prevention and in the monitoring of some kind of disease in the territory. The reverse is in Portugal, Spain and Switzerland, which have relatively low rates of hospital admissions for certain chronic conditions, but relatively high rates of mortality for patients admitted to hospital for heart attack or stroke. Some experiences show that is very important the implementation of monitoring action in order to reduce the rise of some illness, as cancer, or to prevent need of hospitalization due to the intensification of some chronic pathologies.

1.2: CHANGE IN HEALTHCARE SYSTEM

The OECD countries give a relevant importance on the improvement of the health system and for all the nations the progress of the quality in health care is a vital purpose. For this reason, the politicians must make a good performance along the five dimensions of the health. However, the level of the quality is not so easy to assess because it presents several different aspects and perspectives. The main difficulty in the collection of data is that some factors are not quantitative but qualitative. In fact, it is easy to evaluate aspects related to the financial and economic view, but more difficult is to assess aspects associated to the satisfaction of the people. This is the cause that prompts the policy makers to pay attention to the needs of the patients. Now, it is recognized to the patients the right to receive timely, safe and effective care and to be informed about all the risks and the benefits of the care process and the goal of the health system is to deliver services that are effective, safe and responsiveness to patient's needs. This monitoring process is necessary because measuring quality of the services is a first and essential step to reaching that goal. Hence, for assess the

⁴ EU-SILC server.

goodness of the health services and structure, it is relevant to analyse closer the reaction of the people. This is the reason why, today, the health system face a change and takes shape a new model, so called “*Patient Centred Care*”, characterized by:

- Improvement of the coherence and co-ordination of care;
- Prevention of illness and disease;
- More attention that people receive care they need;
- More control on the effectiveness of care;
- Make sure care is safe;
- Reward health care providers for good quality care;
- Current shift of health care system towards outcomes-based, quality-led governance.

The collection of information about these relevant features is useful because can be strength and catalytic for starting with the changing process. In fact, these features are essential to make the transformation of the health system according to the new vision and new expectation on the health structure. However, the adjustment of the health system will be stalled by professional and organizational inertia in the absence of specific steps to follow and that make the change both necessary and possible. Variations in aspects of system performance can be surprisingly difficult to effect in the desired directions. Specially, it is difficult to create a model that all the countries can follow in order to achieve the same goals and to standardize the health care all around the world. Citizens vary across the OECD nations, different are the health issues and distinctive is the way in which the professionals work and be pay. However, the information collected allows identifying some features that might be useful to implement and encourage the change. These features can be grouped in three main keys set, as the Table 1 (Table 1: Drivers of change) shows.

Table 1: Drivers of change		
INCENTIVES	ACTORS	MECHANISMS
Economic	Consumers	Regulatory
Non Economic	Purchases/Founders	Administrative/professional
	Professionals/Managers	Market-based

Source: Sheila Leatherman, 2010

Today, the pay systems for primary care physicians offers for a “*quota*” and a “*fee-for-services*” provided and the amount of both the components is set by a national institution, as

the “*National Collective Agreement*” in Italy. The “*fee-for-services*” provided currently involves financial incentives to encourage primary care physicians to adopt forms of associative medicine. The economic incentives can be added to non-economic incentives linked to the greater supply and use of computer systems or the recruitment of support or other medical staff. In general, economic incentives can be used to promote high-quality primary care services or to achieve specific objectives. One of the incentive strategies is the “*Pay for Performance*” (*P4P*), which delivers for the provision of economic incentives linked to the achievement of specific indicators. The strategy is based on the assumption that increasing the salaries of professionals improves the quality of the services delivered and/or increases their capacity. Incentives can act as a stimulus for changing professional behaviours motivating physicians and organizers through economic recognition. The most important experience of P4P is the quality of the services and the outcome of the English National Health System. With an annual investment of around 1.3 billion euros, provides for general practitioners a supplemental salary (+25%) linked to the achievement of 147 performance indicators⁵. However, in complex systems such as healthcare, where accurate planning and close integration with organizational dynamics are required, incentive effectiveness tests are modest and inconsistent. Incentives are useful in some context, for specific outcomes and to stimulate change to the new methods of delivering health services but there is not evidence that support the use of incentives to improve primary care.

The second group of change drivers is related to the people that work in the health system and the consumers. The population ageing, the raising of new disease, the necessity to the introduction of preventive actions, the needs of the patients to be well informed about the medical treatments are a small part of the features that make necessary to change the way in which the health cares are provided. Related to the change in the delivering of the services and another important driver of the change is the new role that the doctors will assume. Doctors are potentially the best health care managers and it is important that they assume this function: for this reason it will be require an expected training of physicians so that future healthcare managers can acquire that range of skills needed to face the new roles. The abilities that doctors have to gain are of a different kind: first, doctors have to be able to manage in a non-authoritarian way through a system based in the influence and the use of incentives, which are not necessarily economics. In addition, physicians need to have general knowledge of the macro and microeconomic impact of some specific phenomenon and decisions, they must be able to manage information and communication systems, which are a critical node for management and integration between operating units and professionals. Doctors need to be

5 Cartabello A, 2012;4(6)

capable to perform strategic blanks and have a basic understanding of non-profit marketing techniques that can cure the internal and external image of the structures. All these aspects are added to the importance of managing strategic research to understand the importance of new fields such as clinical epidemics, decision making, moral and ethical issues, medical/patients communications techniques, health education, prevention and use of protocols.

At least, the change must be supported by the legislation. The push for change that has been summarized hereunder has been backed up by legislative decrees 512/1992 and 517/1993, and the current reforms are a clear demonstration. Such innovations are parts of forces of reforming the healthcare system. The common goal of all the experiences of the OECD countries is to be able to guarantee equity and efficiency, quality and affordability, universality of services and access to private capital. All the nations, according to their legislation, history and culture, in the last years, develop new plan to adapt the National Health Systems to the macro-environment condition, to the specific economic situation of the country and to the socio-demographic problems. In the chapter 3, the focus will be on the legislation and the reform that drive the change in Italy.

Hence, the health system's change is an on-going process based on the change in the needs of the population and, thus, it is strictly connected to the evolution of the society. But the common goal of the OECD countries is to optimize the health of individual patients and population in an equitable, efficient and effective manner. To start the health system improvement it is, at first, really important understand what does and does not work in real life. The assessment of the performance is the only means by which we can realize what the nations is doing well, where are falling short, and what kinds of solutions have been found effective in other jurisdictions. Health system, in fact, reflects not just evidence about best policies and practice, but also local and national contexts or circumstance and the value or preferences of different communities. No one magic solutions have been found that will achieve this goal through reform of services delivery or finance. However, the improvement requires incremental change at all levels of the health system. This evolutionary process depends on a systematic measurement of the health system performance that is difficult and, sometimes, not so clear. In fact, the general assessment of the population health can be compromise by factors that cannot be managed through the health care system and some indices of system-specific performance can be imprecise and misleading. To drive the change, it will be more useful to develop accurate and reliable data system, at a micro and meso-level, with performance indicators that refers to expensive, complex or high-priority services. Ascertaining the needs and views of all health system users, such as patients or professionals, is essential to develop a data collection system. It is clear that, in order to improve the health

system it is necessary to make an alignment of information system, performance measurement, reporting system, organizational and professional culture and the implementation of the mechanism. The conclusion of the analysis is necessity of a reform of the health system in order to reduce the variation of the healthcare culture through the standardization of scientific and analytical method, the medical practice and the information system. Hence, the change of the health system in something that is more effective and efficient pass through a better alignment of information, incentives and actions with appropriate policy objective, the measurement of health outcomes, that remains a major challenge both for evident based medicine and for evidence-based policy and further measurement of outcomes.

1.3: WHY IS THE CHANGE NECESSARY?

The health system is now under stress and the tensions arise from well-know sources. The flexibility of the demand of services from patients is due to: the population ageing, with an increase in the long term care, coverage by almost universal public and private health insurance, rising public expectations and increase of chronic disease. These features change very rapidly and, in the last years, raise some issues that the “old” health system is not ready to face on. The main challenge that the health system must confront is the economic sustainability of a very complex and articulate structure that covers many aspects of the health of the patients. In fact, the patient care across OECD countries is increasingly characterized by multidisciplinary and high-tech care, which implies more integrated care at all level. This is very important, especially if we consider the chronic disease with continuative care, that can be very expensive. The attention of the politicians is focus on the change of the health system from acute care in the hospital to patient taking over the territory with targeted programmes aimed at specific illness or population group. These include patient’s self-management, clinical follow-up, case management, multidisciplinary care and evidence-based approaches to chance processes of care. These programmes are intended to increase the quality of care through various mechanisms, such as assigning specific management roles to professionals, ITC (Information and Communication Technologies) systems to monitor the care delivery process and facilitated patient self-management. They also aim to reduce overall demand on the health care system by reducing unplanned hospital stays and the use of emergency services. Hence, the most relevant aspects that became the focus of the reform are a health system that gives more attention to the patients that is called “*integrated care*”. This kind of patient-centred care try to improve patient care by reducing fragmentation, improving accountability, patient involvement, transparency and quality of care. But the creation of this

system is complex for a number of reasons: the multidisciplinary professionals have different notions of what quality is and is difficult for them integrated different protocols or procedures. Again, the gap in the communication is due to the fragmentation in the development of information systems because in some sectors there are better quality measurement system than others and many of these are not interoperable. Instead, this concern of integrated care is becoming increasingly and relevant in all OECD countries. Despite the difference between countries in morbidity and mortality of their populations, international health care system are confronted with the same problem: the population ageing; degenerative and chronic disease (which require different care delivery and organizational structure); the increase in the health expenditure; the needs to implement the informatics system. And quality has a relevant role in all of these challenges because poor quality of care undermines every goal of modern health system. It results in poor patient satisfaction, excess morbidity and premature mortality and increase health costs.

The Institute of Medicine's influential 2001 report "*Crossing the Quality Chasm*" identified patient-centred care as one of the most important domains of quality. The report identified several priorities for achieving patient-centred care including the provision of better care co-ordination and integration, care information and education, guarantees covering the patients physical comfort and emotional support for informal caregiver. Orienting a health system around the preferences and needs of people improves the patient satisfaction and health outcomes and even contribute to improve efficiency. The concept of patient-centred care has become one of the key characteristics of modern health care system and it is seen as a way to sustain the high quality but, at the same time, facing the main problem of sustainability, that are the ageing of the population and the high costs to sustain. To overcome these features, it is necessary to rethink the distribution of the health finance resources out of the hospital to make stronger the preventive action and the education of the patients to healthier lifestyle, so to reduce the incidence of avoidable disease.

In the paragraphs below there are a broadly description of these three main feature: it is important to understand the nature and the main aspects of these elements to understand the importance and the necessity of health structure rethink, specially in Italy, to maintain a universal access to the care and to avoid the change of the system from a National Health System to an Insurance Health System, as the American one.

1.3.1: POPULATION AGEING:

Demographic change is recognised as one of the most significant challenges currently facing Europe. The population change occurs as results of two socio-demographic factors:

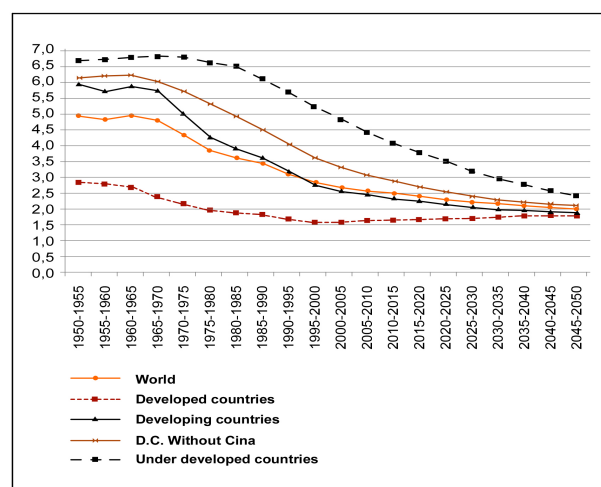
- The differences between the number of births and the number of deaths, so called “*natural change in population*”;
- The difference between immigration and emigration.

In the recent decades, the structure and profile of the EU population has changed considerably do in part to: lower birth and fertility rates, changes in patterns of family formation, shifts in the roles of men and women, greater geographic mobility, higher levels of migrations and increase in the life expectancy. All these aspects change the society’s configuration and modify the way in which the society is managed. The migrations, the different role of the women, that actually occupy a relevant place in the working market, change the economic environment. However, there is another important aspect to consider. An old society, results of both relative and absolute increase in age, changes the policy attention and, now, the focus is on the contribution the elderly can make in both economic life and civil society and on the influence that this social group can have on range of policy areas, including finances, labour markets, housing, social and health care system. To avoid the rise of structural problem it is really important understand what is the way to absorb this consistent part of the community, without break in the pension found and, also, in the health system. The population ageing should have several causes, which should produce different effects on the society and economic structure. The phenomenon can be derived from:

- Reduction in fertility;
- Rate of dependency of older people;
- Higher life expectancy.

Birth rates have been falling across much of the world in recent years and OECD countries are not exception (Graph 1: Rate of birth⁶). In 1970, the average woman in an OECD country had 2.7 children in her lifetime and today is around 1.7 that is a level of rate not sufficient to maintain a stable population size, excluding any impact from migration. Thus, during the XX century, developed countries have seen

Graph 1: Rate of birth



Source: WHO statistics

⁶ Manuela Stranges, 2013

fertility decline and this decrease leads to an increase in average age. The rise of the middle age has drastically enlarged the group of people with more than 65 years, followed by a rapid increase in the extreme range of elderly

population, over 85 years old. The Table 2 (Table 2: Life expectancy in Italy) shows the change of the percentage of older person in the Italian society from the beginning of '900

century to 2050, with a forecast of the increase in the future. If in the early years of 1900 people with more than 85 years old was less than 1% in the society, the percentage will drastically increase and in the 2050 a consistent part of the society will be composed by elder

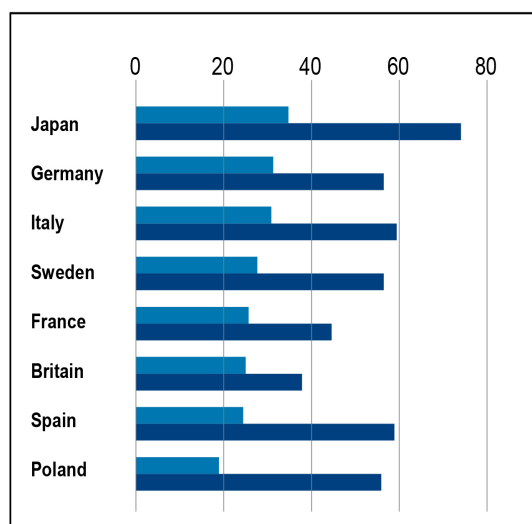
Table 2: Life expectancy in Italy				
	1900	1995	2030	2050
65 or more years %	4	12,8	20,0	20,0
85 or more years %	<1	1,4	2,4	4,6
85 years or more, billions		3,6	8,4	18,2

Source: L'invvecchiamento della popolazione.

(4,6%), that means 18,2 millions of people. The high rate of growth of this age group has important implications, as this range require a particularly high use of resources, due to high presence of psychophysical illness.

Another important deterrent, that gives a clear measure of the ageing of the population, is the “*dependency rate of the elderly*”. This index is compute by dividing the number of retirement age people with the working-age population. It is a really important part of the analysis because the elderly weigh considerably on the pension and health care system. As showed by Graph 2 (Graph 2: Forecast of dependency rate)⁷, the degree of dependency ratio still increase over the years and this element must affect the composition of the society. An increase in dependency ratio means an increase in old people that need health cure, because affected by chronic disease that, over the time, make them limited in the daily

Graph 2: Forecast of dependency rate



Source: The Economist

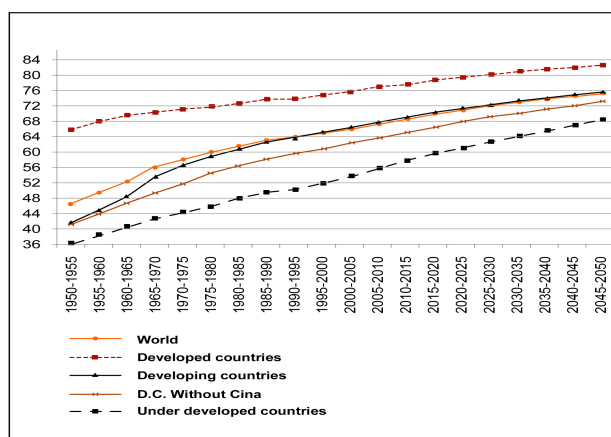
⁷ The Economist, 2015

actives. Governments must face the problem of the redefinition of the society to avoid the collapse of the community. The older band will have to be employed to provide useful services to society. For this reason, it is necessary that the health care system can guarantee the care and control of these people to give them healthier years as possible.

The last reason why our societies are ageing is simply that we are living for longer (Graph 3: life expectancy in the world⁸). Average life expectancy at birth in Italy is now just over 83 years, rising to just over 86 for women, but it is by no means exceptional because in well over half of OECD countries, life expectancy is now above 80. Indeed, much of the major rise in *life expectancy* is related to the *higher surviving birth rate* and possibility to live into adulthood. The better life condition, as major improvements in nutrition and access to

clean water, as well as in healthcare, improve the life wellness and increase the life expectancy and, with the improvement of medical technology and biotechnology, such as mass vaccination, some mortal disease are under control or completely eliminate (as smallpox). Thus, all of these aspects increase the life expectancy at the birth: more child stay alive more people can became adult. In addition to the life expectancy at birth, another important

Graph 3: Life expectancy in the world



Source: WHO statistics

aspects, that allow the population ageing, is the life expectancy over the 65 years. At the beginning of the '900 century, it was rare that men and women survive until the 80 years old: it was usual that people died after a heath attack, ictus, pneumonia etc. Given the importance of these two aspects, the Table 3 (Life expectancy at birth and at age 65, EU-28, 2002-13⁹), shows the increase in life expectancy before as average and after relative for men and women. What emerges from the table is that, years after years, there is a slight steady and consistent growth in life expectancy at birth, from 77.7 in 2002 to 80.6 in 2013, an increase of almost 3 years. If we add to life expectancy after age 65 this data, it is easy to see that average age between men and women ranges between 90 in 2002 to nearly 100 in 2013. Observing the proportion of growth it is clear that in the years to come the average age of senior will rise. Therefore, if in the 1950s a person of 70 years old was considered elderly, today it is not.

⁸ Manuela Stranges, 2013

⁹ Eurostat, 2015

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Life expectancy at birth	77.7	77.7	78.4	78.5	78.9	79.1	79.4	79.6	79.9	80.3	80.3	80.6
Males	74.5	74.5	75.2	75.4	75.8	76	76.3	76.6	76.9	77.3	77.4	77.8
Females	80.9	80.8	81.5	81.5	82	82.2	82.3	82.6	82.8	83.1	83.1	83.3
Life expectancy at age 65	17.8	17.8	18.3	18.3	18.7	18.9	19	19.2	19.4	19.7	19.6	19.8
Males	15.8	15.8	16.3	16.4	16.8	16.9	17.1	17.3	17.5	17.8	17.7	17.9
Females	19.5	19.3	19.9	19.9	20.4	20.5	20.6	20.8	21	21.3	21.1	21.3

Source: Eurosta, 2015

A 70 years old man, if in good health, must be considered an active part of the society and able to produce wealth. This is because the society will no be able to support the tax burden of this range of society. For this, having seen the increase in years of life, now it fundamental understands what is the quality of the years of life earned.

HEALTHY LIFE YEARS

Population ageing is one of the greatest social and economic challenges facing the EU. These demographic developments are likely to have a considerable impact on a wide range of policy areas: most directly with respect to the different health and care requirements of the elderly, but also with respect to labour markets, social security and pensions system, economic fortunes as well as government finances. As the number of older people is growing and the average of life expectancy continues to rise, it is more interesting to understand what is the quality of the years earned. In fact, the main problem related to the elderly is the higher probability of rising of illness and disease: the homogeneity of this group is being altered, reflecting an increasingly diverse group of people, with a wide range of lifestyles, physical and mental capabilities. The “*Healthy Life Years*” (HLY) indicators, that combined the information on mortality with the data of the health status, provide an indication about the quality of remaining years that a person of a particular age can expect to live free from any form of disability, introduced the concept of *quality of life* into an analysis of longevity. The HLY measure was developed to reflect the fact that not all years of a person's life are typically lived in perfect health. Chronic disease, frailty, and disability tend to become more

prevalent at older ages, so that a population with a higher life expectancy may not be healthier. Indeed, a major question with an ageing population is whether increases in life expectancy will be associated with a greater or lesser proportion of the future population spending their years living with disability. If HLY is increasing more rapidly than life expectancy in a population, then not only is people living longer, they are also living a greater portion of their lives free of disability. The computation of the indicator is made by the “*Sullivan Methods*” which is widely used by experts across the world since the 1970's. It combines data issued from a regular period of life table on the one hand and from cross-sectional survey providing prevalence of given health dimension on the other hand, for instance disability. At the end of the calculation, it provides the total number of years spent with disability, the total number of years lived without disability, and summing both, the total number of years lived. This indicator is useful for the measurement of the health status of entire nation: it helps to define vital characteristics of the population because, the increase in the life expectancy leads to the rise of chronic disease, thus raising concerns about the future health status of the population if death rates continue to decline. Healthy life years also monitor health as a productive or economic factor. An increase in healthy life years is one of the main goals of the EU's health policy, given that this would not only improve the situation of individuals (as good health and a long life are fundamental objectives of human activity) but would also lead to lower public healthcare expenditure and would likely increase the possibility that people continue to work later into life. Any loss in health will, nonetheless, have important second order effects. These will include an altered pattern of resource allocation within the health-care system, as well as wider ranging effects on consumption and production throughout the economy. It is important for policy-makers to be aware of the opportunity cost (i.e. the benefits forgone) of doing too little to prevent ill-health, resulting in the use of limited health resources for the diagnosis, treatment, and management of preventable illness and injuries. This is the reason why the health care industry should begin planning now to respond adequately to the needs of the older populations the health care system will certainly feel the effects of this demographic change in the next decade.

ISSUES OR OPPORTUNITY?

The ageing progress is called by Kofi Annan as the “*silent revolution*” (Madrid, 2002) and is a phenomenon that will affect both the industrialized and the developing countries and will be a cause of a drastic change in the demographic composition. What is most striking in the 21st century is the fact that there is an unprecedented demographic redistribution: it is forecast that in 2050 the proportion of older people would tend to double from 11% to 22% of

the total population. Over the next five years, for the first time in the history of humanity, the number of people over 65 years will exceed that of children under the age of five. The expansion of the old part of the society can become more problematic: in fact the fiscal pressure, the reducing of the working force and the increase in the use of the health services can cause a worst resource's distribution. In this work, the focus is on the health system. Old person requires more cure and more services due to the old age and to an increase in the incidence of some pathologies. It means that the governs must face issues linked to the management of the resources in order to:

- Control the incremental pressure on health expenditure;
- Have a continuous and timely adaptation of resource allocation criteria with respect to the various organizational healthcare frameworks;
- Create and implement new health policies aimed to stimulate the expression of innovative capacities in the conception and implementation of alternative intervention models that are as applicable in practice as effective in the results and sustainable compared to the economic sacrifice to be sustained.

Hence, ageing will be one factor in driving up health costs and health systems will need to be rethought to better serve the needs of an ageing population, focusing more on treatment of chronic conditions rather medical emergencies. One of the main aspects of the senility is the psychophysical fragility due to an increase in the incidence of chronic-disabling pathologies and a consequent reduction in self-sufficiency. Cardiovascular disease, cancer and dementia are increasingly common pathologies and will become the primary causes of mortality in the world. In particular, dementia will be one of the most important emergencies that sociocultural system will face in the near future. Hence, sociocultural policies are working to address this demographic emergency by studying and implementing new welfare models that can optimize cost-effectiveness of services and encourage healthier lifestyle. In fact, an improvement in the health conditions of older population corresponds to lower health and welfare costs. Thus, ageing is considered as a multifactorial process characterized by a progressive loss of functional capabilities and increasing comorbidity, proportional to age advancement and which invest the whole life span. However, elderly health now is no longer identified solely with the reduced presence of illness, but also with the maintenance of psychophysical and relational well being, even in the presence of poly-pathologies. The originality of the new orientation lies in identifying as essential goals the maintenance of self-sufficiency and quality of life for the elder. In fact, a crucial aspect of increase in life expectancy is how the elderly population's health conditions will change. If people can live in

a better health state a higher percentage of life then there will be many changes to exploit for the future, as the increase in the work forces and the reduction of health expenses. Scientific evidence shows that to counteract the bad consequences for the pensions and the public health system the only method is to reduce the morbidity so that the population is healthier, even when it ages.

This is the big challenge that the modern society must face: the technical and organizational response of the social and health system needs to be timely adapted to ongoing changes. One of the possible answers to this need is represented by the “*integrated care*” network that sees the interaction of various professional figures (medical, social worker, professional nurse, physiotherapist, etc.) in order to avoid hospitalization, that present higher costs, in favour of personalized intervention in the territory aimed at prevention, rehabilitation and at a strong relationship between doctors and patients. In addition to the specialized treatment and rehabilitation of the disease, which remains essential, the objective to be achieved is to implement preventative interventions that can minimize the major risk factors and promote appropriate lifestyles at all ages, favouring in parallel, access to services and the integration of the subject in the social context. Through this multidimensional evaluation, it is possible to analyse the degree of physical and mental health, the level of disability and handicap, the family, socio-economic and economic situation, and the risk of loss of self-sufficiency. To outline this complex intervention program, it is really important develop a system in which the structures (geriatric ward, health care home, day hospital, rest home, etc.) and services (integrated home care, home-based hospitalization, day care centres, social services, volunteering, etc.) available on the territory work in sync.

1.3.2: COSTS IN THE HEALTH CARE

In industrialized countries, total health spending tends to grow at higher rates than the economic ones and a substantial part of this expenditure, 7.8% of GDP on average in the EU in 2012¹⁰, is public spending, that is a major and growing source of fiscal pressure. It is driven by a series of factors that affect both demand and supply of health care goods and services. The supply side is determined by the availability and distance to health care services, technological progress and the framework regulating the provision of those goods and services. These aspects are dealing in the chapter 2. Now the focus is on the demand side.

The key determinant of the demand of health goods and services regard different aspects. The first aspect concerns the *individual and national spending*. From the individual

¹⁰ European Commission, 2015

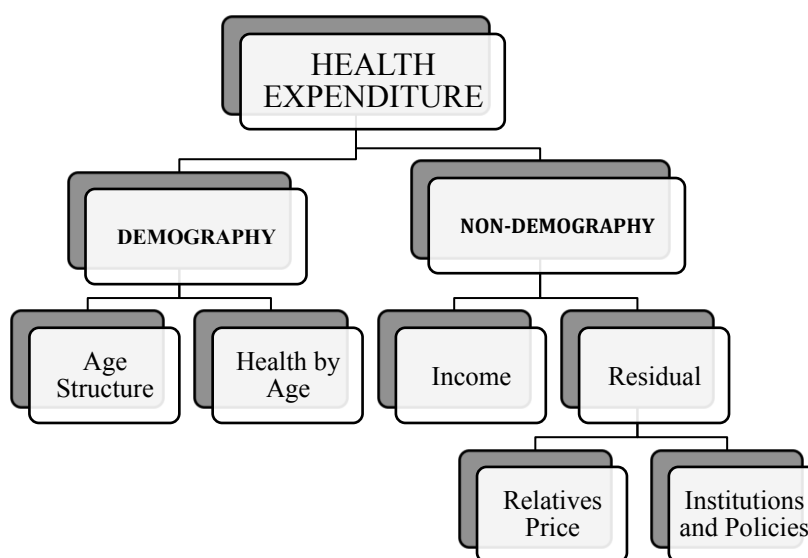
point of view, spending in health care depends in particular on the total or partial insurance coverage of the intervention. If an individual is fully covered by public or private insurance, the health care demand is independent of individual income but, if there is a partial coverage, the demand depends on the income: more people are rich more can spend in health care and services and then require high quality services. The national health spending is related to macroeconomic aspects: the quantity of funds that can be rise and the total investment available depends on the national saving and on the policy measure to control expenditure and on political priorities. Hence, the health spending is highly inelastic at an individual level but at a national level its elastic and this condition can be summarizing in: the health care is an individual necessity and a national luxury good. This macroeconomic conditions influence the way to finance the health system. According to the main population issue (ageing of the population, increase in chronic illness, etc), the demand of health services increase and the government must invest a lot of found to maintain the level of health of the population and the high quality services delivered.

This connects the second element that affects the health expenditure: the *population size and structure* and its related *health status*. As the previous chapter shows, the ageing of the population is the major challenges that actually the state must face and one of the determinants of the health system structure changing. In fact, the demand of the health care and goods depends on the number of people in need of care. This depends not only on the dimension but also on the health status of the population, which is linked specially to the age and gender structure of the population. Elderly people, which are a large part in the overall population, became an important source of costs because them develop multi-morbidity conditions, which require costly medical care. Hence, the population ageing should be a risk for the sustainability of health care financing because for two main reason. The first one is strictly associated to the fiscal pressure: the public health care is largely financed by social security contributions and working population and an increase in elderly band imply a reduction in the number of contributions. The second aspect is deeply connected to the health status and the quality of the living years gain. Increasing in longevity without any improvement in health status, leads to increase demand for services over a long period of lifetime. Today technologies and innovations allow the doctors to save more life and now the challenge is to ensure a high quality life after the disease and the cure. Hence, the increasing in life expectancy is given by the *falling in mortality*, including for older people. In fact today, the cases of mortality has decreased at the expense of increase in morbidity, meaning that more years are spent with chronic illness with a consequently rise of individual health care expenditures and national overall health care spending for people. If increasing longevity goes

in line with an increasing number of healthy life years, then ageing may not necessary translate into rising health care costs. Better health goes along with lower health care needs and may drive down health services use and health expenditure. Projecting the future evolution in the health status of the population is challenging due to the difficulties associated with predestining the changes in morbidity and measuring ill health.

Other elements are the *provision regulating the access to health care* services and goods (in the chapter 2 will be analyse the relevant importance that assume this aspect in the definition of the new health structure) and the *innovation and new technologies*. Empirical research suggests that health technology has been major driver of health expenditures. Whether a particular technological development increases or decreases costs depends on its impact on unit costs, its level of use and whether the treatment complements or replaces the existing methods. If the technological developments leads to a more cost-efficiency treatment of previously treated medical conditions, the new technology is likely to replace the old one reducing the unit cost of treatment. If this reduction is accompanied to no changes in the patients treated by this, the costs are reduced. Instead, if the new protocol became the normal one the costs will increase. However, the medical innovation allows for treating conditions, which were not treated previously, and then expenditures may rise. This is called the expansion or extension mechanism: extending health care procedures to previously untreated medical conditions for specific reasons or economic reasons. The Graph 4 (Graph 4: determinants of health expenditure) shows briefly the elements explain until now. Monitoring the national expenditure is one of the roles of the governments and the health expenditure, as

Graph 4: Determinants of health expenditure



Source: European Commission, 2009

we said before, is a fundamental part of it. The individual and the public part compose the health expenditure and cover different role: the individual expenditure (especially in the countries with partial insurance coverage) determines the personal possibility of pay and obtains health cure and services. The public dimension of the health system is what depends on the national saving ability: the technological innovation, the creation of new protocols and other research's aspects depend on the part of GDP that the governs decide to invest in the medical R&D. For this reason, not only for ensuring the health coverage but also to grant a medical improvement in the care programs, in the drugs, in protocols and in technologies, it is vital create economic and statistical model that allow a deeply analysis of the main determinant of the health expenses and the way in which affect it. Hence, a series of so-called "*scenarios*" test the potential impact of the different determinants of public spending on health care over the next 50 years. The adjustments reflecting the effects of different factors on health care spending are applied by corresponding changing one of the three main inputs:

1. The demographic/population projections,
2. The age related expenditure profiles,
3. Assumptions regarding the development of unit costs over time.

These three elements define different kind of scenarios. However, of the eight existing one, now, we take into analysis the ones that are affected by the first two elements: the demography and age expenditure. The models are:

1. *Demographic scenario*: attempts to isolate the pure effects of an ageing population. It assumes that age-specific morbidity rates do not change over time and so the age-related public health care spending per capita remains constant in real terms over the projection period. As constant health status is accompanied by a gradual increase in life expectancy, in this model all gains in life expectancy are assumed to be spent in bad health. This implies that without a change in the age structure of the population and in life expectancy, the share of health care spending in GDP would remain constant over the projection period.
2. *High life expectancy scenario*: it is a variant to the demographic scenario. It tries to measure the impact of an alternative assumption on mortality rates. In this model are used alternative demographic and macroeconomic data.
3. *Constant health scenario*: captures the potential impact of improvements in the health status. It assumes that the number of years spent in bad health remains

constant over the whole projection period.

4. *Death related cost scenario*: employs an alternative method to project health care spending, taking into account a probable postponement in health care spending resulting from the evolution of mortality rate.

Only on accounts of demographic ageing, the projections show that expenditure may grow to 8% of GDP in 2060¹¹. This consideration shows how strong is this determinants and this is why it is necessary taking it into account during the rethink health care system process. In fact, growing public health care expenditure raises concerns about its long-term sustainability and the demographic scenario assumes that per capita spending grows in line with national income per capita. However, the model assumes that all the years gain are spend in bad health and, consequently, the demographic scenario may overestimate health-spending growth because much depends on whether gains in life expectancy are spend in good or bad health. If all additional life years are healthy life years, the additional cost burden from ageing can be lowered, as exemplified in the constant health scenario. Innovation can produce efficiency gains and thus be cost saving. In medical care they have also expanded the possibilities of life-saving treatments. However, this added costs, both adding extra expenditure to previously non-curable disease and by saving person's life at the cost of longer periods of morbidity, especially at old ages. All in all, ageing as well as non-demographic drivers of health care expenditures will continue putting pressure on the long term sustainability of public finances. Balancing the health care needs of the European population with spending resources, as well as continuous efforts to increase the efficiency and quality of health services delivery, will continue to be high on the political and economic reform of Member States.

The population ageing and the higher life expectancy force the direction on which the change is made. The presence in the society actually and in the future of old more than young oblige the policy makers to put more attention on this band. But it is not the only reason. The bad lifestyle, the increase in probability of survive to serious illness, given by the new technologies and new medical's discovers, increase the incidence of disease that must by kept continuously for a long time. The Long Term Care (LTC) is the challenge of health system sustainability of the XI century. However, before talk about the LTC it is essential to understand what are the main factors, over the population ageing, that cause the rise of illness that require the use of the LTC and that, inevitably, affect the health expenditure.

¹¹ European Commission, 2015

CHRONIC DISEASE, MENTAL ILLNESS AND LIFESTYLE BEHAVIOUR

As we said in the previous paragraphs, the increase in life expectancy at birth and at adulthood is given by an improvement in the life conditions. In the past, the disease that affect the population are the “*primarily infections*”, as diarrhoea, pneumonia, tuberculosis etc., and the proliferation of these disease was due to poor hygiene and low medical knowledge. More hygiene, vaccines, antibiotics and biotechnological advances, which reduce the childhood premature deaths from easily curable conditions, and public health interventions such as preventive actions reduce the incidence of many infectious diseases and have curbed the communicable disease of the 20th century. However, simultaneously, there has been an increase in the incidence of chronic disease, such as cancer and cardiovascular disease, due to the ageing of the population, because the chronic conditions affect elderly and strike people in their later years. Hence, increase in life expectancy and in the proportion of elderly people is accompanied by an increased prevalence of chronic disease.

To develop a realistic analysis of the macroenvironment in which the health system works, it is important understand what are the main factors that cause the onset of these pathologies, so called “*health risks*”. The health risks are considered to be factors that raise the probability to have adverse health outcome and to develop a serious disease. The leading global risks of health is divided into two main group:

- | | |
|---|--|
| <ul style="list-style-type: none">• Factors that caused mortality:1. High blood pressure (13% of deaths globally);2. Tobacco use (9%);3. High blood glucose (6%);4. Physical inactivity (6%);5. And obesity (5%). | <ul style="list-style-type: none">• Factors that caused burden disease:1. Underweight (6%);2. Unsafe sex (5%);3. Alcohol abuse (5%);4. Unsafe water, sanitation and hygiene (4%). |
|---|--|

In addition to the exposure to infectious disease agents or antimicrobial resistance, there are some other factors to take into analysis as childhood unweight, unsafe sex, alcohol use, unsafe water and sanitation and high blood pressure are responsible for one quarter of all the deaths in the world. In addition, wrong life style behaviour as alcohol and tobacco consumption, high cholesterol, high blood glucose, low fruit and vegetable intake and physical inactivity are the reason of the 61% of cardiovascular deaths. Understanding the role

of these factors is important for developing clear and effective strategies for improving global health and for preventing disease and injuries. In fact, these factors are responsible for the development of chronic degenerative disease, which are named “*Noncommunicable disease*”¹²(NCDs). These illnesses present a high incidence in our society and are caused by combination of the different health’s risks describe before. The five leading global risks for mortality (high blood pressure, tobacco use, high blood glucose, physical inactivity and obesity) are responsible for raising the risk of chronic disease and cancer, mainly in the developed country. If in the poor countries there is the problem of the under-nutrition and underweight of the population, which affect primarily the child and is one of the principal causes of childhood death, in the developed countries more of the chronic disease is caused by diet-related risk factors and physical inactivity. Worldwide, overweight and obesity cause more deaths than underweight. Today, 65% of the world’s population lives in countries where overweight and obesity kills more people than underweight. This factor has the greatest effect on cardiovascular disease and it depends on the high blood pressure, which is itself caused by high body mass index and physical inactivity. The high blood pressure change the structure of the arteries and it results in risks of stroke, hearth disease, and kidney failure. Diet, alcohol, lack of exercise and obesity all raise blood pressure and these effects accumulate with age. Globally, 51% of stroke (cerebrovascular disease) and 45% of ischemic hearth disease deaths are attributable to high systolic blood pressure. Strictly connected to the obesity or to wrong diet and life style are other two pathologies, that accumulated year by year, are the cause of the rise of serious illness: cholesterol levels and high blood glucose. The level of cholesterol in the blood is one of the main determinants of infarct, ischemia, and stroke but also the deterioration of the arteries whish is one of the main causes of the senile dementia. People that have high level of cholesterol must make several blood control and follow a diet to reduce it. The high blood glucose is one of main causes of deaths and it is due to the inactivity and wrong diet. High levels of glucose in the long run cause the onset of disease such as diabetes. People with this disease are at risk and daily (family-run) ands public monitoring is necessary to monitor the situation and improve the patient’s quality of life. Normally the presence of these pathologies is closely related to obesity: unregulated weight increase, due to inactivity and eating unhealthy foods, contributes to increasing cholesterol and glucose blood level. All these factors contribute to the deterioration of the patient’s quality of life and are a clear example of how various risk factors are linked to each other. Obesity can be considered as a social plague. WHO estimates that, in 2005, more than 1 billion people worldwide were

¹² World Health Organization, 2014

overweight and more than 300 million were obese. The risk of coronary heart disease, ischemic stroke and type 2 diabetes grow steadily with increasing body mass, as do the risks of cancers of breast, colon, prostate and other organs. Chronic overweight contributes to osteoarthritis, a major cause of disability. Globally, 44% of diabetes burden, 23% of ischemic heart disease burden and 7-41% of certain cancer burdens are attributable to overweight and obesity¹³.

Another important risk factor, related to the life style that increase the incidence of chronic disease, is the use of addictive substance as tobacco, alcohol and drugs. These external factors create dependence and long exposure (and for some genetically predisposed subjects it is even a brief exposure) creates cellular changes that translate in cancer. The death caused by these factors may also be due to overdose, but for the purpose of analysis we consider only the emergence of chronic degenerative disease. Smoking substantially increases the risk of death from lung and other cancers, heart disease, stroke, chronic respiratory disease and other conditions. Globally smoking causes about 71% of lung cancer, 42% of chronic respiratory disease and nearly 10% of cardiovascular disease. Tobacco caused an estimate 5.1 million deaths globally. Alcohol contributes to more than 60 types of disease and injury. In addition to the direct illness caused by the consumption of alcohol, as the oesophageal cancer, liver cancer (30%) and cirrhosis (50%), 20% of the death is caused by motor vehicle incidents. These factors, in addition of all the environmental risk factors as the hygiene and the risks related to the job environment and the stressing life style, contribute to increase disease in the population that affect for long time people.

In addition to these pathologies, in the last years, there has been an increase in chronic degenerative diseases affecting older people. While the disease described before may affect people of all ages, the major of neurological disease affect older people and the incidence increases with the ageing of the population. This is an important sociology determinant that influences the functioning of the health system. Thus, due to the ageing of the population, there is an increase in the neurological disease, as Alzheimer and senile dementia. However, as said before, illness rises because not only one factor but more factors. In fact, the illness normally connected to elderly is not only a direct consequence of ageing but is due to vascular problem. High presence of cholesterol and high blood pressure can affect the incidence of these disease, that create disability and present the necessity of long term care and the use of specific structure for the cure.

Current global mortality from NCDs remains unacceptably high and is increasing. 38 million of people die each year from NCDs, mainly from cardiovascular disease, cancer,

¹³ World Health Organization, 2014

chronic respiratory disease and diabetes. Over 14 millions deaths from NCD occur between the age of 30 and 70, of which 85% are in developing country. These premature deaths are large preventable by governments implementing simple measures which reduce risk factors for NCD and enable the health system to respond. For example, to reduce the bad smoking's and alcohol's effects the governs can decide to promulgate restrictive legislation on it or increase the price of these goods. The same can be made for reduce the obesity, specially the childhood obesity, limiting the sale of soft drinks in the schools or raising their price or introducing educational program or imposing sports courses. Promoting educational activities in the school but also in the ambulatory that shows the risks of these factors and explain how to reduce the bad impact of these in our life can be more easy stimulate preventive actions and reduce the incidence of some chronic disease or stop it in the early phases. In this way, elderly people of the future may be healthier.

The question of how reduces the impact and the death due to the NCD is one of the main themes addressed by the WHO. In order to reduce the impact of these diseases was define the *Global NCD Action Plan* build on key strategies and resolutions each offering a menu of policy options and actions for implementation in Member states. 6 points compose the Action Plan¹⁴:

1. Rise the priority in the prevention and control of the NCDs in global, regional and national agendas and internationally agreed developments goals, through strengthen international cooperation and advocacy;
2. Strength national capacity, leadership, governance, multisectoral actions and partnership to accelerate country response for the prevention and control of NCD;
3. Reduce modifiable risk factors for NCDs and underling social determinants through the creation of health-promoting environments;
4. Strength and orient health systems to address prevention and control of NCD and the underling social determinants through people-centred primary health care and universal coverage;
5. Promote and support national capacity for high-quality research and development for the prevention and control of NCD;
6. Monitor the trends and determinants of NCDs and evaluate progress in prevention and control.

¹⁴ World Health Organization, 2013

The actin plan provides a road map and a menu of policy options for all Member States to take coordinate and coherent actions in order to reduce the premature mortality from cardiovascular disease, cancer, diabetes or chronic respiratory disease. These NCD make the largest contribution to morbidity and mortality and for this reason have a strategic links to the health systems and universal coverage.

LONG TERM CARE

The improvement in health system, protocols and technologies, the higher use of vaccines and preventive actions reduces the infective disease and increase the life expectancy. However, the modern society presents a strong presence of health risks that caused the rise of noncommunicable disease (NCDs), which are chronic degenerative disease. These illnesses do not lead to the immediate death of the patient, but they afflict him for a long time, forcing hit to cure for long time.

Spending in health and long-term care is a first-order policy issue for most governments in OECD countries and represents a non-negligible and growing share of GDP and of public and total health spending. This expenditure is putting pressure on public budgets and is an important item for the long-term sustainability: in addition to other social spending programs, health expenditure increase the level of debt higher than in the past. The ratio of public health and LTC expenditure on GDP has been rising steadily for several decades: since 1970 the expenditure, on average, has increased by 3.5% points to reach around 7% points in 2010 and the forecast of the future predict a rate approximately 13% in 2050¹⁵. In fact, population ageing, if not accompanied by corresponding improvement in health status, leads to an increase in the number of dependent elderly and LCT needs. The increasing need of care it is not refers only in the change of the arrangements in the formal care sectors, but also in the definition of a better work/life balance to make the provision of informal care easier. The main factors that make a growth in the LCT expenditure are:

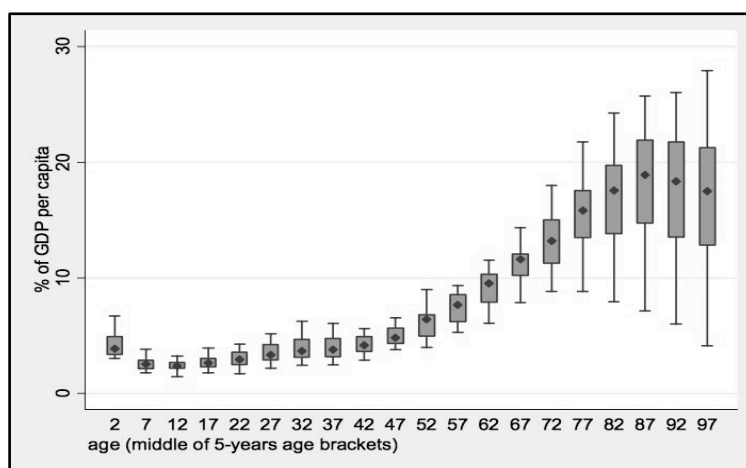
- Socio-demographic developments;
- Health status of the population;
- Pattern of LCT provision;
- Human resources availability;
- Economic growth, because stimulate the development and the use of new technologies and medical progress.

¹⁵ F. Pammolli and all, 2008

The socio-demographic element is fundamental in the determination of the expenditure on LTC: the higher share and numbers of old and very old people expected in the coming decades is a key determinant. This is because the risk to live with physical or mental disability leading to a dependency situation that requires LTC tends to increase with age.

The demographic driver includes three elements that are: *death related costs*, *pure age effects* based on population projections draw from different sources and a *healthy-ageing effect*. As said before, the most useful practice to understand the distribution of the health expenditure is the average health expenditure profile by age group. As show by Graph 5 (Graph 5: Distribution of health expenditure per age¹⁶), the health expenditures are relatively high for children in the early stage of their life, decrease during the teenage and adulthood and after increase rapidly in older age. It could be expected that an ageing population would be associated with increasing aggregate per capita public health care expenditure but from the empirical analysis arise another results. The matters for health spending are not ageing but the proximity to death. It is called as the “*death-related costs*” hypothesis. This interpretation is consistent with

Graph 5: Distribution of health expenditure per age.



Source: The sustainability of European Health

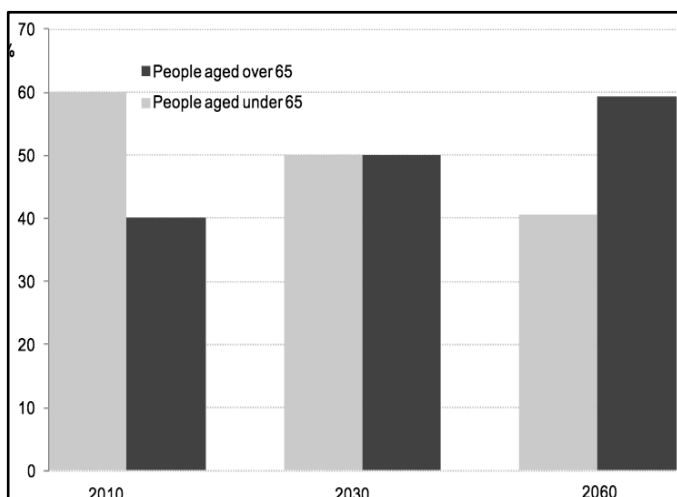
the observed facts that health-care expenditure tends to increase in a disproportionate way when individuals are close to death that normally is associated to the older age. Hence, it is not ageing that pushes up average health expenditures, but that fact that mortality rates increase with age. The death-related costs hypothesis is consistent with a so-called healthy-ageing regime, where longevity gains are all translated into years in good health. The forecast analysis (Graph 6: forecast of the health expenditure¹⁷) display that in 2010 the 60% of health care expenditures were directed to people below 65 years old but, at least 50 years later, the same percentage will be directed to people aged above 65, reflecting an increase from 15% to 30%, it will induce a significant change in the structure of the society and of the spending over time. This evolution is only the consequence of demographic effects because the non-

¹⁶ OECD, 2015,

¹⁷ OECD, 2015, bis

demographic effects are assumed to affect all age groups in same proportion. The demographic aspect is not the main driver of health spending growth but, for the reason analyse in the previous paragraph, it will induce a significant change in the structure of the spending. According to this data is easy to understand that this rhythm of growth is unsustainable and that the only possible scenario is the “*cost-containment scenario*”. To reduce the growing of the health care cost one of the practices, in addition to the control of the drugs spending, is associated to the patient care. The patient centred care regard the shorter length of stay and the reduction of the access in the hospital with an implementation of the primary care. The increasing in the taking care of the patient in the ambulatory helps to enhance health monitoring of patients affected by long-term diseases in order to reduce costly complication and enhance prevention, that help maintaining the health expenditure on a sustainable path.

Graph 6: forecast of the health expenditure

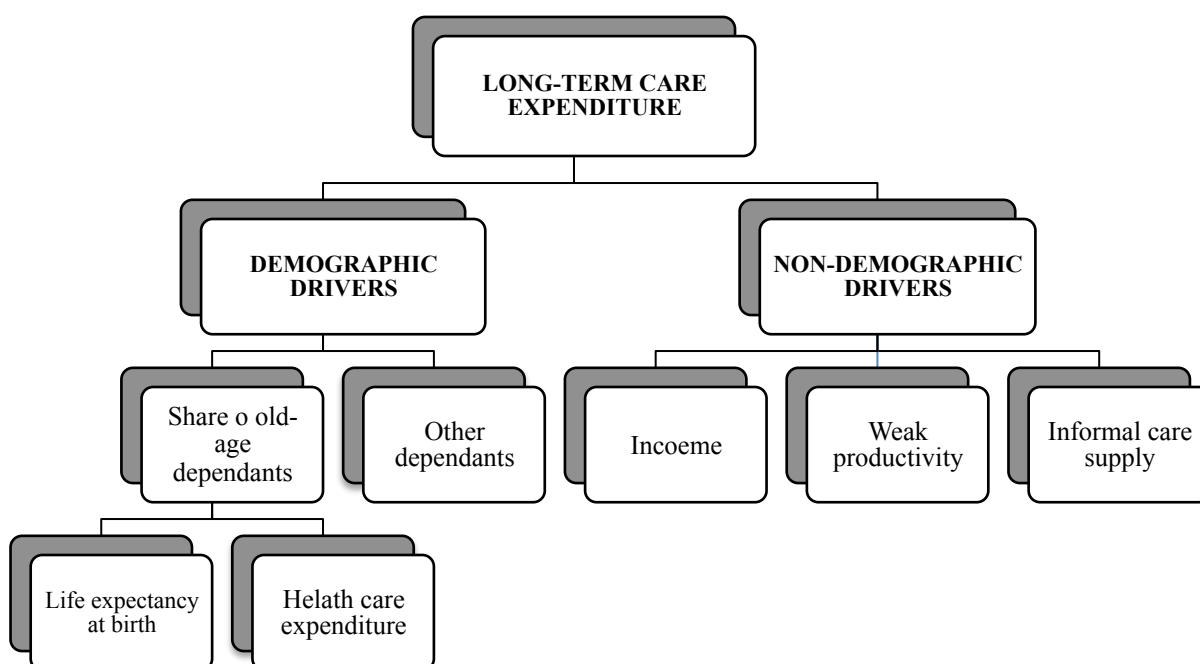


Source: OECD, 2015

While the health care services aim to changing the health situation, LTC merely aims at making the current condition more tolerable. The LTC is employed by people that are affected by disability, chronic condition, trauma or illness, which limit their ability to carry out basic self-care or to do the day-ling living activity (eating, dressing, bathing, getting in and out of bed, toileting) or to perform instrumental activities (preparing own meal, cleaning, laundry, taking medication, getting to places beyond walking distance, shopping, managing money affairs and using telephone or internet). In the LTC are included a small part of health services that are thus not accounted for the health care, such as the services make by the caregivers in the home of the patient affected by some kind of dementia disease. However, the LTC is the total spending of health care and social services, which includes palliative care, long term nursing care, personal care services and health services in support of family care. Two kind of determinant drive the LTC expenditure that is demographic and non demographic (Graph 7: Broadly description of the long term care expenditure¹⁸). The determinant of the long-term expenditure on LTC is different and can be classified in two main group: demographic and non demographic.

¹⁸ European Commission, 2009

Graph 7: Broadly description of the Long-term cares expenditure



Source: Ageing report: economic and budgetary projections for the EU-27 Member-States

A key element of the future public expenditure on LTC is the number of people who will need and receive LTC. The higher share of numbers of old and very old people expected in the coming decades is a key determinant. This is because the risk to live with physical or mental disability leading to a dependency situation that requires LTC tends to increase with age, especially with very old age. However the LTC are not only related to illness that rise with age but also with disease that rise in young years due to serious illness, incidents etc. In fact, the age-related expenditure profiles used in the 2015 Ageing report show that expenditure is rather flat for LTC recipients, which signals that the LTC costs related to severe disability are relatively independent of age. The demographic old-age dependency ratio is projected to increase from 27.8% to 50.1% in the EU as a whole over the projection period. Reasonably, one can expect an increase in the need and demand for LTC. However, the rise in the number of the old and very old people is not the only reason: it is a consequence of sickness or fragility causing dependency on others. As in health care, increased longevity can contribute to an increase of future LTC spending. The increase in life expectancy may translate in an increase in the number of people and years during which the need for LTC increases and thus cost accumulate. This is the case when longevity is not accompanied by corresponding improvement in the quality of life. Dependency is not a disability but is an inability to perform daily personal care tasks and instrumental activities. These are another

determinants of LTC's demand. However the link between dependency levels and demand/use of LTC are not straightforward because there are people with some form of disability who can lead completely independent lives without the need of care services. Disability, in fact, depends on a person's perception of his or her ability to perform activities associated with a daily living. The key question to understand the projection of the LTC costs depends on whether, as life expectancy increases, dependency level increase, remain constant or decrease. Some evidence shows that specific causes of disability may become more prominent with the increasing age: number of people with dementia, Alzheimer's is expected to increase. However, certain studies have noted that as life expectancy increases, the incidence of several disabilities is postponed, leading to a reduction in the prevalence of severe disability for some age-groups. The extent to which a country relies on formal care and the extent to which this is provided in institutions or at home are important determinants of public expenditure on LTC. There is also an increase in the opportunity costs given by the informal care: the impact on labour market and productivity. LTC is delivered informally by families and friends and formally by care assistants who are paid under some form of employment contract. To be considered informal, the provision of care cannot be paid as if purchasing a service, even though an informal care giver may receive income transfers and some payments from the person receiving care.

The non-demographic drivers are related to income developments and changes in the demand for public financed LTC-services. Income has a double effect: direct effect, because increases in living standards and an indirect effect due to the cost of the disease effects, because degenerative illness affect negatively the ability to produce. The demand for public spending on LTC is assumed to depend on developments in formal labour force participation. The projection considers three elements: changes in relative price of LTC, income effects and changes in the demand for public-financed LTC. One of the main non-demographic drivers of public LTC expenditure is the share of the informal and formal care. Family and friends provide most of the informal care. But, changing the societal models, such as the declining family size, changes in residential patterns of people with disabilities and rising female participation in the formal labour market, are likely to contribute to a decline in the availability of informal care-givers, leading to an increase in the need for paid care. Finally, also income plays a role in LTC expenditure.

Hence, the costs that every national health system must sustain change according to the different structure and the different level of insurance. What is clear is that it change according to the increase of elderly in the population and to the higher incidence of chronic degenerative disease.

1.4: CONCLUSION

In the last years, the health system gains more importance and receive more attention by the governs of all the nations because it is considered as a fundamental part of the economic growth. The most evident result of this interest is the implementation of the health activities that allow increasing the life expectancy, that are the years that people suppose to live. Actually the life expectancy exceeds the 80 years in average in the world. Even if every country, according to its culture and historical background, has developed different delivering health structure, all of them must face the same challenges that are: ensuring equity on access and provision; adapt to the demographic trends pointing on the ageing of the populations; rapid raise of the chronic disease; and noncommunicable disease; the shift from the primary to the secondary care; and health inequalities.

The increase in life expectancy means that there is an increase both in the quality of care and in the quality of the system. Due to the fact that not always a high expenses by the governs can be translate in a good delivering of services, was found several elements that helps to understand how is the quality of the health systems. These elements are: health status, risk factors, access to care, and quality of care and health care resources. The first two factors are related to the health of the patients and shows the ability of the care system to grant and maintain a good level of individual health, eliminating or preventing some disease with preventive actions and vaccines or teaching the people what are the risks given by certain wrong behaviour. The other are linked to the efficiency of the health system and to the reduction of inequality in access and in the use of the resources.

However, the health system has to face several issues and challenges that make necessary the need of change. The ageing of the people is the main demographic factors that affect the health system. The increase in the percentage of elderly in the society causes the rise of the fiscal pressure and the increase of chronic degenerative disease. The most common illness related to the age is the senile dementia and Alzheimer, which induce the patient to a long time cure and to a progressive loss of dependency. The index of dependency describes the patient's conditions and the loss of the ability to do the daily activities. This index is not only related to the elderly but also to people affected to chronic degenerative illness due to some other risk factors. In fact, the modern society is afflicted by serious illness that rises because of the wrong lifestyle, inactivity and exposure of environmental risk factors. Smoke, alcohol and drugs are reason of the growth of cancer, respirator's difficulties and premature death. However, another social plug, especially in the developed countries, are the obesity. This illness is catalytic for a group of syndrome as high blood pressure, high blood glucose,

high level of cholesterol that obliges people to cure for all the life. If them do not pay attention to these illnesses in the early phases, them worsen leading to cardiovascular problem. The chronic degenerative disease impose to rethink the health system because presents new problems to overcome. This illness do not require cure during the acute phase but need accurate care and control throughout the patient's life. The new model requires an integrated health, that contemplates a multisectoral and multidisciplinary interaction, to provide a complete set of cure directly in the territory and not in the hospital. These new services define the Long Term Cure, that is the main sources of health expenses. The better cure and the services given by LTC ensure the increase in life expectancy but it is important to understand what are the healthy years gains. In fact, many model, which forecast the health expenditure for the future, assume that all the years gain from the elderly are passed in bad health. It is not true, and the restraint of the cost is given by the health status of the entire populations.

The shift form the primarily infectious to the chronic degenerative disease, the ageing of the population and the consequent change in the society structure and fiscal pressure, make necessary change the way in which the health goods and services is delivered. But, the modification of the system is not always simple and it can be stall by professional and organizational inertia. For this reason it is important to introduce some steps to follow. At first, it is important to introduce economic and non-economic incentives that stimulate the passage. After, it is important to define all the customer's needs and the new role assumed by the doctors. At least, it is important that the law supports the progress.

All these health's problems and how to reduce the impact and the death from the Noncommunicable disease (NCD), as infarct, cardiovascular death, ictus, stroke etc., is now taken into analysis by the World Health Organization (WHO). It was developed an Action Plan that presents key strategies and a set of policy options and actions to implement in all the Member States. The first point is to create a strong collaboration and cooperation between the different countries to implement preventive actions, useful to control and reduce the incidence of the NCD. The preventive actions are the based of the new model: high number of these disease, if found in the early phases, are easy to cure and to eliminate; there is high probability to find some curable kind of cancer; with the vaccinations there is a high coverture of the child but also of the entire population. But, preventive actions are also the educational programs; in which are explain the effects of a wrong life style. The preventive actions also give the possibility to have a epidemiological analysis of the society and understand what are the incidence of the disease. In other word, the model allows a progressive decentralization from the hospital to the patients, developing the primary care system.

2. THE EVOLUTION OF PRIMARY CARE

Strong economies and flourishing societies are building by healthy populations. Citizens in OECD countries are healthier than even before, with life expectancy now exceeding 80 years in average. While such progress is undoubtedly positive, health systems and policy makers must face a growing burden of chronic illness such as diabetes, depression, cancer and obesity. The OECD countries engage a considerable share of GDP to sustain the level of the quality of the health system: the health expenditure is the 9,5% of GDP and, in most of the nations, it is the 72% of the public expenditure¹⁹. In the countries in which the health system is national, as in Italy (NHS), this level of outflow it will be very high and hard to sustain, especially if we consider the results in predicting the future trend of the population with the ageing phenomenon and the increase in the incidence of pathologies requiring long-term care. For this reason, now, building a sustainable health system means making sure that the existing resources are used efficiently. Hence, are more needed today than even before research, innovation and the identification of a new health-care model that supports the care high quality level, the high life expectancy, even if in case of particularly serious illness, and a full charge of the patient in respect of effective and efficient use of the scares technological and financial resources available. Today the health system must face new challenges: low child mortality and the quality of healthier living conditions have led to increased life expectancy with rise of new problems. In fact, with vaccines, timely care, and easily accessible medicines many grave diseases have been attenuated and it has lead to an increase in health. However, this is just a perception because incorrect, unhealthy, sedentary lifestyles, with improper eating, smoking and alcohol, have led to increase chronic degenerative disease. Chronic illnesses afflict the people, not always causing premature death, but accompanying them in daily life with slow and progressive degeneration or staying stable but with need for controls and cures for the rest of their life. Globally, chronic conditions have a profound economic impact on the functioning of health care systems and in people's day-to-day lives because, when poorly managed, them affect with high costs the healthcare system and have a deleterious impact on quality of life. In addition, the chronic diseases affect the productivity of the people in the working age reducing the level of income pre-capita and, thus, the wealth of the country. It is clear that the governance must change the health organization. The main attention, in the last years, was given to the hospital, to the right functioning and to the implementation of the best practice for taking into account the disease in the acute phases.

¹⁹ Gilberto Muraro, Torino, 2013

However, considering the analysis of the factors and conditions in the previous chapter, it is evident that this system is no longer sustainable. It is impossible maintain a healthcare system that intervenes when the disease occurs with violence²⁰ and when the hospitalization is required because access to emergency and hospitalizations are very costly and require a lot of financial resources. The pressure for change originate not only from the public satisfaction, by taking care of the health of the patients, keeping in mind what their health needs are, and monitoring them in the area, but also from the need to find effective ways of promoting health and prevent disease. Policy-makers, financiers and other responsible for health care expenditure have long worried about the growing costs of health care. Currently, there is demand for reform the health system in order to stimulate a more efficient use of the resources. Existing arrangement does not provide a well-organized reaction to the health problem occurring in a society: operational goal are not always shared, the division of the labour is not perfect and, due to absence of coordination, the various elements of health care lack coherence. Poor communication between primary care, hospitals and medical specialists has been well documented in many health care systems for decades. Nevertheless, every day millions of people across the world use primary care services and it may lead to less avoidable hospitalization.

The role of the primary care in managing the entrance to the health sectors and the instruments for reduce the use of secondary care is enhanced, and it is evident that the future configuration of the health organization contemplate the intensive use of the ambulatory, with a strong activities of health centres in which work a team of practitioners that allow the presence of, not only General Practitioner, but also different kind of specialist, that give full services. The switch from the conventional hospital centred model to the new “*primary care model*” is a complex process that includes many aspects of the health system, from the professional to the territorial structure. As a level of care, primary care is often represented as the base of the pyramid of health care and the main activity is respond to specific and common health problems accounting for the majority of the population health needs. Hence, the attention pass from the disease and the cure prescribed to the patients. From a first an general analysis emerge four main elements that characterized and structure the type of services offered and how to deliver it from primary care to achieve the set gaol. These four elements are:

²⁰ Rapidly evolving functional or organic morbidity, ie manifestations of symptoms and violent signs in a short time, and which is generally given a direct causal response. Healing in this case is often possible relatively quickly thanks both to the defense mechanisms in the human body and to the timely medical treatment. An acute illness in a body with poor or neglected body, or unfortunately, poorly cured can eventually become a chronic illness.

- *Regular entry point*: strengthening of the concept of easy access of medical care for the normal ambulatory activities and also for the prevention activities;
- *Person-centeredness*: it is put more interest on the needs of the patients and to the easiness of access to the care services;
- *Comprehensiveness*: it regards the portfolio of primary care services expanding and becoming more comprehensive, reaching the full essential benefits package;
- *Continuity*: The information regarding the individuals start to be recorded over the life-course and transferred between levels of care in cases of referral and to a primary care unit.

Continuity and comprehensiveness show the increase in complexity of the health services. Large portions of patients, in fact, suffer from than one disease and receive a mix of health care provided by several workers from different discipline at the same time, and the arrangement, based on shared care, substitution and teamwork, is hampered by fragmentation. More coordination will be needed to offers of complex care the guidance and navigation to find their way trough the system. Problems of coordination are likely to arise at the key interfaces: between primary and secondary care, between curative care and public health services and between specialities within particular subsectors. This issue belong to the more importance given to the patient and to the right of health, achievable thanks the patient centred care and the attention in makes the health system accessible to all. A core discipline, in fact, in primary care is general practice or family medicine: it is generalistic care (it deals with the full range of unselected health problems and with all the categories of the population), it provide the first contact of care, offer services at all time and at a close proximity. The orientation to the patient's context implies that the individuality of the patient it is taken into account in the treatment as well as social network and living circumstance. The focus is on continuity and the interventions are not limited to one episode but cover patients health needs longitudinally, and on delivery a comprehensive services, that implies curative, rehabilitative and supportive care, as well as health promotion and disease.

Health services work hard to provide safe and high quality care and thanks the primary care, that look actively and systematically for condition in the early stages and identify factors that are know to be health risk, are expected an increase in quality of life and life expectancy. In fact, screening, monitoring and follow-up can only be carried out effectively by the coordinated the efforts of various professional groups on the basis of information concerning the population they serve.

Evidence shows that a strong primary care system is the cornerstone of effective health care delivery and that can have a lot of benefits, not only from a financial point of view. Hence, primary care in Europe and in the rest of industrialized world is facing high expectation because there is the prospect that help the health system become more responsive to achieve the health needs, offer more integrated care delivery and increase the efficiency of the system overall. For this reason the decision maker are searching for theoretical model to redesign primary care systems in line with these promises. The Chronic Care Model, with the related evolution called Expended Chronic Care Model, and the Patient Centred Home Care are a guide to higher-quality chronic illness management within the primary care.

2.1: CHRONIC CARE MODEL

The chronic condition is defined as “*a condition that require a complex response over an extended time of period that involves coordinated inputs from a wide range of health professionals and access to essential medicines and monitoring systems, all of which need to be optimally embedded within a system that promotes patient empowerment*”²¹. This complex response requires the attentions of a several health professional that provide different health services and procedures, but also of caregiver, as nurses, and family members. Considering the upgrading of care and the increase in life expectancy, it is believed that quality of life has improved. But, in reality, there is an apparent progress because contemporary society is burdened by the intensification in the incidence of chronic degenerative malformations that compromise the people’s life. Researchers have found that the most common chronic disease, such as cardiovascular conditions, cancer, respiratory conditions and type 2 diabetes account for 60% of all the death and 44% of premature death worldwide²². Improving the ability to care for people with chronic conditions is significant part of developing a better and sustainable healthcare system that really improve the quality of life and could reduce the negative economic impact of the chronic disease, both in terms of productivity losses and direct health care costs. In fact, individuals with chronic conditions are likely to have much more poorer quality of life compared to others. For these many reasons are emerging an international consensus that the future of the health system is improving care, preventive and monitoring actions to better control the incidence on the population and better manage and reduce the negative effects of these illnesses on the society.

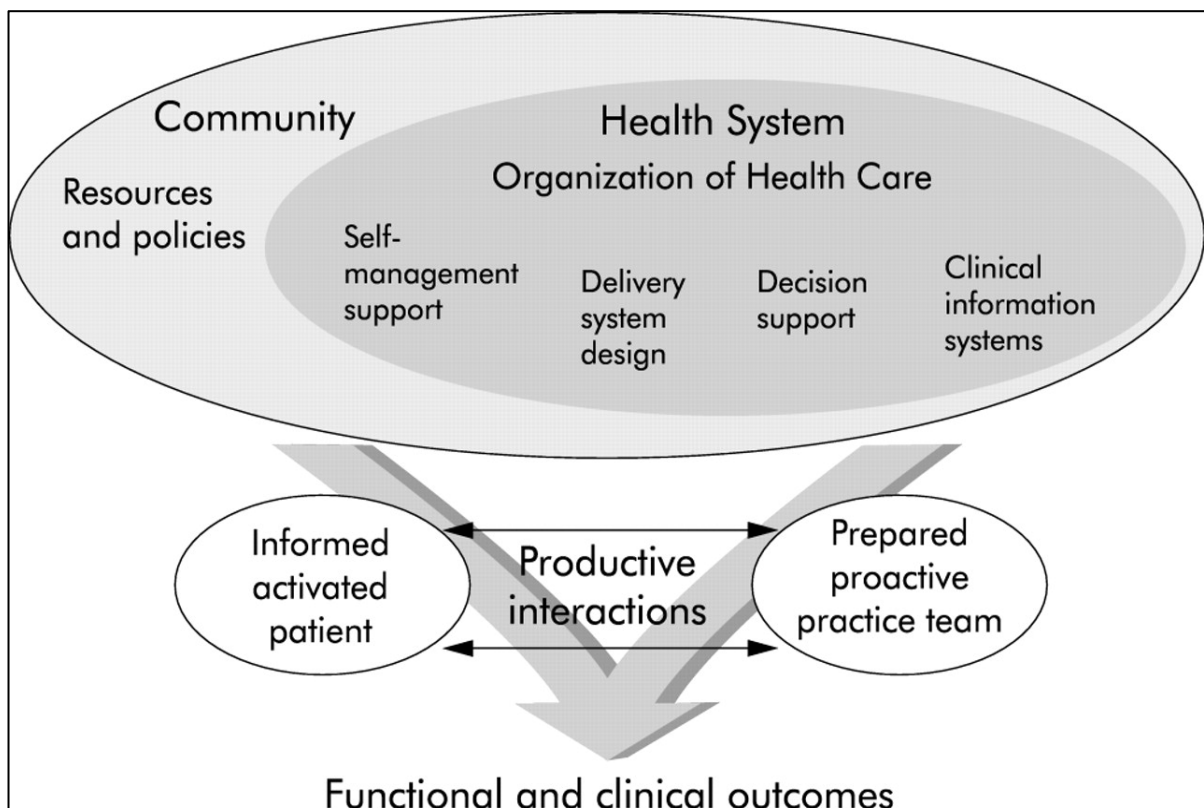
²¹L. Nasmith and all, 2010.

²² L. Nasmith, and all, 2010 bis

Taking care of this type of patient requires a complex structure that involves interaction between multiple specialists and healthcare facilities. For this reason, the need to move from hospital care to care on the territory has been felt, giving priority and more importance to the primary care. Primary care services are increasingly at the hearth of health care in many countries because it can provide an entry point into the health system, on-going care coordination and a person focused approach that allow a better monitoring of the community and a better delivery of health services reducing the health expenditure. This vision of reorganization of the health system is supported by Chronic Care Model, which advocate for activated patients through supported self-management and prevention.

The Chronic Care Model (CCM) (Graph 8: Chronic Care Model, Wagner,1998²³) was developed by Wagner and his colleagues in 1998. It promoted a multifaceted, guideline-based approach for primary care teams underlining the significance of a better access to healthcare, the importance to improve the patient’s satisfaction of care and services and get better health outcomes through the use of evidence, clinical decision support tools, health information technology, performance feedback and payment reform. It is a guide to higher-quality chronic illness management within primary care and it is designed as multidimensional solution to a

Graph 8: Chronic Care Model, Wagner, 1998.



Source: Wagner, 1998

²³ G. Maciocco, 2014

complex problem. Because the majority of chronic illness is performed within the primary care setting and because primary care physicians spend a considerable amount of their time treating chronic illness, the chronic care model constitutes a major rethinking of primary care practice. The CCM provide interaction of three main areas: the *entire community*, the *health care system*, and the *provider organization*.

Disaggregating these three general features of the model, six distinctive elements emerge that are necessary and indispensable for the practical development of model. These elements are:

1. *Community*: to improve the chronic care, the provider organization and medical institution need linkages with the community to rise and use their resources. In fact, the collaboration with hospital or other specialist structure offer to patient education classes, medical performance or support with the care agencies for the care of the patients at home. It allows the completely taking care of the patients with the continuity of treatment and full understanding of the main necessity and issues.
2. *Health system*: it refers to the structure, goals and value of the provider organization and its relationship with purchases, insurers and other specialist provider. It is important that the chronic care is share goal between the policy maker and the professional and that both see this as a priority. Only in this case it is possible to invest and financing the innovation and the changes that are necessary to reorganizing the health system.
3. *Self-management support*: for the chronic condition, patients themselves become the principal caregiver. People live with chronic illness for many years and became vital for them to know the disease and to be able to control and treat them, avoiding that symptoms become acute with consequent worsening of personal health and hospitalization. Self-management support means that patients and their families acquire the skills and confidence to manage their chronic illness, providing self-management tools and routinely assessing problem accomplishment²⁴.
4. *Delivery system design*: the structure of medical practice must be altered, creating teams with a clear division of labour and separating acute care from the planned management of chronic conditions. The primary care's doctors must treat the patient in case of acute illness and also follow the chronic disease cases, with the periodically controls and the prescriptions. Also, to the

²⁴ Blood pressure cuff, glucometers, diets and referrals to community resources.

doctors is linked the education of the team. The non-medical figures is trained to helps the patients in the self-management of the disease, to make some specific function in the ambulatory and to ensure the planning and follow up of patients. The planned visits are important features of practice redesign of the team.

5. *Decision support*: Evidence-based clinical practice guidelines provide standards for optimal chronic care and should be integrated into daily practice through reminders.
6. *Clinical information system*: Computerized information is the most important innovative features and has 3 important roles:
 - a. As reminder systems that help primary care teams comply with practice guidelines;
 - b. As feedback to physicians, showing how each is performing on chronic illness measures;
 - c. As registries for planning individual patient care and conducting population-based care. Registries are lists of all patients with particular chronic conditions on an organization or physician's panel. The registry may feed into a reminder pop-up message on the electronic medical record, which flags laboratory work or examinations not performed according to schedule.

The six components of the chronic care model are independent but all of them, building upon one another, operate to the health system redesign. In fact, the delivery system restructure the formation of the primary care teams with a division of labour but, for make it working, is important that the members of the primary care deal with the accurately compilation of pathology records, which are share between the different professionals thanks the technological information system. All of these aspects can be implemented only with an organizational environment featuring innovative leadership and favourable finances. As its ultimate goal, the chronic care model envisions an informed, activated patient interacting with a prepared, proactive practice team, resulting in high-quality, satisfying encounters and improved outcomes.

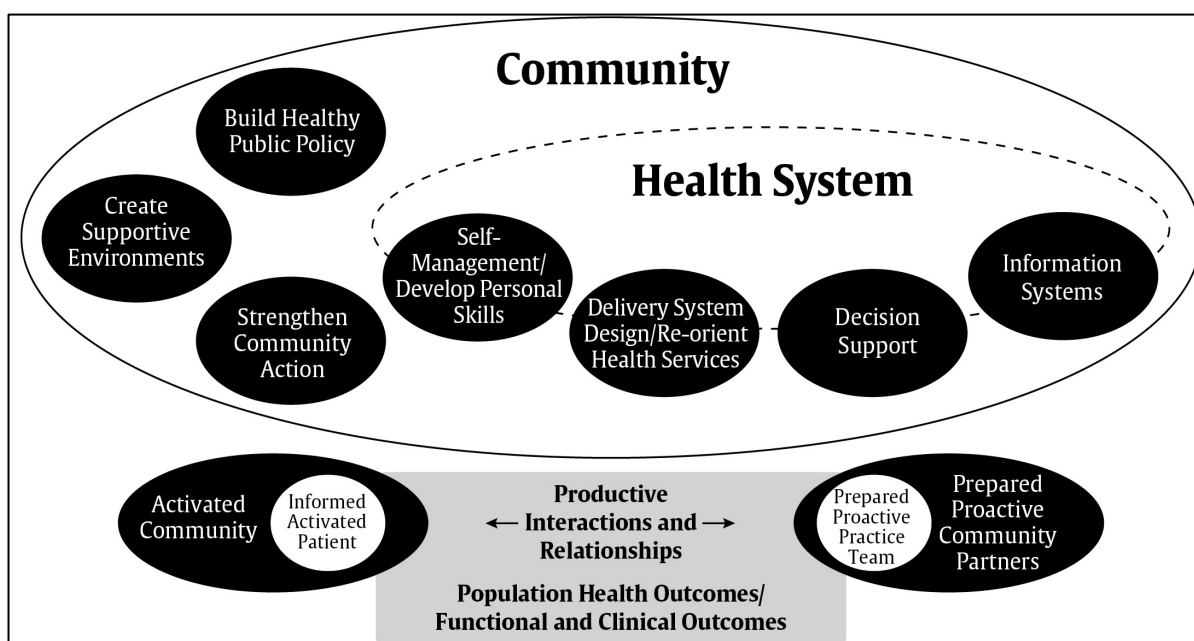
The CCM offers a framework that re-oriented healthcare services to effectively deal with the needs and concerns of individuals with chronic disease. It exhort to operate in multiple areas simultaneously such that to focus on the improvement of functional and clinical outcomes for clients. While the CCM has certainly been helpful for the definition of

the main actions to implement for changing the health structure, it does not reflect deeply the diversity and complexities of these aspects of prevention and health promotion. The current CCM presents a narrow perspective of the roles that both informal and formal community supports play in improving health. However, the role of the community into the promotion of preventive actions is presented but not well describes. For this reasons the model must be enlarge with some more consideration.

EXPANDED CHRONIC CARE MODEL

The “*Expanded chronic care model*” supports the intrinsic role that the social determinants of health play in influencing individual, community and population health. The

Graph 9: Expanded Chronic Care Model



Source: Salute Internazionale

Expanded Chronic Care Model (Graph 9: Expanded Chronic Care Model²⁵) is made on the same six elements analyse in the previous model but introduce a new and significance element: the integration between health system and community. This model described the mergers between population health promotion and clinical healthcare services, strengthening the importance attributed to the patient with the need to make him more informed. In real-life it is translate in a broader, interdisciplinary and inclusive team that work directly with community supports. The larger inner oval represents the health system and presents the same characteristics of the CCM: information system, decision support, delivery system designe,

²⁵ V.J. Barr and all, 2003

and Self-management. However, in the Expanded CCM there is porous border between the formal health system and the community and it describe the flow of ideas, resources and people between the community and the health system. In fact, now, in the representation the four bobble are not in the middle but are in the border and present some changes. These variations are based on the Ottawa Charter for Health Promotion²⁶: was define during the first international conference on health promotion in 1986 in which was discussed the health promotion as the process that enables people to increase control over and to improve their health. In the implementation of this goal the documents describe five actions area that are:

- Develop personal skills;
- Re-orient health services;
- Build health public policy;
- Create supportive environments;
- Strengthen community actions.

Now it is clear that the Expanded CCM integrate the CCM with this directive. The first two characteristics try to modify the health system and structure. *Self-management* is integrated with the possibility to *develop personal skills*. It refers to the support of self-management in coping with a disease but also to develop personal skills for health and wellness. In this new definition the health education goes beyond the traditional one. The conventional health education is a good way to inform the population about the health risk factors but the evidence shows that has a limited impact on health behaviours. The new methods want to make more options available by the people to exercise more control over their health. It is useful in the implementation of preventive actions, especially in the cessation and preventive program: a lot of education plans work with the community, workplace and school-based groups and the health care professionals and it is a effective way of encouraging the development and practice of personal skills. Given the more importance of the health promotion, *re-orienting health services* means encourage the healthcare sectors to change the provision of clinical and curative services delivered to more comprehensive actions to support the communities. *Delivery system design/ re-orienting health services* facilitate the connections between social, political and medical area. This aspect supports both healthcare and population health promotion but needs a strong relationship between the health system and the community, with citizen organization and non-

²⁶ World Health Organization, 1986

profit groups. Again, this model remarks the importance of the *decision support* and of the *information system*. In the Expanded CCM the information system gain more importance because there is a strictly connection with the community: it gives a key support during the changing processes. In clinical informatics, information system can be used to create new program, define the more effective and support new way in working and, also, to support prevention and population promotion. A challenge in building these information systems is that community-based users will demand and integrated picture of not only clinical and functional outcomes but also population health outcomes.

The model presents other three elements that regard the macroenvironment of the health system. They are:

1. Build healthy public policy;
2. Create supportive environments;
3. Strength the community actions.

To develop and implement policy that want to improve the population health it is necessary working towards organizational and governmental policy and legislation. This approach combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. *Create a supportive environments* entail working to generate living and employment conditions that are safe, stimulating, satisfying and enjoyable. The wish to maintain the older people in their home for as long as possible is one example of what means create a supportive environments. *Strengthen community actions* is probably the most important part of the model and of the health system change. This action area involves working with community groups to set priorities and achieve goals that enhance the health of the community. The empowerment of the communities is key to this process. Healthcare and other professional can paly an important role in mobilizing community to promote health.

Hence, the outcome of the Expanded CCM is the improvement of the health of the population given by a productive interaction and relationship among community members, healthcare professionals, organizations, individuals and community groups.

2.1.1: PATIENT CENTRED MEDICAL HOME

The CCM is a great theoretical based on which rethink the health system: it change the point of view and put the individuals and the community in the centre of the medical system and redesign the delivery of the primary care services. As direct consequence of the CCM and the

Extended CCM rise the “*Patient-Centred Medical Home*” model, that is rapidly considered as the main policy vehicle to reinvigorate the primary care. The Patient- Centred Medical Home (PCMH) (Graph 10: Patient centred medical home²⁷) describes mechanism for organizing primary care across the full range of individual’s health care needs. It has the main objective of improving the experience of the key partners in health care: patients and staff. This model emphasizes the core attributes of primary care, as access, longitudinal relationships, comprehensiveness and coordination. Giving more attention to the patients and their family is what helps the policy makers to create a system to manage the chronic disease incidence and the long-term care and, in addition, to make preventive actions thanks the support of the new electronic information system. Hence, the expectations that feed on the PCMH model are that they are able to improve care process, especially for preventive services, and reduce the health care emergency services and costs. The key factors identified for the development of the system on the territory are:

Graph 10: Patient Centred Medical Home.



Source: what is the patent centred medical home

1. *Team-based care*: physically, in the same building, or virtually, thanks the new technological communication system, two or more doctors work in team;
2. *Key features*: for the success of the model is important that the team can enhanced access to the health system, coordinate care between the different structures and specialist, became comprehensive to satisfy all the needs of the patients and that the systems-based approach is oriented to improve quality and safety;
3. *Sustained partnership*: the different social and medical structure cooperate;
4. *Intervention*: there is necessity of a financial intervention to give sustain for the structural change (building of infrastructure and technological innovation) from the traditional practice to the new organization.

Hence, the medical structure change name from “*medical home*” to “*Functional PCMH*” and the health care system became a team-based health care, in which more clinicians work together, giving greater daily coverage thanks to an increase in the working

²⁷ What is the Patient-Centred Medical Home?,2011

hours, during which it is guaranteed to find a doctor in the ambulatory and to take advantage of health services without having access to emergency. This aspect, with advanced electronic communications, open-access to the patient schedule and the opening of health centres 24 hours for 7 days, enhanced access to care make a consistently improve in quality and safety, due to the care planning process, evidence-based medicine guidelines, point of care resources, electronic prescribing, test tracking, performance measurement, self-management support, accountability and share decision making. These implies a long-term relationship between patients and doctors and to the other care providers that require a great level of coordination between the different services to enhance the comprehensiveness and to increase the level of satisfaction of both doctors and patients.

Some international practices, as in the USA, show that this kind of team-care, realized in the form of medical home, can improve patient's experiences with care, quality of care and provider's work environment and, at the same time, save money. However, the medical home introduces new types of work and care expectations to primary care. Physicians and care teams require reasonable-size practice populations to allow doctors to know their patients better, comprehensively address their needs and avoid burnout. One of the most important and successful instruments in the promotion of patients health is the use of electronic health records, including electronic communication, that is the main strategy for engaging patients, maintaining continuity and improving access. This system empowers the delivery of primary care by including patient registered, care reminders and decision-support tools to aid providers.

Therefore, observational evidence shows that when health system emphasizes primary care, patients achieve better health outcomes at a lower cost. Investments in primary care are likely to produce saving by reducing emergency department use and hospitalization. In the actual situation, in which due to the crisis and to the change in the social and demographic condition, that is forecast to persist, it is important make a large amount of funding to develop the infrastructure (staffing, electronic health records and change management) that allows the possibility to make a sensible costs saving: primary care transformation, in fact, represents a complex system redesign that requires a policy environment, that aligns payments and training to support this work and also requires organizations in which leaders, managers and care providers are highly engaged in achieving this change.

2.2: MAIN FEATURES OF PRIMARY CARE

Health sector reform in many European countries has been driven by common challenges related to financial constraints, changing health treats and morbidity, workforce

development and growing possibilities of technology. The change in the demand side, due to the ageing of the populations or to the changing role of hospital, make necessary to enhance the role of *primary care*, through the practical use of the main features analyse in the two model described before.

Primary care services are the hearth of health care in many countries. It is generalist care, focused on the person as whole, and it is the first level of professional care where people present their health problems and where the majority of the health population's issues is satisfied, due to the nearness to where people live and the removal of all the obstacle to access. This reform of the health system gives more importance to the General Practitioner (GP) and the patient-centred medical homes are one of the main health service delivery model promotes by the OECD countries. In fact, the model combines the core tenets of primary care with continuous quality and safety improvement, through the use of the care planning, evidence-based medicine and clinical decision-support tools and quality performance measurement, management and payment. If patient-centred care is to play such an important role in the management of health system, then measuring patient experiences will have become an essential component of health services evaluation. Health technology assessment (HTA) and clinical evaluation can inform health care decisions by providing evidence on the safety, benefits, risks and effectiveness of different treatments and guide the GP in the diagnostic testing, surgery, drugs, medical devices and even improve the organization and management of health care services. This evaluation tools help to create a system that use in an efficient way the resources through macro-cost control and a higher monitor of the clinical evaluation and diagnostic treatment, thanks a general overview of the epidemiological, economical, societal and technological demands on health system from all OECD countries. Even if the cost-control is one of the main issues for the policy maker, the HTA shows the relevant link between cost and the research of a higher quality of medical performance, that want to strength the better practice for achieving the patient satisfaction and safety. These features, in fact, have recently become one of the most relevant objectives to pursue for the health system and, to prevent and reduce the occurrence of adverse events, in June 2009, the Council of the European Union adopted the Recommendation on Patient Safety, in which the actions recommended are:

- Standardization of patient safety measures, definitions and terminology;
- Greater reporting of patient safety events. It is recommended that more comprehensive reporting on adverse events take place. This will be help

monitor and control patient safety, but also provide data on the effectiveness of implemented measures.

- Education and training of health care workers, focusing on patient safety.
- Greater awareness of patient safety among patients. Patients themselves need to be aware of the authorities responsible for patient safety (the patient safety measures and standards), which are in place, and available complains procedures.

Primary care has been shown to be effective in preventing illness and death and, in contrast to specialist acute care, is associated with a more equitable distribution of health in populations and one of the way to grant an effective preventive action, that is useful tool to avoid chronic disease and helps the governments to reduce waste in health systems, unnecessary hospitalizations and cutting treatments that do not add value to the patients. New technologies, including high-cost medicines and personalized pathway cure, offer the potential for greater improvements in care and outcomes. The most important elements that the countries must achieve are:

- Strengthening primary care and the prevention of illness;
- Improving the quality oh the hospital services;
- Tackling waste and helping tight resource go further;
- Adapting health care to address the complex needs of fairly elderly;
- Assuring optimal care for chronic disease, particularly cancer and cardiovascular disease.

Boosted the primary care, by the evidence, it is necessary for increase the level of quality and safety of the patients because nation with an ineffective primary care allow, in comparison with the country in which the primary care is functioning in a good way, an increase of morbidity and of preventable mortality and may lead to the unnecessary use of scarce resources They provide an entry point into the health system and directly impact on people's well being and their use of other health and care resources.

Hence, the primary care is now considered as the core organism of the health system due to the first and very important role that cover: it is the entry point into the health system and, the way in which this happens and control, determine directly the people's well being and their use of the other health and care resources. However, enhanced primary care is a strong financial and governmental endeavour, because it requires a new skill-mixes and professional capable of fulfilling new tasks in a coherent structure. Primary care teams may

be extended to include new functions, such as nurse practitioners, or new expertise on community health or prevention and the multidisciplinary team practice is seen as the best response to the need for new models of care delivery.

The mix of disciplines that make up the primary care workforce may differ from country to country, but *General Practice* of family care is still considered to be the core of the primary care. Given that the essential role of primary care is to be the door of the whole health care system, the function of the GP became the most important to implement the structure: in fact, the health services are preferably offered in the community where people are living, without any physical, psychological or financial barriers, and the “*family doctor*” is the first specialist that meet the needs of the patients, know the disease history of the person and, in most of the cases, is the doctor of the whole family and gains the trust of them. The GP will guide the patient through the referral process and the health care system and, if it necessary in relation to the disease, will prescribe a medical specialist or hospital visits. However, the large majority of the health problems and disease that patients present can be handled within primary care. The bundle of the issues, that can be solved without any hospital or emergency interventions, increase due to the implementation of the preventive actions and the periodical follow up, that allow the doctors to control and manage the chronic disease on the territory and in the GP ambulatory. The enhance of the primary care means strength this professional, but at the same time, familiar relation with more services linked to the general practice in the territory, sometimes positioned in the same structure, to give a more complete bundled of health services. A broad set of treatment’s services should be available to patient through various primary care providers, who are in touch with one other, and that in Europe are: general internists, general paediatricians, pharmacist, primary care nurse, physiotherapists, and podiatrists, home care workers and mental health care professionals, and other.

The more collaboration between GP and other specialist develop important and basilar aspects of the models, as the continuity of care. Wherever the patient is moving through the health care system, the doctors always need to have a general overview of the health status of the patient to better coordinates the treatments and the follow up. This is possible thanks a better function and set of the technological communication and the telematics system that allows the doctors of the whole health system to share, in real time, information and medical records. The more primary care system matches this profile, the stronger it is. It is widely believed that a well-developed system of primary care has beneficial effects on the health care system as a whole. System with a strong primary care level appears to be better able to control costs and have better health outcomes (Boerma & Dubois, 2006, WHO 2008) and, recent

evidence, shows that strong primary care is associated with better population health, lower rates of unnecessary hospitalizations and relatively lower socioeconomic inequality.

Hereafter, the primary care can achieve a good results in the cost-control, in a better distribution of the health services reducing the level of the inequality and in an increase of patient's safety and of care's quality, possible thanks a more attention on the prevention and health promotion actions. However, for seeing good results on this it is require more time. In fact, the engagement of the patients in the self-care and self-management is one of the innovative aspects of the model. It implies a strong connection between the primary care with the community, for example with school etc., because it is important that people learn what health and a healthy life style mean, in order to reduce the incidence of disease as obesity and diabetes. It is hard, because it is related to the behaviour and the consciousness of the person and requires a lot of time to become part of the mentality of the entire community. The education of the patient is an important part for restructuring the health system but it is, probably, the most difficult to achieve in short time.

It may be concluded that primary care systems may have the potential to include systematic prevention and intervention in non-communicable disease, to enhance the relation between patient and health system, to monitor the epidemiological situation of the community and reduce the health expenditure thanks a better communication and coordination between the different specialist structures. To the primary care, hence, are attributed a lot of mansion and it means that the structure of the primary care presents a lot of features. In the paragraphs below there is the analysis of the main aspects that characterized the primary care and that are relevant for the analysis of the case study. It is possible to summarized the ten essential dimension in three main areas:

1. The *structure* dimension, that includes:
 - Governance, that is the government view about the health system and the organization of the structure;
 - Economic conditions, related to the costs ad the incentives;
 - Workforce development, linked to the professional figures, the formation and education of doctors etc.
2. The *process* dimension is focused on:
 - Access to services;
 - Continuity of care;
 - Coordination of care;
 - Comprehensiveness of care.

3. The *outcomes* dimension is focus on the results and the satisfaction of the patients, indicated by:
 - Quality of care;
 - Efficiency of care;
 - Equity in health.

2.2.1: GOVERNANCE, ECONOMIC CONDITIONS AND WORKFORCE

Primary care can be conceived as a sub-system of the overall health care system, with a special focus on the facilitation of the access and utilization of coordinate services for the benefit of the population health. To sustain the complexity of the system and services a strong structure must be built, based on: *governance, economic conditions and workforce development*.

Governance refers to the vision and direction of health policy, which exert influence through regulation and advocacy as well as through collection and using information. The governance is defined as “*the set of principles, norms, roles, and decision-making procedures around which actors converge in a given public policy area*”. Exist several different governance structure that regulate the health system, that can be broadly summarized in the Social Health Insurance (SHI) and National Health Services (NHS) that, essentially, describe the way in which people entre and use the services. Instead, the different level of importance that is given to the primary care is connected to the volition of the policy maker to reduce the inequalities in the distribution and in the use of the resources. In a relatively small number of countries, including Estonia, Hungary, Latvia, Malta, Slovakia and Switzerland, responsibility for primary care have been centralized at national level. In other countries, such as Italy, essential functions, as priority setting, financing, supply planning and management, provision of services or quality monitoring are the responsibility of regional or local authorities or regional health insurance funds, hospitals or primary care trust. A possible disadvantage of decentralization is the existence of inequalities in policies, in the access to and quality of primary care, that it is called “*unequal universalism*”²⁸

The *economic* conditions are dominated by the total amount spent on it and the costs for the patient to access to the health treatments. The expenditure for the patients is related to the kind of health system structure and if it is private or public. Considering the Italian situation, people pay an amount, called ticket, for the hospital performance, but the ticket vary according to the financial situation of the people: someone pay the entire sum but for some

²⁸ F. Spandonaro, 2015, quotidianosantà.it

other have partially or total exemptions²⁹. If the patients go into a private structure, they will pay the cost of the performance according to the private price. Another element, that affects the economic dimension, is the *remuneration* of care providers. Primary care professionals can be salaried or self-employed and may or may not be contracted to health services or health insurance institutions and from the employment status and mode of remuneration depend also the attractiveness of primary care professions.

The *workforce* development refers to the profile of professionals providing primary care services and their position in the health care system. It is important create a well define and complete mix of professional involved in the primary care, to better achieve the goal of continuity and comprehensiveness of care. The primary care professionals are the General Practitioners commonly know as *family doctors*. Also, *dentists* belong to primary care and became quite common the *nurses*, that cover different role, varying from specific nursing tasks (more attention to chronic patients) to more general (inventory, secretarial help). The presence of the nurses in the ambulatory, that work near to the GP, became an important instrument to reduce the number of access to the hospital, because they can manage, under the medical supervision, chronic patients controls, wound dressing or removal of surgical points. In addition to this professional figure, are now considered as primary care professional gynaecologists, paediatricians, ophthalmologists, internal medicine, ENT specialists, cardiologists, neurologists and surgeon.

Current evidence, based on the OECD and WHO analysis, has shows that health care systems based on a well-developed primary care system perform better in terms of population health and cost-containment. Maintaining this complex system is a strong endeavour and is a continuing challenges for the decision-makers and health professional. The financial constraints, the social-demographic conditions, the ageing of the European population and the increased prevalence of non-communicable and chronic disease are the main features that make necessary the rise of new way to deliver and ensure the same services and quality of health. The team working, with a more close collaboration between the doctors and the other professional figures, realize this new concept and can help to treat in a more efficient way the chronic conditions and the multi-morbidity. In prevention and anticipatory medicine an integrated primary care level has a major role to play, preferably in relation to community and occupational services and the professional education should prepare workers for new skills, new skill-mixes and teamwork.

²⁹ 7RQ is one example of “exemption”. The patient requires it and, if it is an ageing people or with relevant financial problem the Health System cover the entire expenditure.

However, this complex structure does not arise spontaneously and to create a strong primary care it is necessary that the administrators deliberate and decide all these aspects, which determine the administrative casing where the doctors will go to work, specifying the division of roles between levels care, the curative and preventive services provided at the primary care level, the coordination function in the health care system and incentives for providers.

2.2.2: ACCESS TO SERVICES

Definitions of primary care are numerous and either more descriptive or normative, depending on the purpose they serve. The normative approach has been closely connected with the WHO Alma Ata Declaration in 1978 on Primary Health Care, in which the focus was on solitary and equitable access of care; on the protection and promotion of health rather than on curing illness; on more influence of the population on health care instead of professional dominance and on broad intersectional collaboration in dealing with community problems³⁰.

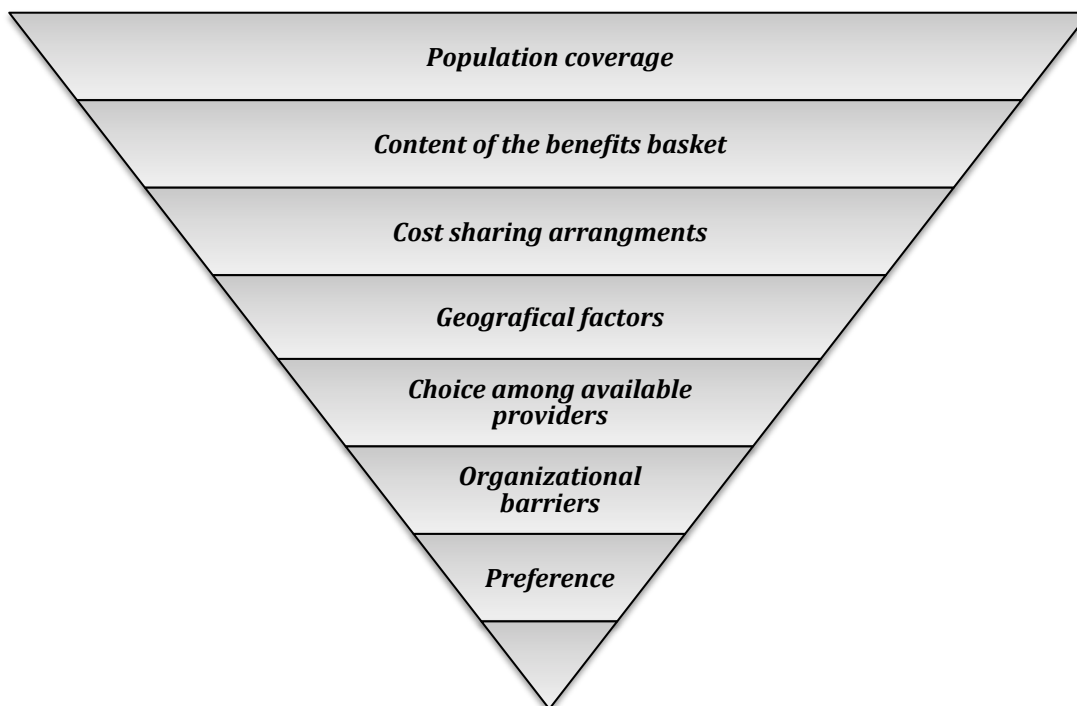
In the current European context of health care, the concept of primary care can be assumed to be as a level of care between informal care and hospital care, a set of functions and activities or a panel of characteristics for the organization of health services. One consistent thread within this variation is that primary care consists of the professional response when patients make first contact with the health care system, and thus it is serving as the point in which patients receive first contact with the professional care. It is the first place in which there is the general identification of the problem, the information about the previous visits of this patient and his or her medical history is taken into account. Large portion of the demand appear not need further intervention and it will suffice to give information, reassurance or advice. For some-other patients there is the need of diagnostic procedure.

The access to health services is the essential features of primary care. The main goal for the World Health Organization is achieving *universal health coverage* and to do this is really important that people of every social dimension can easily enter in the system. Access to health care services is regarded as an essential right in EU Member States. This right is also set out in Article 35 of the *Charter of Fundamental Rights* of the European Union, which states: “*Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of Human health protection shall be ensured in the definition and implementation of all Union policies and activities*”. The WHO Regional Office for Europe (1998) defines

³⁰ WHO, 1978.

accessibility as “a measure of the proportion of the population that reaches appropriate health services”. As a framework to analyse actual access, was developed a model, which identify seven steps, each representing a potential aspects of the entry tools, that sometimes, if they are not take in account or well managed, will become barrier, that constitute an obstacle to be surmounted if universal access is to be achieve (Graph 11, the seven steps of accessing health care services.³¹) A fist step of the reform is to reallocate the entry point to the health

Graph 11: the seven steps of accessing health care services



Source: WHO Regional Office for Europe

system from specialized clinics, hospital outpatient departments and emergency services, to generalist ambulatory care in close-to-client settings. It is a direct consequence of the Patient Centred Care Model and the most importance given to the patient and its needs that wants to achieve the objective of the universal access and full population coverage. A direct and enduring relationship between the provider and the people in the community served is essential to be able to take into account the personal and social context of patients and their family, ensuring continuity of care over time as well as across services. It is important to guarantee that this distinctive feature get due prominence and stay stable over time to give direct and permanent accessibility to the services. But to obtain the overcoming of all the possible issue described in the figure are essential develop or strength some critical figure as:

³¹ Matthias Wismar and all, 2011

- *Care closer to people*: set a direct relationship with the community relocating the entry point to the health system from hospitals and specialists to close-to-client generalists primary care centres;
- *Responsibility*: the primary care providers are directly responsible for the health of a defined population, in its entirety;
- *Strengthening primary-care provider's role*: they became coordinators of the inputs of other levels of care by giving them administrative authority and purchasing power.

Hence, the generalist ambulatory care is more likely to identify common life-threatening conditions as specialist care and generalist adheres to clinical practice guidelines, prescribe fewer invasive interventions, fewer and shorter hospitalizations and have a greater focus on preventive care. This results in lower overall health-care costs and greater patient satisfaction. Evidence from comparisons between high-income countries shows that higher proportions of generalist professionals working in ambulatory setting are associated with lower overall costs and higher quality rankings. Conversely, countries that increase reliance on specialist and hospital have stagnating or declining health outcomes and a high degree of care's fragmentation, which exacerbates user dissatisfaction and contributes to reduce the easiness to access.

The relocation of the entry point into the system from specialist hospital to generalist ambulatory care creates the conditions for more comprehensiveness, continuity and person-centeredness care. With the reallocation of the resource on the territory the services are organized as a dense network of small, close-to-client service delivery points, with the consequently necessary pre-condition of adequate number of practitioner and distribution within the country, to ensure match between need for care and its availability. Small teams make it easier to apply the right treatment because the practitioners know the communities in which they work and, at the same time, are known by people giving the possibilities to establish an enduring and trusting relationship. However, the effectiveness of the structure does not depend only on the number and preparation of the doctors, but also on finding the right place on the territory in which to build the centres. For creating a good delivery of the services it is important to take into analysis the composition of the community, the number of people, the most important hospital and construct the primary care structure in the place that is more easily used by a large number of people. Primary care centres offer a daily coverage of 12 hours with the presence, at least, of one doctor that makes the normal ambulatory activities and also covers the emergency. The goal to achieve is a 24H

daily coverage in these decentralized centres, with the emergency medical services in the territory, to reduce the use of the emergency also during the night.

Due to the complexity of services offered in the structure is important that *secretarial service* run well. In fact, the secretary does not only deal with appointments for the medical team but also performs prescription for continuity of care, compilation of certificates and other prescriptions that do not require medical examination. In this way, the physician can concentrate on the visit of patients with acute problems, for diagnosis, referral reading, etc., thus reducing outpatient work and at the same time allowing them to deal with and solve more problems simultaneously. All of these features implement the work and the services delivered by the primary care structure and enhance the access to the health services: with programmed visits and increased coverage of secondary activities, the medical services is more available.

In addition to this, in many countries, is granted the access to the health services thanks the partial or total elimination of the financial barriers. The ambulatory GP's visit is completely free and all the people, without any financial or social discrimination, can receive visit, advice, control, monitoring activities, treatment and prescription. Less are the countries in which the activities in the primary care are under payment but, more common, is that the home visit have a parcel. It is not the same for the hospital's services that the patients must pay with the "ticket" but, again, in order to permit to everyone to follow the necessary treatment, most countries apply a criteria for exceptions for co-payment on primary care services disadvantaged groups, pregnant women, children, young people in full-time education, blood donors, pensioners.

Increases the services outside form the hospital and reduce financial barriers realize are the better way to realize the wish to make the health coverage an universal health coverage, without any discrimination.

2.2.3: CONTINUITY OF CARE

A direct consequence of the easiness of access to the healthcare service, by removing the structural and financial barriers, is the ability to provide patient with a continuity of care that allow an increase in the quality of services offered and the life of the patient. Understanding people and the context in which they live are not only important in order to provide a comprehensive, person-centred response but also shape *continuity of care*.

Depending on the type of provider and the context of care, Haggerty (2003) distinguish three types of continuity: *informational*, *managerial* and *relational*. *Informational* continuity is the use of information on past event and personal circumstance, to make current care appropriate for the individual. Information links care from one provider to another and

from one event of care to another. *Managerial* continuity is the consistent and coherent approach of several professions to the management of health conditions and involves coordination and teamwork between caregivers. *Relationship* continuity implies that patients benefit from having a long-term relationship with primary care provider that goes beyond specific episodes of illness or disease, also called *personal or family continuity*.

The quality of the longitudinal relationship between primary care providers and patients are a central aspect of the modern health system. In conventional ambulatory care, provider assumes responsibility for the person or for a group of person between which born a relationship based on the trust, that ensure the continuity of care knowing the history of the patients. This kind of response-to-demand approach fails to help a considerable number of people who could benefit from care and allow the creation of preventive actions and the collection of data about the local determinant of ill health. Thus, each primary-care team is entrusting to have explicit responsibility for as well defined community or population. The simplest way of assessing responsibility is to identify the community served on the basis of geographical criteria, which is not always the best one. In fact, some evidence shows that it is not a good method because the map of the territory does not reflect the sociological reality, especially in the urban area. One example of this is the redesign of Local Health Authorities (in Italy are called A-USL) distribution in Tuscany that has given rise to cases of low health. Due to the new reform, there was a reallocation of the resources with the concentration of some A-USLs under a big one. This procedure presents a lot of challenges, especially in Italy, due to the territorial conformation that it has hill and mountainous areas where the dislocation of the inhabited centres has peculiar characteristics and makes it difficult and not immediate to link. Many times there are isolated cottages in the countryside that, to be identified, need local knowledge. Redesigning the healthcare structure of Tuscany on geographic map, without considering the real urban distribution and the needs of the community, is what caused fatal delays causing people death.

Sometimes happens that the health history of a patient depends on the familiar situation. It explains another aspects of continuity that does not depend on the treatment but on the long-term relationship established between the patients, the family of the patient and the practitioners. Not by chance, primary care practitioner is called “family doctors”. Giving new importance to the person rather than to disease, for doctors is vital know the main aspects of the life of the people and know the health history of family. The concept of “familiar nucleus” allows the entire family to have the same reference doctor. In fact, not always the patients that choose a clinician, can be admitted, due to regulation that imposes an assisted maximum number but the only exception is if the new patient belongs to the same patient’s

family already enrolled in the records with that doctor. It permits to offers a continuity of care and a monitoring of the same family, knowing the chronic disease problem and establishing and controlling the likelihood of it. Knowing the clinical history and having clear clinical picture of the patient and of the family helps the practitioner to deliver a more effective services. In addition to this, a long-term relationship has many benefits for both practitioner and patients. The GP, after an initial diagnosis, will guide the patient to the most appropriate specialists to deepen the severity of the disease and to find the best treatment to heal. After completing the specialist visit, the patient will return with the report from the doctor, who will report everything in the clinical record and will follow the patient in the healing phase. Therefore, in primary care, continuity is usually seen as the continued relationship between a patient and a particular provider beyond care episode. The sense of affiliation between patient and caregiver is stronger in general practice than in some other professions, such as nursing, where the transfer of information emphasizes a consistent approach.

Continuity is a difficult feature to achieve because it means that the services are delivered in a complementary and timely manner. For this reasons it is necessary the creation of a tool that let to collect and manage all the available information and permit the implementation of the system. Thus, an important determinant of model's effectiveness is the *advances information technologies*.

ADVANCED INFORMATION TECHNOLOGY

Continuity of care depends on ensuring continuity of information, as people get older, when they move from one residence to another or when different professional interact with one particular individual or household. Missing information is a common cause of delayed care and uptake of unnecessary services. Today's information and communication technologies give unprecedented possibilities to improve the circulation of medical information at an affordable cost. Advances in technologies create a mix of challenges in health care. Over the past decades computers and information and communication technology (ITC) applications have drastically change the work and increased the possibilities of health care workers and they continue to do so. They will enable medical record system to create databases for population-based working, which is relevant for prevention and more integrated collaboration with the public health sector. The upgrading of the list, with new and timely information is facilitates by the GP works, that create a list of patients for whose medical care they are responsible, either personally or as a group. Naturally, patients have an active role in it because they must go to doctors for periodical control. Advanced information technology helps to increase the interaction and the share of information between primary care and

secondary care, because it provide rapid access to appropriate, patient-specific information, an e-connectivity infrastructure, reminder to assure patient follow-up and methods to track patients to monitoring the health situation. The clinical information system contains the following components:

- Electronic Health Records (EHR);
- Practice management system;
- Customized encounter forms;
- Disease registries;
- Secure messaging and connectivity;
- Online clinical information;
- Practice decision support;
- Patient decision support;
- Electronic diagnostic technology;
- Scanning;
- Network faxing;
- Interfaces with laboratory, radiology and hospital system;
- Medical group intranet;
- Telecommunication system.

It is not just the individual components, doctors and patients, that produce a higher quality care but it depends on the way in which the components are connected to each other and integrated to the clinical workflow matters. The most important aspect of the IT is the disease register, which is a tracking system necessary for the optimal provision of chronic and preventive care. Registries generally draw their data from EHRs and present the data to clinicians. They perform three functions:

1. *Visit planning*: they provide summarized, patient-specific reminders for chronic and preventive service needs at the time of the visit;
2. *Proactive care*: they identify patients who are due for services, independent of whether or not they have a visit schedule (for example, can identify all the diabetics that need a blood test)
3. *Performance measurement*: they provide aggregate, real-time data on performance.

The power of this functionality cannot be overestimated because the work made by the model cannot substitute the work of the doctors and is important to remember, “*Disease registry is only one component of a more comprehensive disease management strategy. To effectively manage chronic conditions and provide better care to patients, a registry must be integrated into a program that includes elements such as provider support, use of multi-disciplinary provider teams, and increased patient self-management. A registry can enhance disease management of a population, but it is not a disease management program by itself*”³².” However, the benefits derived from this instrument are undeniable. In future will be possible to think a merger between the EHR system directly to a secure message system, so that patients are automatically informed of their care needs via e-mail, without the need of the human intervention. Actually, this idea can find some issue, such that not all the people have e-mail, but it is although true that e-mail is a pervasive form of communication and its use is increasingly rapidly. Another valuable aspect of available information technology is the capabilities of knowledge management. In the absence of risk-stratification and population monitoring capabilities, many low risk patients received treatment when it is not indicates, and many high-risk patients remain undertreated. Thanks the HER is possible to create a simple risk stratification analysis of the population. Actually, the IT system permit to think the creation of a system with a higher complexity and a integrated multidisciplinary groups in which the work of all the practitioners is based on that sharing of the patient information. IT infrastructure permits all providers’ instant access to patient’s information, direct electronic communication and feedback between clinicians and much more.

The impact of technology is not only on the communication and information but also on the medical treatment. Medical technology has so far been most dominant in hospitals, but it is likely that it will be sweeping in primary care and home care as well. As expending care options will undoubtedly put pressure on health care budgets, decision-makers may need to take measures to avoid uncontrolled increase in expenditures. For primary care the development of specialized test for us in GP practice will be relevant, such as rapid office-bases laboratory tests or near-patients test. Furthermore, portable pulmonary function testing has the potential to enhance the quality of follow-up and patient adherence to treatment for chronic respiratory diseases. Tests that were formerly exclusive hospital based, such as 24-hours electrocardiogram (ECG) monitoring, may allow patients to undertake those exams at home. In fact, patients affected by hearth attack, linked to the telephone, have a instrument that maintain under control the life signal and, in case of non regular bit, the cardiological department will be immediately informed. Enhanced diagnostics and possibilities for follow-

³² J. Simon and M. Powers, 2005

up in an ambulatory care setting may further increase the autonomy of primary care. The developments of telemedicine may create the opportunity to operate remote technical procedures or clinical collaborative work. Telemedicine can facilitate access to the primary care practice of specialist's advice in real time, which will improve service delivery in rural areas or in a context of scarce human resources.

Thus, continuity is the degree to which a series of discrete health care events is experienced as coherent and connected and is consistent with the patient's medical needs and personal context. Essential in this definition is the personal perspective of the patient: continuity is what patients perceive. Coordination and teamwork is what providers do for the benefit of continuity.

2.2.4: COORDINATION OF CARE

One of the main characteristics of primary care is the mix of professional figures that work together to grant the satisfaction of the patient's needs and when more than one provider is involved in administering care to an individual patients, some form of coordination will be necessary. The degree of coordination needed in specific situation depends on the complexity of the case of the options open to the patient.

Primary care physicians can have an important role in coordinating the health care of their patients, including coordination within primary care, coordination of input from medical specialists and coordination with public health. In fact, primary care teams cannot ensure comprehensive responsibility for their population without support from specialized services, organizations and institutions that are based outside the community served. In conventional settings, ambulatory care professionals have a broadly knowledge in how hospitals and specialized services contribute to the health of their patients and feel little inclination to reach out to other institution and stakeholders that are relevant to the health of the local community and can erode the effectiveness of the health system and can lead to unnecessary costs, duplication of services and higher risk of medical errors. One method to achieve coordinated care is for access to a specialist to be available only by referral from patients GP, the so-called "gatekeeper" function. The organization of primary care can facilitate or hinder coordination, both within primary care and between primary and secondary care. Primary care may be organized around single-handed or group practices or broader grouping including primary care and secondary care specialist. GP working in group or mixed practice have more face-to-face meetings with other primary care providers and offer more specialist session or clinics for specific patient groups, than single-handed general practices, thereby facilitating coordination of care. As health care networks expand, the health care landscape becomes far

more crowded and pluralistic. More resources allow for diversification: the range of specialized services that include emergency services, specialists, diagnostic infrastructure, dialysis centres, cancer screening, environmental technicians, long-term care institution, pharmacies etc. this represents new opportunities, provided the primary-care teams can assist their community in making the best use of that potential, which is particularly critical to public health, mental health and long term care. The coordination role this entails effectively transforms the primary-care pyramid into a network, where the relations between the primary-care team and the other institutions and services are no longer based only on top-down hierarchy but on cooperation and coordination. The primary care team then becomes the mediator between the community and the other levels of the health system. Where primary-care teams are in positions to take in this coordination role, their work becomes more rewarding and attractive, while the overall effects on health are positive. Reliance on specialists and hospitalization is reduced by filtering out unnecessary uptake, whereas patient delay is reduced for those who do need referral care, the duration of their hospitalization is shortened and post-hospitalization follow up is improved. The broader the range of services that are offered to patients in primary care, the smaller the dependency on secondary care services and the stronger primary care is. Possibilities to provide services are related to the availability of medical equipment in primary care practice. The range of services offered includes the following domains of care: first-contact care and triage; diagnostic services, treatment and follow-up care, medical technical procedures, prevention and health promotion and reproductive health care.

2.2.5: COMPREHENSIVNESS OF CARE

The continuity of care is not really achievable if the organization of the primary care is small scale and fragmented. Structural characteristics of health care determine possibilities for the provision of primary care. Financing arrangements influence not only how and where patients enter health care, but also the opportunity to establish a longer term relationship between patient and primary care provider and the number of diversified services offered. To satisfy the necessity of the community is needed a comprehensive and integrated responses. The diversity of health needs and challenges that people face call for the mobilization of a comprehensive range of resources that may include health promotion and preventions as well as diagnosis and treatment or referral, chronic or long-term home care and social services. It is at the entry point of the system, where people first present their problem, that the need for a comprehensive and integrated offer of care is most critical. Moreover, it maximizes the opportunities for preventive care and health promotion while reducing unnecessary reliance

on specialized or hospital care. Specialization has its comforts, but the fragmentation it induces is often visibly counter-productive and inefficient. That does not mean that entry-point health workers should solve all the health problems that are presented or that the primary care team has to be able to respond to the bulk of health problems in the community. It requires to be able to mobilize other resources, by referring or by calling for support from specialists, hospitals, specialized diagnostic and treatment centres, public health programs, long term care services, home care or social services or self-help and other community organizations.

The primary care team remains responsible for helping people to navigate this complex environment. Comprehensive and integrated care for the majority of the assorted health problems in the community is more efficient than relying on separate services for selected problems, partially because it leads to a better knowledge of the population and builds greater trust. Health services that offer a comprehensive range of services increase the uptake and coverage of preventive programs, such as cancer screening or vaccination. Comprehensive services also facilitate early detection and prevention problems, even in the absence of explicit demand. Primary care brings promotion and prevention, cure and care together in a safe, effective and socially productive way at the interface between the population and the health system. What needs to be done to achieve this result is to put people first. William Osler said that *“it is much more important to know what sort of patient has a disease than what sort of disease the patient has.”* Insufficient recognition of the human dimension in health and of the need to tailor the health services response to the specificity of each community and individual situation represent major shortcoming in contemporary health care, resulting not only in inequity and poor social outcomes, but also diminishing in health services.

People with multiple chronic health condition and complex health care needs often receive care that is fragmented, incomplete, inefficient and ineffective. The comprehensiveness tries to reduce this issue offering a large number of services that can cover all the possible people health problems. This service delivery reforms aim to put people at the centre of health care in order to make services more effective, efficient and equitable.

2.2.6: ENGAGEMENT OF THE PATIENTS

The new main issue of the model is the more importance attributed to the patients. Each individual has its own way of experiencing and coping with health problems within their specific life circumstances. Dealing with health problems is complicated because people need to be understood holistically: their physical, emotional and social concerns, their past and

their future and the realities of the world in which they live. Thus, the higher importance given to the patients allow the implementation of structures with focus on the person.

The engagement of the patients has main benefits that arise from the new essential role that the patients gain as co-producers of their health. In fact, according to the new theory, it is more important understand what kind of patients is affected by the disease instead understand what kind of illness affect the patients. It simply means that is more interesting for the doctors to know the life story of the patients that does not regard only the health status but also personal situation. This because they hold key information vital for process and is the only way to make the primary care structure really effective. Engaged patients can give more information to help the practitioners to make the right diagnosis and implement the right treatment and became an active part of path of treatment. People, that are using health services, are increasingly asking for more responsiveness, open and transparent health care system. Patients are informed by the doctors about all the main aspects of the disease and are trained to face the illness and the treatment in the daily situation. This is a new aspects: the training of the patients and their family. Especially in the case of chronic disease, the evidence shows that patients and family well informed and train helps to reduce the health expenditure in the emergency but also the patients, that is more engaged, gain more motivation in the treatment phases, that is important than the cure itself.

At least, the engagement of the patients is necessary to implement the preventive actions. The health organization can create prevention plan but are not useful if no one, or a small part of the community, participate. It is essential that the patients understand the importance of follow up and screening to reduce the incidence of certain illness. However, the best way to promote the health in the community it to teach the importance of a good life style, and it depends only on the consciousness of people.

2.2.7: PREVENTION

The modern society is afflicted by high presence of chronic and noncommunicable disease. As said in the chapter 1 the noncommunicable disease, as cardiovascular one, are the main death's causes. These illnesses arise for a concomitance of elements, as wrong life style behaviour, genetics, and environmental factors. Hence, governments have the responsibility to ensure that appropriate institutional, legal, financial and service arrangements are provided for the prevention and control of noncommunicable disease. A policy action to implement is strength the provision of adequate, predictable and sustained resources for prevention and control of noncommunicable disease and for universal coverage.

Prevention, now, plays a central role in health system governance. Understand the health risk factors in advance with preventive care can help to create effective intervention in order to reduce the presence of noncommunicable and chronic disease and to reduce the negative effect of them on the people and on the society. This is a relatively new element in addition to the other health services and, hence, became very important to measure and evaluate the quality of this system to:

- Understand the mechanism of action and potential benefits and risks;
- To measure their impact and appropriateness;
- To monitor their relevance in terms of stopping health inequalities.

The prevention activities are implemented to achieve and sustain the health and the wellness of the people trying to control and prevent the rise of illness and disease that can hit the individual or the community. The main goals to reach are protect the individual, monitoring and control the pandemic disease with the objective of extirpate them. Exist three level of prevention:

1. Primary prevention;
2. Secondary prevention;
3. Tertiary prevention.

The focus of the primary prevention is to avoid the raise of the sickness, with the information, the education and some policy activities or with the vaccinations. With this first kind of the prevention the health system and the policy makers want to try to eliminate the main factors that caused the illness. These types of preventive actions are related to the life style and pay more attention to make the behaviours and consumption choices of the people healthier. The secondary prevention is, for example, the cancer screening. It considers the monitoring actions and the control of people to make diagnosis in timely or reduce the negative effects of the illness and hope in a completely healing. The tertiary prevention wants to allow the inserting of person in the society trying to eliminate or reduce the chronic and disabling effects of disease.

The preventive actions are gaining more importance in the last years because countries are increasingly reluctant to accept the consequences of tobacco smoking, harmful use of alcohol, unhealthy diets and sedentary lifestyles. The evidence show that the unhealthy life's choice doesn't depend to the people consciousness but are also related to social determinants and on market dynamics. The intervention in the creation of an effective and efficient

prevention structure present high level of cost and a good decision whereas place the resource. Resources, in fact, are scarce and careful choices have to be made. These decisions may be even more important in any downward phase in an economic cycle and countries, where public finances including health, social care and education budgets are under even greater pressure. There are at least four key economic questions that can be helpful to decision-makers in the difficult task of allocating resources:

1. What are the economic consequences of not taking action to promote and protect the health of the population?
2. What would it cost to intervene by providing a promotion or preventive measure?
3. What is the balance between what it costs to intervene and what would be achieved in terms of better outcomes?
4. What economic incentives can encourage more use of those interventions that are thought to be cost-effective and less use of those interventions, which are not?

If no one action will be made, the economic analysis includes not only quantifying the resources needs and the cost of delivering health and other services but quantifying the broader impacts of risky behaviours and poor health. If the politicians will decide to set in the prevention action, it is important to identify all the cost linked to the building all the necessary infrastructure for a health promotion program, as well as the on-going maintenance cost of the program. Potentially, the economic benefits of investing in health promotion and disease prevention could be high, but it is important that well-designed evaluations are undertaken prior to large-scale investments. And the benefit are connected to the reduction of the Non-Communicable Disease (NCDs), that is a barrier to achieve the goals as the reduction of poverty, increase the health quality, increase the economic stability and human securities. The intensification of preventive actions can diminish the premature death and prevent morbidity and disability caused by hearth disease, stroke, cancer, diabetes and chronic respiratory disease.

A particular feature of many prevention programs is a concern with health inequalities. Prevention programs aim to improve or maintain the health of individuals who have a predisposition to disease, and to treat those who have a disease by preventing repeat events or worsening of the disease. To evaluate the impact of prevention programs on health inequalities, it is necessary to define and measure health inequality. Evidence suggests that systematic disparities in health exist and are concentrates among disadvantage groups of the

population. These activities are the aim of reducing health inequality. Gains in health equality are likely to be largest where prevention programs are targeted at disadvantaged communities and individuals, and for those interventions that do not require behaviour change on the part of the recipient. However, for the large majority of interventions to improve health it is essential that people first access and then take up the plans and the access to the health system is more difficult for some kind of social groups. There is a high degree of uncertainty associated with the effectiveness of prevention programmes in reducing health inequality as a result of differential access and uptake between social groups, but, once taken up and once the behaviour changes are instilled, prevention programmes may be effective in reducing health inequality. Most of them require that changes in behaviour take place, but behavioural change is not so easy to instigate or sustain, and cultural norms and organizational structures may hamper behaviour change. While health inequality is a central objective of prevention programmes, there is relatively little evaluation to assess the effectiveness of prevention programmes and the impact of these programmes on health inequality. This is particularly the case in terms of assessing the cost-effectiveness of prevention programmes, where is almost no explicit evaluation of health equity. There is generally recognition that health disparities are likely to persist as long as social structures allow some degree of inequality. It has been argued that health inequalities, at least to certain extent, are acceptable, or even desirable, because of trade-off between equity and efficiency, non-modifiable risk factors and individual choice. Prevention is bound to have distributional impacts. Different individuals and groups have different probabilities of developing chronic disease and have different outcomes once such diseases occur. Different individuals groups also respond differently to preventive interventions. Potential distributional effects cannot be ignored in the design of preventive interventions.

It is for all of these reasons that the health system structure must be rethink and the way to do it is to put the patient care as the focus of the model. This is way the health structure now gains a new form and is based on the primary care.

2.3. CONCLUSION

Primary care is, since 1920 in Italy, the base of the health system. It is the first point of touch between the health organization and the community but, until now, to the territorial structure is given less importance than the hospitals. Now, according to the new challenges, the new social-demographic conditions and the new financial constraint the territorial structures gain more importance and the administrator see in the implementation of these features a way to reduce the public expenditure.

The increase in the noncommunicable disease, and the case of death due to these, and in the chronic degenerative illnesses because of the ageing of the population create alarm all around the world. For this reason, was establish an Action Plan that describe the main policy action to implement to reduce the bad impact of these disease on the society and on the economy of the country. The necessity to reduce the cost, to increase the universal health access and coverage and the new social needs make necessary to develop a stronger territorial structure, that is able to manage the epidemiological situation and that try to reduce the incidence of the disease. The activity of the General Practitioners became more important and to them are require to control the disease, reduce the hospitalization and implement preventive activities to inform the patients about the risk factors and to discover in the early phases mortal illnesses. Thus, primary care slowly pass from the General Practitioners that work in the ambulatory to a team of doctors, with different specialities, that work together to offer a complete and integrated mix of services. Several features as characterize the primary care: easy access to services, the continuity of the care, the high coordination between different practitioners and specialists that grant comprehensiveness of the cure. They can find their general practitioner; specialists and nurses that help them in the management of normal practice but also extraordinary situation, without require unnecessary hospitalization. It is an innovative prospective because, thinking about the needs of the patients, and the increase of the incidence of chronic degenerative disease, what the health organization due is to take out part of the hospital services in the territory. In fact, raise new health structures as hospice, retirement home, community hospital that offers a professional treatment out of the hospital. It is made not only for the expenditure aspects, which is show to decrease in delocalizing the services, but also for the patients. The wellness of the patients is what drives the creation of the new model and the engagement of the people in the treatment helps to make more effective the cure, not only because it take consciousness of the disease, especially if it is chronic, but also for the motivation during the cure. The engagement of the people is enhanced through the prevention action and the continuity of the care, based also on the long-term relationship between the patients and the practitioners. The complexity of the new structure allows the creation of a technological system that strength the structure thanks a sharing of the information and an improvement in the communication. The trust relationship between doctors and patients is strength by the this information system that allow the doctors to record all the health aspects of the patients that, added to the knowledge about the life of the people, create a comprehensive analysis of the health situation of the person.

Primary care is the only instrument thanks that is possible grant the right of health due to reduce the health expenditure and increase the easiness of access. The implementation of

the integrated group is the future of the health system. However, the way to go is long and the challenges to face are many. One of the issues is the identification of the better disposition of the centres in the territory, considering the territorial layout and the social division. Other problem are related to the financial sustainability of this model and, at least, what will be the quality of the care and of the relationship between doctor and community, considering all these features, than make very complex the health system.

3. REORGANIZING STRATEGIES OF GENERAL MEDICINE AND PRIMARY CARE IN ITALY AND IN VENETO REGION

The General Medicine of the territory, in some countries called family medicine, is a professional sector of modern healthcare systems. It assumes recurrent features in the various national contexts: primary care, first access to health services, substantial uniform delivery of care processes to all citizens, secrecy of the medical/patient relationship, independent of censorship, religion, age, sex and income. However, in Europe the health system presents significant differences in the organization and in the practice, but outlines essential features about the education of the new general practitioners and the core activities that the system may deliver to grant high quality services from the point of view of the patients and of cost-efficiency. In the Italian reality of healthcare systems, the services of General Medicine represent an evolution and integration of the primary care service. Initially was a highly disaggregate system and charities institutions operating autonomously on the territory without any external control or support offered health care: public health was well planned but not guaranteed by the State. Afterwards, attempts were made to create models that would guarantee the delivery of increasingly efficient and effective services. So, existed the “*mutualises*³³”, similar to the existing unions, which guaranteed the provision of health services for different categories of workers by offering a specific targeted provision at the health risks that could affect the various categories of workers. However, there was no controversy and central monitoring to evaluate the quality of the services, which left excessive freedom of action to structures and produced situations of bad health. These services did not provide universal access but differentiated medical and health services for income bands, social security institutions and affiliated workplaces. With the end of World War II, there was a need to modernize the nation and one of the steps was to create a modern healthcare system that would allow universal coverage of citizens and facilitate access to health services for all, independently whether belonging or not to groups of workers, social extraction and wealth. In the 1950s, during the second Fanfani government, the first step was taken towards a national sanctuary with the establishment of the Ministry of Health³⁴, which was responsible for the provision and maintenance of health services throughout the country, according to criteria of fairness and easy access to performance. It wanted to achieve a unified

³³ Roberto Buttura, 2004

³⁴ Saverio Luzzi, 2004

National Health System, which would ensure internal stability of the care, with the use of several professional figures who cooperated each other through continuous communication between the various health care institutions. Initially, the role of the Ministry was to connect the various institutions distributed in the territory, in order to give continuity to care plans and an imprinting of the mode of provision of services that should be the same for all structures. Italian primary care was organized around medical practices, and only in the 1950's saw the birth of Mutual Medicine. Therefore, the initial variability of the meaning of the term "*primary care*" derives from the subjective absence of the exclusive connotation of the function. Born in the public health environment, as the first rough medical surveillance and medical care facility for the poor and miserable population groups, it was then supplemented by medical services ensured by specialist, who in the health systems assumed the connotations of General Medicine. Thus, in 1978, Minister became the pinnacle of health that controlled not only the enjoyment of healthcare activities, but also coordinated the activities of the physique structures and doctors of general medicine. But soon the centralization of control in a single institution was found to be ineffective: it is difficult for a single power centre, obviously far from the real needs and problems of the population, to offer sufficient and specific services to meet all the needs of citizens. The Ministry of Health had short life and was integrated into the ministry that is now called the Ministry of Welfare, that is, the Minister of Labour, Health and Social Policies.

Hence, from its birth until now, the health system was change many time in according to the needs and the political and social conditions. However, any change must be supported to law, that make it available. Now are presented the main legislation that made possible the implementation of the health model: first, are presented the National law and after the focus is on the specific law implemented by Veneto.

3.1: PRIMARY HEALTH CARE BEFORE AND AFTER 883/78

The National Health System was initially superordinate by a ministry that control it in every aspects: from the purely administrative to the practical one, by deciding how much fund was given and in which way they was used and how the services was implemented. But, this method was unhelpful, because in order to provide efficient healthcare, it is necessary to be able to monitor the entire activity on the territory, by filling in the shortcomings that are perceived and reinforcing the areas that require interventions. For this reason from a ministerial, then State, management, it goes to Regional Management. Health service answers to the needs of people and cannot be something abstract but it must cope with real request and situations. The National Health System must focus on the territory, so as to get closer to the

real life of citizens and to find the most effective methods to meet the different needs. With the Decree Law 883 of 1978, the normative importance of the territory began to take place. From the explanatory principles of the law, it was assumed that the Republic is charged with guaranteeing the health of all citizens according to criteria of equity, always ensuring that it respect their personal freedom. Health, therefore, turn out to be a primary asset, which must be guaranteed to all citizens without discrimination of any sort. In order to make health system accessible to everyone, it was clear that the service must be provided on the territory and, according to the principles set out in the decree, "... *The implementation of the national health service competes with the State, territories and local territorial bodies, the participation of citizens ...*"³⁵. Local territories and local authorities become, theoretically, the cornerstones for health action. Their roles are listed in Article 10 of the same decree, which said: "...*The unified management of health protection is uniformly applied across the national territory through a comprehensive network of local health units. The local health unit is the group of presidencies, offices and services of municipalities, individuals or associates, and mountain communities who, in a given territorial sphere, perform the duties of the National Health Service referred to in this Act. Based on the criteria established by regional law, municipalities, individual or associated, or mountain communities articulate local health units in basic health districts, such as technical-functional structures for the provision of first-rate services and early intervention...*" The health system, considering the vastness of the national territory and the consequent difficulty of administering it all in one unit, was divided in areas of intervention by giving more power to the regions, which in turn gave the power to administer resources and actions to territorial entities that operate on a restricted district, that was called "*Health district*". Although the text of the law recognized the importance of these frames, which are at the heart of healthcare, in practice, there was not available all the main features to make it workable.

Law 833 of 1978 prefigures a process of progressive integration aimed at overcoming the issue in establish the MMG against the independent contracted physician. With these insights, a reform of the healthcare model will begin, which in the following years will lead to a total revolution in medicine. Until now, it is clear that the future of medicine cannot be locked up only in hospitals, but must be moved to the territory.

³⁵ Law n 883/ 1978

3.2: DECREE 502 OF 30 DECEMBER 1992.

In order to organize a model that develops in the area by decentralizing activity from hospitals to territorial districts, a control mechanism must be created that is closer to the actual activities of the institutes. The control was distributed from the state to the region: in fact, the regions are increasingly given more autonomy and freedom of action in healthcare. Each region has different characteristics from one another, from a morphological point of view, for example with more complex mountain areas to be managed, and from a cultural point of view and a unique model of territorial management of healthcare can not be adapted to cover all necessities. This is why each and every region is given the option of managing health activities freely, in accordance with national plans. By Decree Law 502 of December 30, 1992, were assigned to regions increasingly complex tasks both organizational and administrative. The main articles dealing with this matter are articles 2 and 3. Article 2 lays down the legislative and administrative functions of the regions in the field of health and hospital care, leaving them free to manage the health services delivering process and administer funding, given to local authorities, to support the action in order to maintain high quality skills and services. The region is entrusted with the task of articulating the territory in health units that ensure the distribution of services to promote health in living and working environments. It must therefore provide for the formation of districts, which will have the task of regulating the activities of the local authorities, establishing the arrangements for monitoring and checking the actions taken and maintaining the quality of the services. Regions are becoming increasingly important in health management and control (which will be final with the modification of Title V of the Constitution, which radically changes the relationship between the State and the Regions) by guaranteeing them more independence in action. Article 3 of the decree analyses these structures, defining their characteristics and describing their functions. These organizations become "*entities with autonomous legal personality because they manage their action as self-employed entrepreneurs.*"³⁶ Local health authorities acquire greater managerial importance, becoming the pinnacle on which to base health care reform.

³⁶ Decreto legislativo 502 del 1992, articolo 3, comma 1-bis, Gazzetta Ufficiale, 1992.

3.3: HEALTH NATIONAL PLAN 2003-2005/2006-2008

With the modification of demographic and economic variables due to the crisis period in which the world has plummeted in recent years and the increase in the incidence of noncommunicable and chronic disease, the importance of these entities has increased further. The healthcare system we are familiar to, is a model that is no longer sustainable: the costs to ensure this service are too high and funding to maintain it is lacking. The hospital-centred logic has to be eliminated, weighed by the excessive length of waiting lists, which is no longer sustainable and can be implemented today, in favours of a new model, that reorganizes the healthcare system by targeting the territory and a more efficient use of resources, trying to avoid situations of underutilization or improper use of the one available.

In reforming healthcare to try to make it less expensive, the administrative do not want to lose the fundamental characteristics of the system, such as the universality of access to care, to ensure that all citizens have access to medical care. To do this and transform an existing system in terms of efficiency and effectiveness, we must start from the greater exploitation of structures that over the years have proved to be valid and functional in carrying out their activities, thus also supporting the population's desire. On the basis of statistical surveys, the user has proved to be more in favour of basic care than hiring hospital resources: well-liked and, in addition, less expensive than hospitals, it is obvious that they need to be valued resources, and make them the centre of health reform. Optimizing the activity of territorial structures inevitably requires General Physicians and Paediatricians of free choice to play increasingly complex roles and to have critical parts in ensuring proper service at all times. This emerges from the National Health Plan drawn up for the period 2003-2005, which, considering the worsening of the global crisis and the resulting financial, which includes the reduction of health funds, describes a new healthcare system where hospitals become the last bastion of medical activity, reorganizing healthcare on the territory with the principle of maintaining a high quality of the service at a low cost. The main aim of this healthcare review, in addition to cost reduction, is to bring continuity of care processes with a high degree of integration between the various local spatial entities: it aims to create a unity of the services provided by creating continuity of care and rehabilitation process in a multi-professional intervention logic. It is well known that, since the birth of the National Health System, it is crucial to find forms of coordination of the services offered, because only in this way can the health of citizens be protected. Hospitals will not disappear, but their action will be complemented by all the structures and professional figures operating in the country and who, thanks to the internal communication mechanisms, will not work in

isolation but in continuity with colleagues to best follow the patient during the time of discharge. In fact, the territory has always been considered a provider of extra-hospital services: post-discharge care, care of cancer patients, and so on. However, due to the social-demographic issues, it is no longer sustainable the use of the hospital system but it is necessary to create territorial structures that can meet the needs of all different types of patients. With this health plan, it transforms the old hospital paradigm awaiting the citizen who needs to be treated to a new paradigm of an active territorial medicine that takes care of patients, trying to prevent hospital intervention. If in the Health Plan 2003-2005 the transformation of the Health System was just theoretical, by expressing the basic concepts that should be pursued and implemented, the whole health chapter 2006-2008 was used to describe how the new model should be structured. Although the country was experiencing a crisis period, where national accounts are kneeling and cuts are on the agenda, the administration did not want to reduce the ability of system to offer healthcare without income discrimination. The public service, guaranteed to everyone, was replaced by the professional freelance work of specialists who, at a charge, offer the same services, which erroneously appear more accurate, but which only the most prosperous citizens can access. It tried to eliminate such imbalance situations, making the fairness of treatment became the pillar of national healthcare. So, in the new health plan there are two fundamental goals:

1. The first is to give more importance to *primary prevention*. In fact, the goal is to move from the treatment of diseases with hospital interventions to health preservation, avoiding the onset or aggravation of certain pathologies. Territorial controls, screening and prevention of cardio-circulatory diseases are thereby established, proposing initiatives to make the disease known in every respect: from genesis, to cure to the management of chronic diseases.
2. The second most innovative goal is the reorganization of primary care, with an organizational restructuring that increasingly involves the doctors of General Medicine and Paediatricians of Free Choice. The model involves an integrated action between different professional figures: it goes from the logic of the individual intervention of the physician, who works in isolation in his surgery, to a new paradigm that seeks active collaboration between the various doctors, also addressed to family doctors and medical specialists, to provide a more complete service. There is a continuity of care that provides citizens with health care 24 hours a day, 7 days a week, without excessive involvement of hospitals.

Increased education of the citizen through preventive actions and reorganization of primary care is expected to improve the delivery of healthcare making it more comprehensive and able to satisfy every need. Greater involvement of primary care will reduce improper access to first aid, thus saving valuable resources. In addition, to complete primary health care services, a *mid-term treatment* is provided by hospitals with facilities in the area that will ensure the citizen is properly followed and supported according to the different needs of the disease. To offer more inclusive services, it seeks to incorporate in the territorial endeavour the activities of Free Choice Paediatricians, which were often not involved, so that families feel compelled to care in every respect. Over the years, since decentralization has been started, it has been shown that widespread network-based health care activities bring considerable benefits, thus it is worth exploring the model and spur all regions to adopt it. Facilitating the spread of healthcare throughout the territory, making it easily accessible and exploitable by the entire population, makes it easier to understand what the needs of the users are to promote integrated action among the various operating physicians in the area, whether they are Doctors of General Medicine, Hospital Specialists or Free Choice Paediatricians. This is what has always been missing in our healthcare system: a strong collaboration between local doctors and hospital doctors, also evident from the critical declarations that move one another. The so-called National Health System allows creating pathways for integrated care, aiming to protect the health of the patient more fully, being formulated by a multi-professional and multi-disciplinary team. All of this allows practitioners to follow the patient in an increasingly appropriate way, implementing care services with continuous monitoring of the assisted and quality of the services offered and through patients education actions, so that they are increasingly aware of their disease, knowing and learning how to handle it. In spite of the continuity of care, hospitals have to find a way to link care with territorial ambulatories, and territorial ambulatories must find ways to provide the necessary care to cater for chronic or terminal illnesses. All this is seen in the perspective of economic savings, so patient stays, should be made possible, only if there are obviously debilitating deficits or the care that the patient needs to perform are too complex to be able to manage them autonomously or with family help, without the support of qualified staff.

Finally, communication tools must be implemented to make clear what is the health demand, that needs to be answered in an effectively and comprehensively way. It takes full care of the patients and provides them with the most complete healing path, constantly supported by specialists. The areas, where the need to introduce information and care continuity is felt, is the treatment of the chronic degenerative disease and the noncommunicable disease, as cancer, cardiovascular disease, diabetes and neurological

pathologies, that can lead to a progressive decrease in functionalities, thus losing personal autonomy.

3.4: NATIONAL COLLECTIVE AGREEMENT 2009

These general considerations arise in 2009 in the National Collective Agreement of General Medicine, in which the Functional Territorial Aggregates (FTA) comes into being. Unlike other previously born structures, such as UTAPs, Functional Territorial Aggregates should realize the dream of integrated medicine, enabling the health system to provide ever-more comprehensive services by bringing together multiple professional figures. This is done not only to ensure a better service but, above all, to reduce costs that are becoming more unsustainable. The National Collective Agreement, signed by the unions and confirmed by the state, becomes mandatory, and all doctors of general medicine, paediatricians of choice and specialists operating in the territory will have to adhere to it. Within six months of the entry into force of the Agreement, unions, with the regions, will have to identify the Territorial Functional Aggregations present on the territory and distribute them uniformly, subject to two criteria:

1. The size of the territory managed by the district on which they are to be placed;
2. The number of assistants: an aggregation is created every 30,000 assistants, with no more than 20 doctors working.

The National Collective Agreement sets out the guidelines that all regions will have to follow but become functional only through the signing of the Regional Agreements, which define the ways of physicians' participation in territorial aggregations. The national directives are not directly applicable in the regional territory: with the amendment of Title V of the Constitution, in fact, regions have full autonomy for the management of the health system. The directives imposed by the national plan and the collective agreement must also be approved by means of regional decrees, which sanction their viability, defining the guidelines for their implementation. Doctors adhere to aggregations to promote the fairness of access to health, socio-health and social services while respecting the essential levels of assistance, including through the identification of integration paths between primary care and continuity assistance. The aim is to promote the clinical and organizational quality of care through practical peer review procedures. Such aggregations must promote behavioural patterns that lead to prevention, care, rehabilitation and assistance actions that meet the efficiency criteria by providing high quality services with the best use of low-cost resources. In order to be able

to handle all the action, a strong internal regional communication is needed, which involves a link between the bodies present and operating in the territory with the Health District both for the organization and for the quality of services, by obliging healthcare professionals to participate Training courses to improve knowledge and medical skills.

3.5: BALDUZZI DECREE 2012

The Balduzzi decree, or decree n. 158 of 13 September 2012, is the last act for the transformation of the National Health System. The decree considers many aspects of medicine: it analyses and defines defensive medicine, establishes action plans to manage psychological diseases such as ludopathy, and so on. But the decree now introduces the first step of the transformation of the health system, pointing to the "*rules for the rationalization of health care and health care*"³⁷. According to the decree, the regions must define the organization of health care in the territory "*by promoting social integration, including with regard to home care, and hospital services, in order to improve the level of efficiency and grip capacity In terms of operating arrangements that include forms of organizational monopoly, called Functional Territorial Aggregations, which share, in structured form, objectives and assistance pathways, assessment tools for quality assurance, guidelines, audits and similar tools, as well as' forms multi-professional organizational units, called complex primary care units, which, in line with regional planning, provide welfare benefits through the coordination and integration of doctors, other professional services contracted with the National Health Service, nurses, midwifery professionals, rehabilitation, prevention and social health care.*"³⁸,

The regions need to build an ambulatory network equipped with all the tackle necessary to provide a functioning and open system throughout the day and during pre-holidays and holidays and in continuous telematics communication with hospital facilities. The facilities ensure that staff with the national healthcare system, which is made up of doctors of general medicine, paediatricians and outpatient specialists, implements the service. It is possible, without additional burdens for finance in the region, to provide nursing and personal staff with secretarial services, a member of the National Health Service. The decree stipulates that compliance with the ever-essential financial limits of medical care, always during the day and week, is made available by supplementing the offer with the service offered by free choice paediatricians, specialists and medicine of continuity. This allows practically to implement the Territorial Functional Aggregates, "*which share, in structured*

³⁷ Law decree, n.158/2012.

³⁸ Law Decree n.158/2012 bis

*form, objectives and care paths, qualitative assessment tools, guidelines, audit and similar tools, and" multi-professional organizational forms, called complex units Of primary care, providing care services through the co-ordination and integration of primary care and social care professionals, taking into account the peculiarities of territorial areas such as metropolitan areas, sparsely populated areas and smaller islands.*³⁹ "The Decree provides for a definition of the ways in which the regions determine the funds with which the activities are supported, and the ways in which the corporate health facilities define the objectives and agree the programs that will be implemented during the periods of activity. With the definition of this standard is expected to be adhered to complete with general medical practitioners and the information system defined by each region. Within 180 days of the entry into force of the decree, all national collective agreements must adapt the directives that coordinate the attitudes of the various doctors operating in the territory.

3.6: HEALTH NATIONAL PLAN 2014-2018

The Italian National Health Service (NHS), like other health services in other countries, is funded by general taxation and is therefore affected by the current difficult economic and financial context. Despite this, it is still considered by the World Health Organization as one of the first in Europe and in the world, based on three key indicators: improving the overall health status of the population, responding to health and health care expectations of citizens and the healthcare insurance to the whole population. Health promotion is a determining factor for the well being of the person, for the quality of life, but also for the sustainability of the health system.

This is the assumption under which is define the Italian Health Plan for 2017 and the primary objective in 2017 will be to maintain and consolidate the quantitative results achieved in the quality of the services, in the prevention activities and in all the actions that helps to ensure the health of the community. However, the Health Plan must consider the sociological and epidemiological factors that continue to afflict the country, as the probability to have important migratory movements that require an involvement of the Central Health Administration in different level, and the ageing of the population and the increase of the incidence of noncommunicable disease. The communication and institutional information will be strengthened through planned measures also aimed to increase the accountability of citizens, in order to enable informed participation and not passive to the promotion and health care process. In addition to the vaccine sector, among other things, it will also act to affect the

³⁹ Law decree n.158/2012

perception of health research by the community, highlighting not only its immediate utility, but also its strategic function, in relation to possible significant reductions in future expenditure generated from patents that will be realized through its investments in the industry. All these are added to the objectives of re-qualifying expenditure on health care, prevention, rehabilitation and health research and facilitating the coordination of the various public actors involved in health care in the broadest sense, in order to reach benefit from efficiency use of resources and investment growth. In this direction, Health National System will need to continue to reorganize and rationalize hospital care, generally by enhancing existing support to the regions in a “*Return Plan* ⁴⁰”, but without forgetting to facilitate the move to the territory of the socio-medical treatment of the main chronic diseases (Territorial Departments, Houses of Health, forms of aggregation of Doctors of General Medicine), also considering the economic difficulties affecting ever larger sections of the population, and therefore obliging the administration to make health services accessible, reducing both economic and territorial barriers, and also enhancing humanitarianization aspects of care. These strategic objectives of health policy over the next three years, in terms of opportunities and constraints, as outlined below, will affect the following macro-areas:

- Prevention;
- Communication;
- Health research policies;
- International health policies;
- Promotion of the quality and appropriateness of health care;
- Information and health statistics system;
- Medical devices, narcotics and other health-care products;
- Promotion of public health and veterinary safety;
- Policies for Managerial Efficiency.

All these aspects cover an important role in the redefinition and in the reform of the health system. However, for the purpose of the analysis, the focus is on: the directives about the preventive actions, the communication and the promotion of the quality appropriateness of health care and the related information system.

⁴⁰ Return plans are aimed at verifying the quality of the benefits and achieving the rebalancing of regional health services accounts. The Ministry, through SIVEAS, is committed to helping the regions achieve the goals set out in the plans.

PREVENTION

From the health plan it is evident that the promotion of health and the protection of the person's psychophysical well being require inter-sectoral and transversal strategies involving central and local institutions and civil society. It is necessary develop integrated policies and act on key health determinants. At the same time, it cannot ignore some important sociocultural elements, as important migratory movements and the anti-vaccination actions that hind government's activities that aims to consolidate vaccine cover. Therefore, for 2017, particular attention will be given to balancing the activities of preventing communicable diseases (especially of epidemic relevance) and the prevention of chronic non-communicable diseases. The new vaccination prevention plan will be consolidated in all the living contexts of the community and high priority will be given to the promotion of health and prevention and control of chronic-degenerative diseases in the general population both in the healthy or at risk individual. Therefore, activities for universal and individual prevention and epidemiological surveillance of chronic-degenerative diseases and their determinants will be consolidated. Health promotion, by addressing the four major risk factors for chronic illnesses (poor nutrition, inactive lifestyle, smoking and alcohol abuse), the main cause of morbidity and mortality in our country, will also use the "*Intersectoral approach and transversal of the national strategy program*⁴¹" to promote health not only by strengthening the capabilities of individuals (empowerment) but also by changing the context of life of people.

Another aspect considered by the Health Plan is the population ageing. With the gradual ageing of the population, for the purpose of active and healthy aging, the life course approach to health promotion and the prevention of major chronic degenerative pathologies will be implemented, continuing to monitor and describe all aspects of the disease to the welfare of the elderly (health and social aspects), also with the aim of raising awareness among local communities of interventions with the scope to create living and social environments that facilitate the participation of the elderly in social life and enhance their role and contribution in society. Dementia is highlight as one of the factor of progressive aggravation of the economic and social weight of the chronic disease, which requires action to prevent and slow down their progress, ensuring a dignified path to the people affected. In 2017, it will continue along with the regions with the monitoring of the National Dementia Plan and with the restructuring and reorganization of Centres for Cognitive Decay and Dementias (CDCDs). The document presents the main focus to reinforce the health system in order to pursue the action to protect human health in all ages through primary, secondary and

⁴¹ Il Ministero della Salute, 2017

tertiary prevention interventions and according to a unified approach to controlling risk factors, including environmental, predictive medicine, public health programs, early diagnosis for the prevention of recurrences and complications of illness. In this sense, will be emphasize the relationship between schools and health, in collaboration with the Ministry of Education of University and Research (MIUR) to promote interventions on cognitive disorders, reproductive health, nutrition and abuse of dangerous substance.

However, the main risks do not come only from the wrong behaviour lifestyle and genetic predisposition, but also on macroenvironment. In the Health Plan gains more importance the analysis and the consideration of the environment and the protection of the territory. In the face of the future scenario, characterized by many sources of pollution with implications for human health, the National Health Service is called upon to give effective answers not only to medical care but, above all, as regards primary prevention issues and promoting health. For this, it is necessary to develop and update the procedures and tools available to health services. On the other hand, the spread of the perception of environmental and health issues by the population must correspond to an improvement in the capacity for prevention by the operators. In this context, the communication of the risk concerns both ordinary citizens' communication activities aimed at spreading empowerment, as well as that comprehensive and timely information activity in environmental cases. The National Prevention Plan 2014-2018 for the first time covers a specific macro-area dedicated to "*Reducing potentially harmful environmental exposures*". In addition, the role of environmental epidemiology should be strengthened as a function of the NHS, which, using observation provides a complex response to allow for the integration of current information, flows with literature and HIA (Health Impact Assessment) data.

REORGANIZATION OF HEALTH SYSTEM

Given all the features that affect the modern society, in the Health Plan is recognize the necessity of the reorganization of primary care according to a network that allows the patient to take the continuity of cure over time and with diversified skills. One of action describes in the document is the increase in the connection between the hospital and the territory, that is seen as instruments of intermediate care. It is also necessary to follow the arrangements for organizing and activating the regions for the treatment of vulnerable persons with chronic and non-self-sufficient pathologies, including through the Territorial Functional Aggregates of General Medicine and Paediatrics of Free Choice, as well as Primary Care Centres (UCCP), pursuant to Law 189 of 2012 and taking into account what will be defined within the new National Collective Agreement (NCA) of General Medicine. The

empowerment of the ambulatory health system will grant the continuity of the relationship between patients and doctors in all the three main aspects: relational, informational and managerial, given the possibility to decide together the health care process. Particularly in the hospital resignation's phase and taking care of the territory, continuity of care must be guaranteed through the multidimensional assessment of the need, which examines the clinical and socio-assistance conditions of the patient in order to define, in agreement with the general practitioner, the most appropriate care path, consistent with the existing social and district social services network. This process of reorganizing territorial assistance, through the activation of new organizational models, adapted to the different territorial contexts, is aimed at ensuring both continuity of care and the reduction of improper recourse to emergency and emergency services. A useful tool for achieving these goals is the integration of the Continuity Service with the Emergency Territorial System 118. Another effective tool to achieve continuity of care is the direct involvement not only of preventive, hospital and territorial levels, but also of the various professionals involved, whose interaction can give a decisive impetus to telematics use, for example through telemedicine programs. To this end, it will be necessary to define a network system that allows the integration of the canvases among the performance modes throughout the national territory. In particular, a program for the use of these tools will be promoted in comparison to people with chronic illnesses. It is important to verify the effectiveness of the system through the recognition of the results through appropriate monitoring and evaluation tools for the delivery of primary care in quality and equity across the Italian territory. For this purpose, within SIVEAS, the process of updating and implementing the national flux on hospitalization needs to be completed and interviews, integration and interconnection models of information sources needed to build suitable and valid indicator systems.

In the reorganization of the hospital network, particular attention will be given to organizational models relating to the management and treatment of pathologies requiring early and appropriate health care (time dependent) and that relate to cardiovascular emergencies, stroke and trauma. Attention to these pathologies are correlated with the health impact they cover, as they require not only a specific clinical path for the patient, but also a networking model that ensures homogeneity of diagnosis and care, the integration of the services involved and patient orientation. It is therefore necessary to continue within the framework of SIVEAS in monitoring the actions undertaken by the regions for the implementation of these networks, including by promoting improvements, with particular reference to the problems of interaction between territory and hospital.

Linked to the issue of the cure networks, the Health Plan want to define the modalities and criteria for the accreditation of palliative care, pain therapy for both adults and the paediatric area, which also sets the timing for adapting to homogeneous criteria and quality factors across the country. Only a decisive action to promote the shift in the area of socio-sanitary treatment of the main chronic diseases will allow the process of improving the quality of care to evolve in line with the need for containment and rationalization of healthcare expenditures. In particular, the Plan intends to make the care path more smoothly possible and to support the regions in the transition process towards a new integrated system model, aimed at enhancing all actors of assistance and aimed at achieving the following objectives: to achieve and maintain time to have good disease control, ensure quality of life, prevent and cure complications, optimize the use of available resources, provide links with primary prevention and early diagnosis drawings. The need to strengthen territorial services is particularly strong in the regions undergoing reorganization, upgrading and strengthening of regional health services ("Returning Plans").

Large attention in the Plan is reserved to the efficient containment of the health spending. With the agreement of 2 July 2015⁴², the Government and Regions shared the need to introduce governance measures that will contribute to system efficiency and should be developed in the framework of the Spending Review work. The Stability Law 2016, then, in according to the points of the July 2, 2015 cartel on spending levies, marks the importance of the change in the NHS expenditure on the basis of two fundamental aspects:

- A policy based not on linear cuts, on individual production factors (personal, private accredited, drugs...), but on the improvement of the clinical and organizational processes of all public and private actors, who contribute to NHS. Fundamental, and paradigmatic, of the above, the rules on the productivity and quality of care of public companies and on the accentuation of purchases of goods and services at the hands the regional power.
- A change in the relationship between the state and the regions: the state provides tools and tools while the Regions are accountable for achieving the defined economic and quality objectives.

⁴² Convention of the State Region of 02.07.2015: Agreement between the Government, the Regions and the Autonomous Provinces of Trento and Bolzano on the identification of measures for rationalizing and expediting the expenditure of the National Health Service

The state also provides support to help the region to implement these guidelines and provides:

- Update of LEAs and the establishment of the Commission for updating continuation of LEAs and the promotion of appropriateness;
- Business return plans aimed at increasing the quality and productivity of the public dispensers;
- The qualification of the offer and free choice of the citizen (derogation from the limits for the purchase of benefits from private facilities provided by D.L. 95/12);
- Interventions for recruiting staff after validation of needs and reorganization plans of the Regional Health Services;
- Interventions related to prevention and management of clinical risk;
- An improvement in the process of purchasing goods and services, aimed at the creation of centres of expertise for the processes of buying certain categories of goods, the dissemination of the best experiences, also based on a HTA program.

The affiliate activity will be aimed at achieving budget balances of hospital healthcare companies with a structural deficit. It will initiate support for the implementation of business returns that will be addressed to define the methodologies, tools and effort needed to support the business level in pursuit of efficiency and quality assurance of care by identifying leverage to support change and by supporting the company's functions in the implementation of the interventions envisaged within the Plans themselves. The interventions that will be implemented include:

- The rationalization of the activity delivered: from the analysis of production and the role of the company in the regional supply network must be defined as the appropriate and efficient production, respecting and guaranteeing the protection of the assistance;
- The pursuit of productive efficiency: from the analysis of the use of production factors (in particular personal and goods and services), rationalization interventions can be outlined which will include both intervention on the quantities consumed and unit cost interventions of consumed factor.

COMMUNICATION

The healthcare services of economically developed countries today face a complex scenario characterized by major demographic, epidemiological and socioeconomic changes. In this scenario, more and more factors are highlighted, such as the progressive population ageing, the increase in the relevance of chronic illnesses, the lack of self-sufficiency and disability. All of these factors require a profound change in the care scenario, which must necessarily be increasingly focused on managing the chronic illness and the ability to take over the individual over the long term, as well as on the systematic implementation of models diagnostic-therapeutic approaches that place the citizen at the heart of the system, leveraging hospital-to-hospital continuity and integrating health, socio-health and social health. This is a key elements in the Health Plan 2017 and large part of it take into analysis this features and tries to define the best use of it in empowerment and implementation of the new health system.

Digital healthcare is recognized to be useful elements to provide responses to the above-mentioned needs, and not just that. Digital healthcare, in fact, represents a strategic influence that can trigger a process of transformation into innovative optics of models, processes and care paths, while generating fundamental stimuli for economic and entrepreneurial development at national and European level. A digital healthcare innovation plan is a priority for the country's relaunch. However, in the near past there was recorded a fragmentation in the evolution of the innovation process. To avoid this issue, the plan set up a digital healthcare strategy at countrywide level, with unitary direction of the Ministry of Health in line with the provisions of the Digital Health Agreement. The Ministry has long been promoting, in collaboration with the regions, numerous initiatives to develop digital healthcare, such as single reservation system systems, electronic health records, telematics disease certificates, Prescription, Dematerialization of Health Documents, Telemedicine etc. It is important to reinforce this tool for several purposes.

The first reason is that the digital innovation can implement both welfare and organization model that respond to the new health needs of the population. This is a basic tool for support the new characteristics of the health system as the continuity of care, care management, de-hospitalization and full cooperation between all the people involved in the health. It becomes a instrumental operation aimed at improving the appropriateness, efficiency and effectiveness through the overall efficiency of NHS. With the agreement of July 7, 2016⁴³, the Government and Regions have therefore defined the Digital Health

⁴³ The new state-region agreement, 2016

Agreement, which constitutes the unified and shared strategic plan for achieving the objectives of efficiency, transparency and sustainability of the National Health Service through employment systematic digital healthcare innovation. The pact was born with the objective of drawing up a three-year Master Plan (2016-18) for e-Health, identifying the possible areas for activating public-private partnerships capable of triggering a virtuous circuit of economic resources to finance investment needed. Among the priorities of the Agreement may be listed:

- Dissemination of the Electronic Health File;
- Solutions and services for the continuity of hospital-territorial assistance (PDTAs);
- E-health, as an innovative service of chronic patient taking, with remote transmission of clinical parameters interpreted and managed by health professionals within an individual care plan;
- Teleconsultation, telemedicine, telediagnosis, telecommunications monitoring and integration with the Electronic Health File;
- Drug logistics;
- New information intensive services platforms for citizens;
- Definition of guidelines for Hospital Clinical Folder;
- Service solutions with centrally defined interoperability levels.

An important aspect of the digitalization of the health system is given by the creation of the New Information Health System (NIHS). It allows collecting vital data on the benefit provided by the National Health System to the individuals: it gives the possibility to collect important qualitative information about the quality of the services but also on the use of the resources. The availability of the information collected by this instruments is also a key prerequisite for determining the regional standard cost and requirements inherent in the health sector, as well as for defining “*Essential Level of Assistance*⁴⁴” and for monitoring and balancing the costs. Through an ever-wider and more comprehensive information asset, particularly in order to take care of patients in the spatial sphere, the NIHS will then provide support tools for the evaluation and decision-making process, which will allow the regions

⁴⁴ In Italy Essential Level of Health, are called LEA (livelli essenziali di assistenza) and are the benefits and services that the National Health Service is required to provide to all citizens, free of charge or on payment of a ticket (ticket)

and the ASL to assess in transparent way of improving (or worsening) the time the patient received assistance and achieving the goals set in regional planning, and will allow comparisons between the best-practice regions in order to identify the best one. The NIHS is, however, constantly evolving with the aim of increasing the available data assets through the activation of "analytical" information flows relating to care settings whose information has not yet been detected, and in particular those resulting from health care provided on the territory. The Pact for Health 2014-2016 has foreseen the further increase of this tool through the establishment of three new information systems relating to:

- Information Monitoring System for Benefits Provided by Primary Home Care Residential Hospitals (Article 5, paragraph 18),
- Information system for monitoring the benefits provided in the field of primary care (Article 5, paragraph 21),
- Information system on the performance of territorial rehabilitation facilities (Article 5, paragraph 22).

For the implementation of the information systems, the Plan suggests the creation of specific working groups, which involve national and regional institutional actors in the preparation of feasibility studies.

Thus, the regulations enable the NIHS to have a strictly connection with the National Health System in order to have access to all the sensible information on the patients, to well define the ELA, the costs of the health system and, on the basis of the analysis of the information presents in the National Assistance Register, have a clear and deeply analysis about the quality of the services delivered and about the epidemiological situation of the Nations.

3.7: PRIMARY HEALTH CARE IN VENETO REGION

With the variation of the Title V of the Italian Constitution, the regions gain more independence from the State in many area of intervention. Sanity is one of them: the region can autonomously decide how invest founds, how manage the services and can deliberate law to introduce the State law in the regional statute. Thus, the regions are oblige to respect the directives given by the State, but can decide autonomously the way in which they are implemented. This is the reason way, in order to make the reform o the health system, in Veneto was define different regional decree and agreement to activate this process. Now are presented some of the more important related to the health system reform.

3.7.1: REGIONAL GOVERNMENT DECREE 41 OF 18 JANUARY 2011

Each region must ensure that the agreements reached at national level are enforced through the adoption of Legislative Decrees that impose the national directives. In Veneto, for example, four different legislative decrees were made to make the Functional Territorial Aggregations mandatory and functional. With Regional Government Decree n. 41 of January 18, 2011, primary care takes on a definitive role in Italian healthcare, recognizing the duty of the Region to organize it and make it available to all citizenship. We begin to lay the foundations for the creation of an integrated healthcare delivery system, seen increasingly necessary to manage the complexity of health demand and the need to make medicine more close to the individual. Doctors of general medicine need to increase their work to identify, through outpatient work, all cases of pathology present in the territory so that they can remedy it before the disease degenerates and that hospitalization is needed. The de-localization of services begins, so as to make them closer to the users, making use of the doctors' union made possible by the aggregations so as to gather district patients at the same place. A model that provides for the integration of primary and secondary care is integrated in order to divide the areas of intervention and to enter into the common conception that the hospital must be perceived as the last resource after requesting help for the facilities present in aggregations. The objectives listed in the decree and that the model must pursue are:

- The treatment of post-stroke patients after discharge from the hospital, which require a continuum of care;
- A chronic or fragile patient who needs stabilization, with reintroduction at home, with the possibility of inappropriate admissions;
- Healthy overall chronic patients who need periodic monitoring of health conditions.

Over the past decade, a parcel of primary care has been shifted to an integration of primary care that provides shared paths between various professional figures to provide continuity of care to the user. Citizens are made aware of their health, involving them more in the care and management of the sick. The Venetian functional model is based on various strategic processes: it visualizes the total utilization of community resources by building support structures that help the individual's care. This promotes self-help mechanisms that help manage the patient out of hospitals so as to avoid excessive spending on regional economic resources. To provide these services, multi-professional groups are created, able to handle different situations of different levels of severity and to give the right treatment, thanks

to the exploitation of a new computer system, which allows continuity of care through a continuous computerization of medical staff, with the real-time update of the patient's medical records. The model provides a dual line of intervention:

1. *Horizontal Network* that can guarantee daily 12-hour continuity from Monday to Friday and pre-festivals through the structural and functional articulation of MAP (Matching Aid and Person) activities. To create a functional integration, you create computer services that provide easy access to network component assisting information. In addition, we can ensure moments of review of the quality of the activities and the internal appropriateness of the network;
2. *Vertical Network* between different bidding structures that provides a framework for operations between the network and the map and the corporate IT structure, with the aim of ensuring effective synergy in the adoption of appropriate organizational modes.

Creating an effective and comprehensive coverage network means integrating the various services such as Continuity Assistance, the various networking specialist physicians, the hospitals, but also the community centres and social services.

3.7.2: REGIONAL GOVERNMENT DECREE 1666 OF 18 OCTOBER 2011

The second Regional Decree implementing the legislation on territorial health is Regional Government Decree 1666 of 18 October 2011. The starting point is the one outlined in Regional Decree n. 41, which describes the basic features of the model. But the theoretical description is not enough: administrative have to identify the actions that can make this system operational. To pursue the goals are set up within the Health Districts of Territorial Functional Organizations (AFTs), which become the subject of intervention by doctors of General Medicine and Paediatricians of Freedom Choice who work together to pursue the objective of “Healthcare work in teams”. If hospital activity already has very clear and precise aspects, the same cannot be said for work on the territory. The Healthcare District and Territorial Aggregates District, with the work of family physicians, have not yet found a clear and homogeneous implementation in the operational environment that can best meet the needs of the population. It is clear in the decree, that it has greatly influenced international literature to redesign the operational activity of the national healthcare system, considering as one of the points to achieve the WHO's goal of making health care more and closer to the patient

(*care near patients*), inspired by the principles of ease of access to health services, scientific validity and methodologies, the involvement of the community in the design, implementation and management of the activities and their economic sustainability, while maintaining the high level of clinical appropriateness and quality of the service. The objectives set out in the health plans and the regional agreements, analysed so far, have been recalled to seek to implement and make operational as soon as possible the new paradigm for the use of the hospital as the principal acute care institute while the territory must be equipped to cure chronic degenerative diseases.

Territorial medicine is rediscovered in its fundamental feature: it is a type of generalist medicine that embraces various areas of healthcare. Thus, one identifies two fundamental characteristics: the territory's medicine must be holistic because it is more interested in the individual, in its family and community, and continues because it carries out the strategies of care in which it is taking full patients load, continuing the course of care and control over time. Now, gains more importance knowing how to read and interpret the needs that are felt in the area to achieve a more effective response to health demand. This is made possible through the creation of a three-year program of demand and health delivery consistent with the health needs of the citizen, with the formation of effective primary care systems but also by the creation of an organizational model that helps to rationalize accessibility to primary care, while continuing to maintain the duty to make it easily accessible throughout the territory. According to the long-term model Primary Care must be able to:

- Improve access to health services and the level of health of users;
- Addressing chronicity in the territory using specially created facilities;
- Encourage patient care in the family environment;
- Maintain a high level of quality of the characteristics of general medicine, such as the interpersonal relationship between patient and physician.

This is why the need for developing a plan for requalification of the associative forms of the licensed medicine leads to the creation of multi-professional teams that integrate the action of the various specialist figures, specifying the roles and areas of intervention. By implementing such structures, it is possible to create a system that allows the taking of chronicity through active medicine methods, made possible by the creation of an information system that allows the exchange of the patient's clinical record.

The decree introduces, in paragraph three, the first description of AFTs. They are described as the structures that must implement the healthcare model of primary care with the most advanced organizational structures that will allow for an ever-increasing number of

assistants and ensure an adequate response throughout the 24 hours of the day. This decree implements what had been described in previous decree 41 of January 18, 2011⁴⁵, going to define the mechanisms for developing the model. The Functional Territorial Aggregations carry out coordinating functions, not dispensing, among the medical studies in them. In the Veneto region, 3 AFTs were created for the 159 districts that were still operating in the territory with the definition of a doctor who will be appointed General Manager and will become the reference point for coordination by the district. In the decree, the listed principles, which these structures must carry out, cover many aspects of health. They must promote fair distribution of healthcare to all citizens by identifying ways of integrating the treatment process. The model, also, features self-control mechanisms, such as the use of pathways comparing various structures such as peer review, and spreading clinical practices based on the principles of "*evidence based medicine*" in the broader perspective of the "*clinical governance*". The decree provides that the model will implement citizens' prevention and information actions, thus creating a control action, also, through patient education and analytical methods that will help manage the information obtained from work on the territory. Hence, the increase in the quality of the services is implemented through the education of the citizen, thanks which there a full exploitation of the resources made available and the collection and analysis of the information that comes from the user. In this way it is possible be aware of which are the sectors that work best and which instead need improvement.

The associative forms found within the Functional Territorial Aggregation can be of two types:

1. Integrated group medicine with unique headquarters;
2. Integrated group medicine without a single seat.

Integrated Group Medicine with a unique headquarters, that needs to be implemented by the Regional Council, must be in line with the guidelines outlined in the Regional Collective Agreement and uses, for its operation, the resources made available by the District and Municipal Administrations. These are the most sophisticated forms distributed in the territory because they collect the positive experiences that UTAP has implemented and distributes throughout the territory. The characteristics of this structure make it fundamental for the management of the activity on the territory: it is aimed at a very large population base and becomes the point of connection and reference well recognizable. It

⁴⁵ Territorial assistance through primary care. Guidelines and operational guidelines for the implementation of D.G.R. n. 41 of 18.1.2011 - general medicine.

is based on multi-professional work involving doctors of General Medicine and Free Choice Paediatricians, nurses, social workers and administrators, and is a privileged place for social-health integration. It is supported by a well-functioning information system that ensures implementation of diagnostic and therapeutic pathways. With such structure, it is possible to divide the health action, so that different tasks can be overcome in different areas, always with approval and with a specific contract of employment. The intervention areas are:

1. Prevention through vaccination actions, counselling and screening activities with modification of patient lists that may need these controls;
2. Benefits and welfare processes, which provide home-based interventions for both diagnostic and therapeutic purposes. They become the first intervention points for treating common pathologies requiring the intervention of the General Practitioner, and not the hospital, and the first contact for the initial diagnosis and treatment of acute or psychiatric disorders;
3. Manage chronicity by trying to give more support to self-management of the disease by the patient, helping him to acquire the information needed to deal with the disease and with the patient's terminal care, managing the domiciliary, the patient's discharge and the eventual admission.
4. Social-health integration facilitated by the presence of the social worker's outpatient clinic, facilitating communication between the District, social and administrative bodies, organizations, including volunteers, to meet the diverse needs of families. In the headquarters of the group, various activities will be carried out, not only for health care purposes but also bureaucratic: it will be possible to manage booking appointments for CUP specialty visits or outpatient visits; Will be distributed the medical reports viewed and you will be able to make withdrawals and manage the services sent from the emergency room that correspond to white and green codes.

Integrated Primary Care Team is scheduled for a short time until December 31, 2012, *"to allow the planned development of the evolving associative forms, determined by the need to ensure a standard for primary care compatible with the development of conventional medicine, Group medicine is unmanned, experimentally introduced."*⁴⁶ It is needed to ensure continuous availability of the service even during the restructuring of the healthcare system. A physician working in a non-home medical group is also asked to be able to coordinate with

⁴⁶ DGR n. 1666 del 7/08/2012

other doctors in the group, so as to ensure outpatient services, including with colleagues' assistants, to continue their visits homeopathic patients and integrate patients' clinical records in a way that information is available to all physicians. A family physician working in a non-hospitalized group medicine is required to ensure 32 hours of work that can be distributed over the 6-day activity week, as explicitly stated in the contract. In addition to outpatient hours, 8 hours of home-based coverage should be guaranteed, which will be distributed among physicians belonging to the AFT team based on the service card that is signed by all doctors in the group. The decree also describes the action that must be done by doctors of continuity. They become a key figure for integrating the group's work. They spend 14 hours a week in daytime activities, ensuring that additional functions are provided. This decree highlights all the features that should be employed in a functioning healthcare system, but firstly, two objectives must be pursued: education of the citizen in choosing the appropriate healthcare facility to solve the health problem and consequently making the outpatient clinics distributed the territory of the valued substitutes for first aid in the eyes of the citizen and in the actions carried out.

3.7.3: REGIONAL DECISION 1510 OF 31 JULY 2012

This decree gives clearer framing of what the Functional Territorial Aggregates need to be and what their modes of action should be. To move to the implementation of this model, it seeks to acquire the favourable support of Doctors of General Medicine through meetings to define business plans by common agreement. The basic content of the plan is to implement the onset of this restructuring of health care, finding UTAPs already operating on the territory and re-modifying them based on new organizational needs. The decree affirms the duty of the FTA to provide a 24-hour service and the duty to appoint a coordinator of the group working with the District. All team physicians are eligible by the OO.SS and the regions regulations. They necessarily need funding to be able to operate and are determined on the basis of the expected workload. To see if the model can be really applicable, you can create a trial period for 2012/2013. In this time frame you can activate three modes of group activity:

1. Integrated Group Medicine or UTAP;
2. Group medicine;
3. Network organized in teams.

Within these three organizational forms there is the presence of nursing staff and a secretarial service, also given by the District, at the time the group is determined. For their

operation, the decree stipulates for the provision of funds (21,471,194.40 €) necessary for the maintenance of activities, but the region may freely decide to use such resources on the basis of the amount of family doctors employed in the associated forms. Funds for 2012 will be disburse in this way: 50% at the beginning of the business and 50% at the first half-yearly report. Computerization is a cornerstone of the model, which is considered essential to avoid returning to a division of healthcare that the family physician works individually in his outpatient clinic. Along with the need to transform the old hospital and land paradigm and cost reduction, the creation of a telematics system, that allows a linearity of care, is recalled in all the decrees analysed. It states that it is necessary to create a well functioning computer system to ensure the easiest collaboration between physicians belonging to the group. The use of integrated technology makes it a huge leap in quality in patient management and allows a deeper bond with social services. The computer system, implemented with DGR n. 3494 of 2009⁴⁷, allows doctors to follow the Company Plan as best as possible and to determine indicators to monitor the quality of the service. The objectives the model must pursue are:

- The centrality of primary care, implemented through the implementation of health plans that are operative, with the use of monitoring and union methods in groups for all physicians present in the territory;
- Continuity of care with the integration between hospital and territory and the definition of a local welfare network where roles and tasks are clearly defined;
- Extension of home care with the care of the endocrine patient in collaboration with the palliative care team;
- Use of extra-hospital facilities with the aim of reintegrating the patient to their homes.

This decree, with the definition of all the main features, set the focus on the economic availability of the model. Economic constraints must be respected while, at the same time, ensure the quality standards of services defined by health care and represent the general level of the region imposed on doctors of general medicine and district activities. These are described in the Services Card, which specifies the level of service quality; participatory needs assessment, and quality of care.

The Decree states that Primary Assistance must be implemented in two respects:

⁴⁷ Expenditure commitment, 2008/2009

1. Governance (strategic dimension) through territorial planning tools, such as health plans, agreements with conventional medicine and the process of evaluation and continuous improvement of primary care;
2. Management, which represents the operational dimension, with the creation of Territorial Functional Aggregations, with integration processes both at computer level and in collaboration between hospital and territory, and continuous training.

Thus, the actions that AFTs must perform are defined. They are recognized as the coordination and analysis sites of the needs of the community and as a place for creating action plans to determine the improvement of the services offered. The creation of a model that reforms health action by moving it from the hospital to the territory is born to allow chronic patient management in the area, thus saving on hospital interventions and on many times inappropriate hospitalizations. Thus, the decree contains all the provisions for managing the patient: an evolved form of General Medicine that is spread throughout the territory must be created and the result is the improvement and empowerment of the processes. We must therefore eradicate an existing principle to make the new structures create the only possible and achievable model, making it easier to manage and access. As part of the health reformulation process, chronic patient takeover is a key step.

3.7.4: THE NEW REFORM OF VENETO HEALTHCARE SYSTEM

The Regional Socio-Sanitary Plan, approved by L.R. 23/2012 calls for a rethinking of the health service offering in a system and network logic as well as more extensive territorial spheres than the present, with a view to optimizing organizational and financial resources, which are also confirmed in the provisions of the Stability Law 2016, which sets out rules for the achievement of cost savings through the process of aggregating the structures and activities of the persons responsible for the provision of the health service. There are two key innovative features on the law, that reflect the wish to contain the costs of the regional health system that are:

- The establishment of the Local Health Authority;
- The merger of the A-Ulss Companies, adjusting its guiding principles, functions and organizational aspects.

However, the reform wants to reduce the costs but preserving the high quality of the services and the Universalist access to the care system, without any barriers. In fact, the

citizens are the centred of the model and the focus of the region is to define a supply system appropriate to the needs of the population to provide assistance and services with fast and appropriate responses to the health of citizens. In addition to this the law provided:

- Clinical Governance: define and use a "standard" system, backed by literature and field application, enabling you to program and monitor the organization of services, processes, performance, human resources, technology and health results of the Regional Health and Social Service;
- Less bureaucracy and health: the creation of “Local Health Authority” as an administrative technical support infrastructure to allow healthcare companies to be dedicated to institutional activity;
- Measure, monitor, verify, penalize and reward: apply a multi-level monitoring and control system for compliance with standards and regional planning by healthcare providers.

The project aims to support the people involved by providing theoretical methodological tools to govern the launch of new healthcare companies and support the launch of the new organization of Veneto healthcare. One of the instrument to do this is the establishment of the “*Local health Authority*”, which responds to the need for a strong simplification and rationalization of the system by transferring the activities of a management nature from the regional administration to a new regional health service, which will also absorb a significant share of the technical and administrative activities. With the creation of this territorial administration unit, the simplification of the system is due to the reduction of the number of A-USll, from 21 to 9, that are:

- Belluno: n. 1 Dolomites;
- Treviso: n. 2 Marca Trevigiana;
- Venice: 3 Serenissima and 4 Veneto Orientale;
- Rovigo: n.5 Polesana;
- Padua: n. 6 Euganea;
- Vicenza: 7 Pedemontana and 8 Berica;
- Verona: n. 9 Scaligera.

The new A-Ulss have the role to ensure a comprehensive organization of branches and services, increase by 15% the number of beds in community hospitals by 31.12.2017 and the activation of at least 80% of GPs in integrated primary care teams by 31.12.2018. The "new"

Local Health Authority will have in particular the task of centralizing purchases, personnel selection procedures, insurance management, public relations offices, rationalization of the logistics system and management of labour disputes, and health. The territory of former A-Ulss becomes district territory. In each District, the Committee of District Auditors is established.

3.8: CURRENT SITUATION OF INTEGRATED PRIMARY CARE TEAM IN VENETO

The growing sustainability issues of the Socio-Sanitary System for the Regions (SSSR) required synergies at various levels of government to redefine the socio-sanitary planning lines. The SSSR's economic sustainability has therefore been pursued through a multi-level governance system (regional, municipal and districts) that ensures the best balance between the Essential Levels of Assistance (LEA) and the funding system. In this context, the health offer required a continuous improvement in equity and productivity of healthcare facilities, enhancement of accessibility to health care services and their quality and continuity of care; innovative solutions that have become conditionals sine qua non to ensure the clinical and organizational appropriateness as well as the proper utilization of socio-sanitary services. To overcome the sectoral and self-referential logic and to ensure a link between the institutional levels, the "*health agreements*" are signed between the various actors and the management level, which guarantees the adoption of coherent organizational models and professional level that allows harmonizing the skills of professionals involved in achieving common health goals. In an increasingly less sectoral and parcelled view of the patients and their needs, the coordinated intervention of all the components of the system represented the recognition of the person in its entirety by allowing the implementation of an institutional framework founded on the municipalities (as bodies planning and implementation of social and socio-sanitary services), the socio-sanitary districts (which are crucial in the territory for the services and services of the area) and the MMGs and PDLs⁴⁸. This organizational model, homogeneous and fully responsive to the health needs of citizens, in attracting the care of the near-patient World Health Organization, the principles of accessibility, equity and community involvement in design, has crystallized in the territory the main activities for the cure of the chronicity while in the hospital the acuity, ensuring the connection between the different structure through the electronic file for each assisted. This results in a remodelling of the hospital supply and a reduction in the number of beds that induces the use of virtuous welfare

⁴⁸ Decree Law 229/99.

models that move, in different regimens from hospitalization, diagnosis and care in the processes of continuity of care through a continuous connection between hospital and territorial care: the integration of various professionalisms and the building of care and organizational connections that integrate skills, knowledge and abilities allows the patient's global involvement with the creation of an integrated path between territory and hospital coordinated by the case manager. The demand and supply programming, through the formulation of a Primary Care Plan, becomes the governance tool for health policies and business strategies for achieving goals related to integrated patient management and continuity of care. Innovation is to be found in organizational models for improving and rationalizing access to primary care throughout the business territory. Through a widespread and qualified network of multiprofessional interconnection, the decentralization of the district is realized by allocating human and instrumental resources that become the fulcrum of Primary Care. This "*initiative medicine*" guarantees a high quality of primary care based on the person rather than the disease that, through multidisciplinary and multidimensional pathways, is embodied in continuity in patient taking through protocols shared between the hospital, the territory and the community, and through a requalification plan of the contracted medicine, aimed at the exploitation and liberation of bureaucratic fulfilment, is developed an unprecedented task of interaction with citizens and with the health institution. Through integration with nursing, home care, specialist outpatient care, social service and Health National System staff, in command positions, the new system is composed by multiprofessional teams that provide comprehensive, continuous and fair care focused on the person, which consists of prevention of palliation, chronicity and comorbidity: thanks the efficient and appropriate use of the various skills and professionalism in the territory and the non-marginalization of healthcare professionals, it is possible to create a welfare model appropriate for preventing unsuitable hospitalization by favouring instead, de-hospitalization and primary care. The characteristics of this organizational form make it decisive in the territorial deployment of primary care because it is the "*final node*" of a welfare network and a recognizable territorial point of reference in addressing a particular population basin. By building on a multi-professional job, it makes a unitary reference for the patient, ensuring LEAs are earned through clinical and organizational quality goals, measurable through appropriate indicators. It is a privileged place not only for socio-sanitary integration through therapeutic-diagnostic pathways for the acute and chronic patient but as tools for prevention because it maps the socio-epidemiological data and detects the connotation of need the health of the population. The reorganization of territorial assistance through the creation of territorial polyclinics networks with their own budget, basic equipment, open to the public throughout

the day, requires the definition at regional level of the objectives and programs of activities to be carried out and a regulation of the ratio guaranteed by a "*type-service contract*" (*Carta dei servizi*), in accordance with the regional reference developed framework that will have to contribute to the economic and financial holding of the new implemented system.

With the approval of the Socio-Health Plan 2012-2016⁴⁹, the Veneto Region has relaunched the function of Doctors of General Medicine (MMG), recognizing its central role in the Regional Health System. The main recipe for the new centrality of MMG is the association of physicians, to be achieved in different forms: from simple medicine to network to the most articulated MGI. This is in all cases a model inspired by the WHO conceptions and the result is a complex path: after the initial assessment contained in the Healthcare Plan, a Memorandum of Understanding between the Department of Health and Trade Union Organizations was signed in 2013 with a type of operating contract scheme revised in 2015. The regional standard currently provides that MGI's implementation progressively takes place over the four-year period 2015-2018, but at the same time contemplates the possibility of other forms such as "*Network Medicine*" and "*Group Medicine*", which should, however, still have to be transposed within the deadline set. The minimum number for the establishment of an MGI is *four* doctors and no maximum number is indicated. The reform, also, envisages the development of mandatory associative forms at a higher level called AFT, which perform coordinating and non-delivery functions among the group medicines belonging to them and it is established among an average of an AFT per 30,000 inhabitants. The main purpose of the reform is to reorganize the MMG structure to ensure continuous and complete care for patients by coordinating the responses of all social health services and in particular transfers to and from the hospital, intermediate structures and rest homes. In the case, for example, of the MGI, there is the presence of nursing and administrative staff whose amount is to be agreed with Healthcare Professionals by specific contracts that involve physicians on specific goals to be achieved. Group medicines are set to become a privileged place for social inclusion integration and a well-recognized landmark, based on multiprofessional work involving MMG but also nurses, psychologists, social workers, and administrative staff. As mentioned, the gain in terms of centrality in the social network will, as a rule, correspond to the enhancement of the skills of the new subject, in the case of the MGI disciplined by the contract of employment to be approved by the Local Health Authorities. The MGI helps to:

- Realize prevention programs;

⁴⁹ Regional Law 23/2012

- Deliver performance to the acute patient and manages the chronic patient with the possibility of "personalizing" the treatments;
- Implement diagnostic-therapeutic pathways based on scientific evidence;
- Collect socio-epidemiological data and maps local needs;
- Using a computerized network, share patient management with ULSS and with other MMGs.

The Regional Council of Veneto has ratified the agreement reached with trade unions of general medicine agreed to for the whole territory of MGI. The Agreement defines, inter alia, a standard type contract and provides transitory forms for a gradual extension of the model across the country, fixing 25 million (25.000.000 €) per year for 4 years (2015-2018) the required regional investment to realize the whole network⁵⁰. This is to finance the fundamental aspects of the health, which is enhancing and strengthening the field of medicine and the good practitioners who practice it, as:

- Bringing services closer to the citizens and maximizing their pay-as-you-go range;
- Create a network of first diagnosis and care in the area, which can avoid many improper accesses to emergency, enabling to save monetary resources.

After three and a half years of work and even clashes, the Veneto is about to launch, from 2016, the famous revolution of doctors of general medicine. They will come together on the basis of the "Primary Care Health Team" model, and by giving them shifts and with adequate staff, they will guarantee to all their assistants that the outpatient clinic will be open all day, from morning to evening. And this obviously has a huge goal: on the one hand, to broaden the basic health service for citizens, of course, but on the other hand, to get free the hospitals to accept people with common "*white code*", that hanging up the waiting rooms. In this way people can receive immediate cure, without waiting for hours. However, there will be no revolution in just a few days. The agreement envisages that the years until 2018 are those of the transition to a fully-fledged system. From the point of view of users, the one that will spread to the inhabited centres is precisely a revolution of timetables: the group of doctors MGI, who at the regime must be formed by at least four General Practitioners, will have to ensure that from 8am to 8pm Monday to Friday in the studio there will always be someone responding to patient calls and there will always be at least one doctor. Same speech

⁵⁰ Elena Cipolletta, Sole24Ore, 1 settembre 2015

is also on Saturday morning, but only from 8 am to 10 Am. Not only: nursing and administrative staff will be present besides the doctor. Access to medical studies, however, will have to occur mainly by reservation.

The process of adhesion by doctors to the combined forms of medicine goes hand in hand with what is foreseen by regional planning. Since the beginning of the present millennium, in order to cope with the progressive chronicity of diseases linked to the population ageing, the spread of associative forms of family medicine has been witnessed in Veneto in an attempt to contain healthcare expenditure by investing in de-hospitalization and strengthening primary care pathways. Hence, in the four-year period 2001-2004, there has been a spontaneous emergence of associative forms between family doctors until the creation, in the period between 2005-2008, of more complex experimental forms of association, such as the “*Territorial Units of Primary Care*” (UTAP), which already included employment in the next four years of nurses, study associates and specialists for the integration of the doctor's work. But, it is with the regional healthcare plan 2012-2016 which outlines a true framework for the development of primary care in Veneto, introducing the concept of “*supply chain of health care*” to represent the articulation of structures that compete with to respond to nursing needs and to protect each stage of the person's takeover. This new regional framework identifies the strategic goal of the dissemination, throughout the Veneto territory, to the MGI, in accordance with the provisions of Law Balduzzi⁵¹. The development of primary care through the dissemination of MGI is contracted by DGR n. 751 of 14 May 2015, implementing the Decree n. 953/2013. In the text of Regional Decision is clear that the regional health care system has the main objectives of fulfilling the prevention activities and the education to healthy lifestyles and guarantee the high accessibility for acute problems and ensuring the continuity of care keeping the informative individual health card. Again, it allows the presence in the surgery of non-medical staff and nurses, who helps doctors in outpatient and bureaucratic work. However, the situation just described in the technical plan is in the early stages of application and the development of MGI has so far been implemented with different modes and intensity in the various A-Ulss. The following data, reported in Table 4 (Table 4: % of MMG in different associative forms) and referred to January 2017, describe the present situation of the distribution of different associative forms and the number of MMG that adhere to each one. In the last years, the MMGs start spontaneously to create aggregation in which they work together: working with other professional, in the same building, give more benefits to both professionals and patients. In fact, the patients are sure to

⁵¹ National law 189/2012

Associative forms	n. MMG	% MMG	n. Patients	% Patients
General practitioner	472	15%	448.761	12%
Simple Aggregation	327	10%	450.071	11%
GP in network	976	30%	1.300.368	30%
MG	1031	32%	1.454.548	34%
MGI and UTAP	407	13%	557.563	13%
Total	3.213		4.211.311	

Source: Veneto Region 2016

have grant always a services and the professional can be helped in their daily activities from the colleagues: in case of emergency, in which the doctors must go out from the ambulatory for domiciliary visit, it is always assured by colleagues coverage for outpatients emergencies and normal ambulatory's activities. This is the reason why, at the beginning of 2017, and also before the implementation of the reform, there are only the 15% of the General Practitioners that work alone. However, with the implementation of the Health Plan, at the end of 2019, in Veneto, as in the other region, all the doctors must be part of MGI. The large part of the professional belongs from the simple MG and UTAP or work in network. This is a profitable base on which start the building of the new health system, because it can be converted immediately into the new system and allow to achieve quickly the goal of the reform: by the 2017 the 60% of the General Practioners working in the Region must bring together in MGI forms and in the 2018 must be the 80% of them. Despite this, the work to made is considerable and not without difficulties and resistance. At 1st January 2017, the situation in Veneto of the doctors that was grouped in MGI is described in the Table 5 (Table 5: Total number of MMG, patients, nurses and staff involved in MGI in January 2017):

	TOT in VENETO	TOT in MGI AUTHORIZED	% OVER TOT REGIOAL	MGI TOT ACTIVATED	% TOT
MMG	3.213	753	24%	574	18%
PATIENTS	4.925.000	1.043.926	19%	814.268	16%
NURSES		263		175	
STAFF		394		263	

Source: Veneto Region

At the beginning of the years 2017 in Veneto 574 MMG, over a total of 3.213, work in activated MGI, that is distributed on the Region and it corresponds only on the 18% of the

total amount. Before 2018, it is expected that the MGIs planned and authorized will start to work and the amount of total MMG involved in the health reform will be 695, the 22% of the total General Practitioners in Veneto. However, this situation is far from the main objective of the Region that foresees the involvement of 60% of doctors by 2017 and 80% by 2018 in the reform of the territorial delivery of health services.

The reorganization of the health services pass also in the union of the existent 22 A-Ulss in the new 9⁵², with a creation of more health districts, distributed in the territory, that helps to control and manage the health activities focusing on the real needs of the community. This decentralization of the management of the health services is useful to have a reduction in health expenditure because the activities delivered are gauged timely on the real necessity of the people, which should change from community to community. The Regional Law 19/2016, art 26, comma 1,6, define the existence of 26 health districts distributed in the nine A-Ulss as describe in the Table 6 (Table 6: Number of districts in the A-Ulss of Veneto):

Table 6: Number of districts in the A-ULSS of Veneto	
A-ULLS	DISTRICTS
A-ULSS 1, Dolomiti	2
A-ULSS 2, Marca Trevigiana	4
A-ULSS 3, Serenissima	4
A-ULSS 4, Veneto Orientale	1
A-ULSS 5, Polesana	2
A-ULSS 6, Euganea	5
A-ULSS 7, Pedemontana	2
A-ULSS 8, Berica	2
A-ULSS 9, Scaligera	4

Source: Veneto Region

The work of all these districts is under the supervision of the Local Health Authorities, which has key administrative function and directs the distribution of the resources. However, the action of the districts is defined by the A-Ulss that has competence over the part of the territory. Thus, Azienda Zero has the main authority in the region and gives the main directives but the single A-Ulss have the possibility to decide autonomously how to implement the directives and achieve the goals. Every A-Ulss definite, autonomously, the plan to activated the MGI and it explains the different state of progress: every A-Ulss

⁵² Regional Law, 19/2016

refers to particular territorial and community situation and the development of the health structure must consider these aspects. In the Table 7 (Table 7: MGI Planned and activated distribution per A-Ulss) there is representation of the distribution of the MGI in the different A-Ulss:

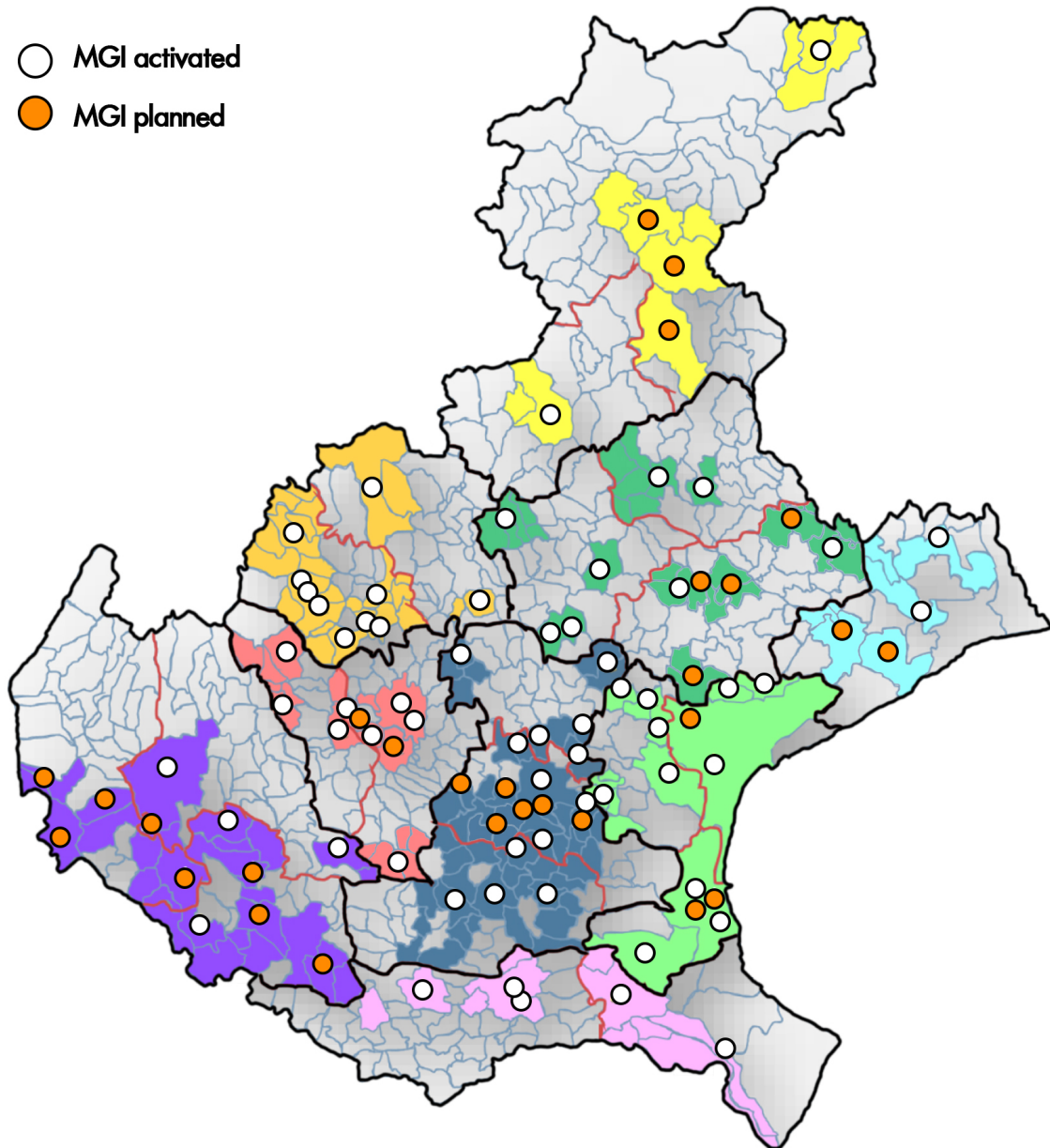
Table 7: MGI Planned and activated distribution per A-Ulss				
	Total population	Total MGI	MGI activated	MGI programmed
A-ULSS1 DOLOMITI	206.795	5	2	3
A-ULSS 2 MARCA TREVIGIANA	885.349	12	8	4
A-ULSS 3 SERENISSIMA	640.399	14	11	3
A-ULSS 4 VENETO ORIENTALE	215.391	4	2	2
A-ULSS 5 POLESANA	243.212	7	3	4
A-ULSS 6 EUGANEA	934.659	19	13	6
A-ULSS 7 PEDEMONTANA	367.961	10	10	0
A-ULSS 8 BERICA	499.430	9	7	2
A-ULSS 9 SCALIGERA	931.804	12	4	8
TOTAL	4.925.000	90	62	28

Source: Veneto Region

The Figure 1 (Figure 1: MGI Planned and activated distribution per A-Ulss) shows graphically the distribution of the MGI in Veneto: the black lines define the nine new A-Ulss and the red ones, inside the macro-areas, outline the boundaries of the ex A-Ulss. The colour areas are the municipal and surrounding areas covered by the MGI services and, so, it makes clear what is the proportion of territory currently affected by the reform and how the A-Ulss are implementing the directives. The map shows only the MGIs activated and planned: in fact, according to the Regional Decision n.122 of 20/12/2016, in Veneto at the end of 2019 should

be 400 MGI but actually there are only 90 MGI projects presented to the “Crite⁵³” and, of these, 62 start to work and 28 are waiting the approval. The high quantity of MGI planned and activated reflects the presence of more positive features and less internal resistance but also the population dynamics.

Figure 1: MGI Planned and activated distribution per A-Ulss



Source: UO CP e LEA Veneto Region

The most virtuosos A-Ulss seem to be the A-Ulss 2 Marca Trevigiana, A-Ulss 3 Serenissima, A-Ulss 6 Euganea and A-Ulss 9 Scaligera: these are metropolitan areas that presents a high concentration of the population and high number of professionals. The

⁵³ Regional decision table for the approval of the MGI projects.

demographic condition, but also the geographic configuration of the territories, allows the old A-Ulss to develop in the years before AFT, which simplify the creation process of the network team of primary care. The same is for the A-Ulss 7 Pedemontana, that presents in the last month a high number of project presented and activated, even if later than other. There is a noticeable delay in the A-Ulss 5 Polesana due to internal resistance of the doctors. The actual MGI developed is a reorientation of the pre-existent UTAP in the new MGI but the creation of ex novo group finds some obstacle. The main reasons that have prompted the General Practitioners to stop the transformation is the few assurances and the low clarity of contracts: especially the doctors are worried about the future turnover, because it is evident that the number of young family doctors is less than the number of doctors who are retiring, and raise doubt about the appropriateness of consist investment in the redefinition of the health system if, in the future, there will be lack of the main professional figures that work in it. However, after initial resistance, also in the A-Ulss 5 the health services start to be delivered in this innovative way. A different analysis must be made for the two A-Ulss Dolomiti (1) and Veneto Orientale (4). In these areas the MGI are less developed and implemented but for different reason. The tourist reality of Veneto is an important economic aspect in the life and management of the region. For this reason, in healthcare reform, there has been a great deal of attentiveness to this dimension, and therefore, despite the consolidation of the health in the territory and the birth of A-Ulss 4, the territorial competence in A-Ulss has remained virtually unchanged. In fact, the A-Ulss 4 has maintained its tourist vocation and includes localities such as Bibbione, Caolre, Eraclea and Jesolo, which bring about 23 million tourist attractions. In the summer this A-Ulss becomes the largest healthcare company in Europe for attendance. For this reason, the train in this A-Ulss is not a re-launch of the health structure but an increase of staff and services offered, promoting the creation of more efficient models that could be exported in the rest of Veneto. Thus, in addition to the reorganization of hospital centres, new first access points and a strong increase in persons with language skills, Ulss 4 also proceeds with the activation of integrated group medicines, at the moment 4, with about 30 doctors engaged, that guarantee the provision of health services to a large part of the population, thus allowing hospitals to take over foreign patients. It is evident that the natural affluence of tourist affect the configuration of the entire health system and it is required a reorganization of the entire organization in order to contain the health expenditure. The composition and distribution of the population is one of the aspects that affect the A-Ulss 1 Dolomiti. Also this area, that include the ex A-Ulss of Belluno and Feltre, hand in a high number of tourist during the whole years but presents a real important issues that is the territorial conformation. In fact, the different plan present to the *Crite* is

developed by group of professional that autonomously, with the supervision of administrative and cooperative, decide to define this team group and require to the region the financial support in order to activate it. However, in a mountains are, it is more difficult for the practitioners to ensure a services as the one define in the National Agreement: it is hard that the doctors can sustain a double services in the principal and peripheral surgery and, also, to find a strategic place in which locate the ambulatory to engage the high part of population as possible. In fact, at this moment, the two MGI activated are located in Belluno and in Feltre, areas in which there were before two UTAP that are reconverted to the new activities. The other MGI planned are located in place as Longarone and Cortina, which cover a relevant role in the European tourism. Despite the territorial obstacle, also in A-Ulss 1 the general practitioners start to rethink the organization and try to use this structures as an opportunity to reach better the distribution of the health services in the mountain areas.

The Veneto Region define the creation of around 400 MGI and it means one MGI, in average, for 15.000 inhabitants, ad so 2 for every AFT (1 for 30.000 people). When the team of general practitioners send the definition of the main characteristics of the project to the Crite, the region starts to analyse it and, if the features of the MGI are compliant with the main directives, give the approval and deliver the funds necessary for the activation. The initial investment foresees by the Region, as said before, is about 25.000.000 € per year for 4 years. With this amount it is expected to be able to finance the implementation of the model and grant the activation of a number of MGI per year. However, there is not fixed amount for singular MGI, because it depends to different features: with the requalification of the UTAP it is enough provide the specific equipment but in some other cases it is necessary to build a new surgery, which receives all the required features, from the acceptances to the medical aspects. For example, in the A-Ulss 6 Euganea for the activation of the MGI in Maserà was used 1.000.000 € while, for the development of MGI in Saonara and Guizza there are an investment of, respectively, 430.000 € and 570.000 €. In A-Ulss 4, for the creation of four MGI was financing 2.000.000 €⁵⁴ and in A-Ulss 5 382.849 €⁵⁵ for the five activated. The Region invests fund to the creation of the physical place in which implement the health activities, but also to provide the staff that work inside the surgery and that helps the doctors to do the non-medical services describe in the contract. These investments are expected to return back to the region as saving in the total health expenditure: it could be considered as an investment over the long run. It is to early at the end of this years to give a clear definition about the costs and if there is a real amortization and a real saving in the health expenses.

⁵⁴ La tribuna di Treviso, 17 Gennaio, 2017

⁵⁵ Rovigooggi.it, 7 maggio 2017

Anyhow, it is possible to have a general idea about what are the costs that Health System must sustain and they are describe in the “*contratto d’esercizio*”.

OPERATING CONTRACT (CONTRATTO D’ESERCIZIO)

The DGR n. 751/ 2015 sets out how to implement the primary care development project and confirm the contents of the “*operating contracts*” or “*contratto d’esercizio*”. This agreement defines the main aspects that characterized the MGI: there is a description about the surgery, the staff and the main activities that the doctors must do and the relative economic incentives. In the implementation of the MGI there are some “*structural standards*” to respect. The surgery must be adequate to the population that use the ambulatory and the access to the services must be made after reservation. The surgery provide:

- One personal office per 2 MMG;
- One office per 3 MMG that maintain the peripheral surgery;
- A multifaceted space;
- Nurse’s office;
- Waiting room for the acceptance.

The available spaces, in which the ambulatory raise, can be given by the A-Ulss or it can finance the renovation to convert exiting facilities. However, even though the Local Health Authority carries out work, doctors who benefit from the facilities will have to agree to a payment of a usage fee, which is divided between the doctors in the way they define (some can divided it in relation to the number of patients, some other for the hour of use, etc.). The Health System, also, equips the MGI of additional personnel that assist the General Practitioners to the daily activities. The costs of the secretarial and nursing service, needed to ensure the structural standards provided for this contract, are entirely paid by the A-Ulss because the benefits are completely received by the patients, implementing the territorial assistance, and without any direct or indirect income incidence for doctors. That standard of the number of the staff will be compute on:

- The number of General Practitioners inside the MGI;
- The number of patients that use the MGI;
- The number of patients affected by certain kind of disease;
- Number of PDTA activated.

Thus, the standard number of the personnel is: 1 nurse per 3.600 patients and 1 collaborator of study per 2.400 patients. Again, the A-Ulss, according to the contract, must provide medications material, drugs, specific instrumentation for small surgery and the tools needed to meet the requirement of PDTA. However, all these aspects are not managed by the A-Ulss and the task of providing these services is entrusted to a third part: the cooperative. The cooperative assume a relevant role in this new configuration because helps the Local Health Authority to identify, hire and monitor the staff that works between the doctors and helps the MMG to manage the administrative and organizational aspects of the ambulatory, allowing them to do their daily ambulatory activities. Instead these figures is so important, the complexity in the relationship between these three actors increase uncertainties and can create some resistance in the activation of new MGI. Actually, through meeting between doctors, administrative and union, it is rethink the relation between these elements: between the Health System and the cooperative there is an economic relation, because the A-Ulss give the fund to the cooperative in order to manage the staff in the surgery, that is created by the collaboration between the doctors and cooperative in order to in identify the right team and implement the best functions. Thus, the cooperative cover administrative tasks and the general practitioners implements the daily ambulatory activities.

Inside the “contratto d’esercizio” are define, also, the main functions and features of the doctors and the linked economic incentives obtainable achieving the goals. The Table 8 (Table 8: Main features of typical “contratto d’esercizio”) gives a broadly presentation of these aspects and related incentives:

QUALITY FACTORS	OBJECTIVES	INCENTIVES (€/patient/year)
Equity	Prevention activity	1,50 €
	Chronic disease assistance	4,55 €
	Education and audit	1,00 €
Computerized individual health card	Use of informatics’ system for the cooperation within the MGI	DGR n. 1753/2013
	IVAO index with the value of 0,50 for the first year and at least 0,65 in the years after	1,35 € (Quota B Paths)
Accessibility	MGI must ensure the daily assistance 12h, pre-holiday and Saturday, until 10 am.	3,05 €
Participation in governance	Participates in respect of the goals assigned to the A-Ulss	3, 10 € (Quota A paths)

Start-up and co-ordination benefits	Una tantum contribution for single doctors	1.000 €
	Identifying a MGI referent that cares for the relationship between the district and the group.	400 €/month + EMPAM (4-6 MMG);
		600 €/month + EMPAM (7-10 MMG)
	800 € month + EMPAM (+ 10 MMG)	

Source: DGR 751/ 2015

The contract is in line with the main directives of the WHO focusing on the universal accessibility of the health services and the preventive actions. The preventive actions gain a relevant role in the MGI: it allows the record of a health sanitary card in which are reported the data related to the health and life style behaviour, in order to monitor the probability of cardiovascular risks, the incidence of diabetes and the pulmonary chronic disease. In this way, it is easy to have an epidemiological study of the community in which the MGI operate and control the impact and the development of the chronic degenerative disease. Achieving the goal in this particular area means having a reduction on the health expenditure because it can reduce the access in hospital due to the sharpening of these pathologies, but also, if the life style behaviour is correct in the early stages, it is possible to avoid the occurrence of the disease with as consequences the reduction in number of cures and an increase in wellness for the people. The health card is included in the informatics system of the MGI, that allows the doctors to share the main information of the patient with the colleagues to ensure the continuity of care and the interoperability of the MMG.

The universal accessibility to the care is the focus of all the sanitary reform all around the world and putting the point of access near to the people is the first step to achieve the goals. The MGI consent to offer daily services for 12 hours (from 8 a.m. to 20 p.m.), including Saturday and the day before the National festivity. In the ambulatory the MMG and the nurse carry out their duties by offering continuous services to the citizen: at least two physicians must always be present in the ambulatory, respecting their turn and the activities in the peripheral surgery. The right application of these directives makes the MGI a vital component for increasing the economic sustainability of the health system. In fact, it permits to reduce the hospitalization index and the use of laboratory investigation and unnecessary specialists visits. Also, it is strictly controlled the pharmaceutical expense for every single doctor and the prescriptive appropriateness of diagnostic investigations. In addition to the costs linked to the staff and the surgery, the SSSR pays an incentive for the creation of the MGI and ensures to the doctors a refund for the expenses incurred during the transition from one structure to

another (1000€ una tantum). The complexity of the system and the difficulties in activating the MGI is managed by a “*referent*”, a doctor of the team that coordinates the actions in the surgery but also meets the other groups, follows training lessons and improves the tools inside the team with the collaboration of all the other MGIs in the A-Ulss.

This is the practical act thanks to which can be implemented the WHO organization plan: increase the control over the population, granting the universalism of access to the health system and focusing more on the chronic degenerative disease with the aim of control and reduction of the health spending.

3.9: CONCLUSION

From its origin the health system was changed and adapted to the historical period, to the demographic structure and to the cultural environment. In Italy, from 1950 until now, there was a succession of normative and law that gradually began to transform the system and adjust it to the needs that rise in the nations. What is clear from the beginning is the necessity to have an efficient system near to the community, that helps to analyse the real needs of the population and delivers the required services. The world population shows a quick change, due to the boom in birth in the '40 years, and a rapid reduction in nativity that translates in an ageing of the population, and the challenges that the health system must face cannot be supported by the existent organization. Inspired by the declaration of the WHO, also the Italian National Health System introduced new legislation that reorganized the health system in a more efficient manner, with high implementation of the territorial ambulatory and the use of the hospital services only in case of emergency and disease in the acute phases. The different reform and health plan have led to the current reorganization of the health structure with the creation, from 2016 of the MGI. The MGI can translate in an operative way the ideological objectives of the WHO and OCSE as the equity, the freedom of access to the health system, the universalism of the cure and more attention to the person and to its real needs. The health system humanization can be made thanks to the introduction of ambulatory that can grant a continuity and comprehensiveness of the care thanks to the use of technologies and information system and the possibility to create a personalized path of cure. In addition to this, the activities of the MGI can be assisted by a network of services in the territory, that helps to take care of the community under every health aspects: prevention, education to healthy life style, rehabilitation and cure to the chronic patients. The “*contratto d’esercizio*”, signed between A-Ulss, General Practitioners and Unions presents and describes all these key aspects of the new health structure and defines the importance of the territorial medicine: the family doctors, in fact, can help to contain the health expenses not only through the control of the

daily ambulatory's activities (as containment in the pharmaceutical expenses), but also thanks the control of the life style of the patients and reducing the access to the Emergency for white code, given in the surgery the possibility to have the cure needed, thanks the presence of the nurses.

Despite this agreement is well done and the health plan reform is apparently real good, there are some difficulties that start to rise:

- Internal resistance by the MMG;
- Excessive bureaucracy of work;
- Block of MGI approval by the Region.

With the reorganization of the health system the MMGs cover a key role and are the centre of organization. However, some general practitioner presents doubt about the real positive effects of the reform: today, also for being MMG, the aspiring doctors have to follow a specialization course, stretching the studying period more longer than before. In addition to this aspects, the MIUR, block the access to the course of specialization, leaving a large number of medical aspirants (more or less 8.000), in the limbo of precariousness. For some general practitioners, it is absurd spend high amount of resources to organize a new system that will be not longer supported for lack of medical staff. For other, the reason of the resistance are more personal: with a 12 hours activities of the surgery, the doctors cannot maintain their other related health activities and for this reasons they prefer to stay in the MG, without receiving the incentives.

Other resistance comes from the way in which doctors perform their works. The computerization of the system is useful because it allow the doctors to have timely all the information about the patients, its health and the cure and to share this information with the other colleagues. However, create a good-recorded card means spend time to out in all the information. In addition to the time that the MMG must spend in the compilation of these informatics documents, they have to write down the activities made every day, to send to the region at the end of the month. The MGIs, in fact, are useful tools for the monitoring of the implementation of the services in the territory and to be sure that the doctors achieve their goals before receive the economic incentives. It is a way to see if the plan is realized in the respect of the key features, as accessibility, equity, continuity of care but also in the reduction of the pharmaceutical expense and the right use of the hospital's facilities. However, send the

“*flussi*⁵⁶” means for the doctors spend much time in the collection of all the needed data: a large part of the MMG said that there is a strong bureaucratisation of the medical activities. With this condition it is difficult to achieve the objective to increase the efficiency and the quality of the services delivered. Probably, with the nurses and the secretaries, in the surgery must be present an administrative figure that helps the GP in the daily reporting occupations, in order to send more appropriate information to the region and do not take time to the doctors useful for the visits.

At least, the problem does not arise only from the doctors but also from the region. FIMMG has launched a series of strikes due to the block of MGI activation. In fact, many projects presented to the region, until now do not have received the approval. The region decided to stop the activation because of a lack of funds for the implementation and for the maintenance of the new organization. The doubt is that this system is not sustainable and that the expected results are not real. In fact, there are fears that the destiny of the SSSR will be similar to the one in Lombardia, in which the Local Health Authorities open to the possibility of having private health services. It means to make a step back to the outcomes obtained until now, thanks to which every person can use the health services without any discrimination. Due to these uncertainties, the model, that presents great potentiality, must be stopped in order to identify all possible problems and build an efficient system.

⁵⁶ Documents that hold all the information about the medical activities made in the ambulatory, in the territory (domiciliary visits), the PDTA, BPCO and other prevention actions made in accordance to the Health Plan and the “contratto d’esercizio”.

4. THE CASE STUDY: INTEGRATED PRIMARY CARE TEAMS IN TREBASELEGHE (PD)

The Regional law n. 19 of 2016, reorganize the configuration of the health organization in Veneto, with the joining of the Ulss (from 21 to 9) and the creation of the “*Local Health Authority (Azienda Zero)*”, which is dedicated to the rationalization, integration and efficiency of social and health and technical administrative skills of regional health services. In this context, it is therefore to take the opportunity to work from a benchmark point of view, relying on good practices already established, creating the conditions for the best experience and transferring them from a service development perspective to the benefit of the community.

Before the new legislation, Trebaseleghe was part of the Ulss n. 15 and now, with the Ulss n. 16 and n. 17, become part of the new Ulss n.6, called “*Euganea*”. Ulss Euganea is the largest health company in Veneto with about 1 million inhabitants and with a territorial extension that includes the entire Province of Padua. The province of Padua extends over an area of more than 2,127 square kilometres and it records the presence of 934,332 inhabitants⁵⁷, which results in a population density of about 439 inhabitants / square kilometres. From a comparison with the other provinces of Veneto, the province of Padua is at the same time the most populated and the highest density of housing throughout the region. This is a very important condition in relation to the new legislation and the new organization of the health structure, because it shows the challenge that the Ulss Euganea must face. In addition to this information about the dimension of the territory, it is interesting understand the demographic composition and characteristics of the population:

- There is a very different distribution of the population density in relation to the areas: it is in fact higher in the national territory with a strong difference in district 5, which corresponds to the territory of the former ULSS17;
- The natural balance appears negative by highlighting the difficulty of regenerating the population given a death rate that significantly exceeds births and is only partially offset by the migratory balance that has a positive value at the provincial level;

⁵⁷ *Statistiche demografiche provincia di Padova, 2016*

- The total dependency index points to a high ratio of inactive to the active population.

The different distribution of the population highlights the differences in the implementation of the activities. In fact, different density can be translated in different quantity of services delivered and require a less complex system. Instead, in the districts with a higher density it is required a more complex structure to satisfy all the needs of the population. In the Table 9 (Table 9: Main demographic indicators⁵⁸) there is the description of the population in the Ulss 6 and with the distinction of the ex Ulss. The indexes, that are used, present the distribution of the density and the relative births and deaths, which affect the dependency index.

Table 9: Main demographic indicators				
DEMOGRAPHIC INDEX	ULSS 6 EUGANEA	EX-ULSS 15	EX-ULSS 16	EX-ULSS 17
Superficies (sKm)	2.128	583	656	889
Population	934.418	258.039	493.509	182.870
Density	439	443	752	206
Births (per 1000 inhabitants)	7.7	2.3	3.9	1.5
Deaths (per 1000 inhabitants)	9.6	2.3	4.9	2.4
Dependency index	54,6%	51,7%	56,2%	54,8%

Source: ISTAT, 2016

The ex-Ulss 16 (Padua) shows the highest density (metropolitan city), with the highest dependency index. It is possible to see a clear difference in the three spatial spheres: the “Alta Padovana” (ex-ULSS 15) appears as the relatively younger population, while the area of “Bassa Padovana” (ex-ULSS 17) shows a similar situation but positioned in an average elderly population. Case in itself, in this comparison, is the central area (ex ULSS16) where, due to the dynamics of the population of a "metropolitan" city, it has an average degree of ageing between the two other territories. In the Ulss 6 the dependency ratio, that shows the correlation between old people and presence of chronic degenerative disease, is 54,6%, which is in line with the studies and the evidence all around the world. The Table 16⁵⁹ (Table 16: Main ageing indicators) describes the percentage of the population divided by age and the distribution in the ex-Ulss, according to the analysis made previously. The percentage of the

⁵⁸ Fonte: ISTAT, Anno 2016

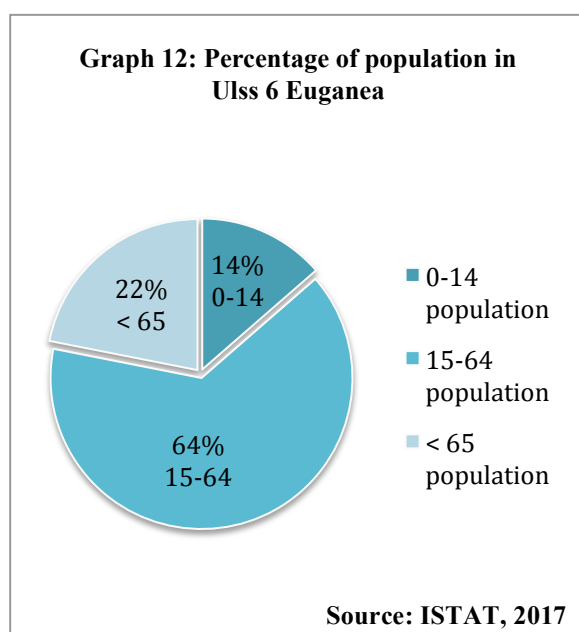
⁵⁹ Fonte: ISTAT, Anno 2017

population with more that 65 years old is higher than the younger band of the population 0-14 in all the three areas. From these two features is possible compute the ageing index that determines the aging state of a population. It is worked out by dividing the number of individuals with an age of 65 or over the number of people who are not more than 14 years old. This determines the number of elders per 100 young people. In this Ulss 6 the index is 161, 2%, that it is expected to increase over the years.

DEMOGRAPHIC INDEX	ULSS 6 EUGANEA	EX-ULSS 15	EX-ULSS 16	EX-ULSS 17
0-14 Total population	13,6%	15%	13,2%	12,6%
Elderly index (+65)	21,9%	19,5%	23,1%	23,1%
Tot. Ageing index	161,2%	/	/	/

Source: ISTAT, 2016

What emerges, is that the population of the Ulss 6 Euganea trends to age and the younger bands is lower than the medium and elderly groups. Thus, the ageing index is 161,2%, in 2016, but it is forecast to increase.



In fact, the Graph 12 (Graph 12: Percentage of population in Ulss 6 Euganea⁶⁰) gives a clear picture of the community composition: young people are the 14% of the entire population and the elderly are 22%. The middle band (people between 15 and 64 years old) is the large part of the population, due to the boom of birth in the years of the economic raising. It is actually good information, but must take into account in the reform of the health system and in structuring the new delivering system because this large part of the population is the

elderly of the future. This ageing action creates the problem to offer and guarantee the necessary distribution of health services with the respect of the constraint of the reduction in health spending.

According to these socio-demographic aspects, to the global population ageing and the consequent increase in incidence of the noncommunicable and chronic disease and the

⁶⁰Source: ISTAT, Anno 2017

reduction in spending, the creation of an adequate web of services is vital. In Ulss 6 Euganea, the health services are granted by several structures that form the Territorial Operative Centre (COT, Regional Decision 565/2014). COT allows the health system to foster the integration and the continuity of the care between territory and hospitals. It is the cornerstone of the territorial organization as it has a coordinating role for protecting the user and linking them to the welfare network. This is used to handle frail patients with complex situation requiring multidisciplinary care and direct patients, who need a sheltered discharge, to different care setting. Thus, the COT is composed by:

- Community Health District;
- Hospital and Care Homes;
- Intermediate structures;
- Domestic services;
- Integration with the hospital: residential and semi-residential offer;
- MGI and MMG.

Hospital care is guaranteed in the area by 7 hospital and 5 accredited Care Homes. With reference to direct management, the following Table 11 (Table 11: Hospital indicators of A-Ulss 6, Euganea, in 2016⁶¹) shows the number of seats at 31/12/2016 and the volume of activities delivered from October 2015 to September 2016. The table presents the number of hospital beds that, in all the Ulss 6, reaches a total of 2.112, divided in ordinary admissions and in day-hospital activities. These places must be necessary to protect people in case of emergency and in the case of acute phases of illnesses. According to the Health Plan 2017, describe in the previous paragraph, must be empowered the territory and the use of the hospital must be reduced. It is due to the spending review and with the necessity to reduce the health spending. In fact, as we can see, the hospital spending is 291.996.228 €, and, considering the future health scenario that is described, this cost become unsustainable. Thus, the hospital, with the entire specialist services, remain an important centre of care but taking care of patients will have to be sustained on the territory.

To support the hospital activity, the territorial structure of Ulss 6 is reorganized with the aim to best use the resources present in the territory. The first aspect to be implement is the role of the district. District becomes the most important organizational structure in the territory for managing the chronic disease and the relative cure path.

⁶¹Regione Veneto, 2017

Table 11: Hospital indicators of A-Ulss 6, Euganea, in 2016									
AZIENDA ULSS 6	HOSPITAL BEDS			N. OF DISCHARGES			VOLUME OF HOSPITAL ACTIVITES (DGR tariffs)		
	ORD	DH	TOT	ORD	DH	TOT	ORD	DH	TOT
Hospital of Camposampiero	332	19	351	12.308	2.593	14.901	46.438.267	5.907.407	52.345.674
Hospital of Cittadella	318	29	347	11.509	2.837	14.427	44.851.805	5.651.281	50.503.086
Hospital of S. Antonio (PD)	296	21	317	9.071	1.169	10.240	34.446.241	2.036.716	36.482.957
Hospital of Piove di Sacco	160	22	182	5.760	1.427	7.187	19.204.092	2.544.195	21.748.287
Hospital of Padova Sud	328	45	373	12.937	3.386	16.323	47.503.078	5.598.788	53.101.865
Hospital of Conselve	36		36	473		473	3.037.882		3.037.882
Hospital of Montagnana	40		40	303		303	2.413.101		2.413.101
External Accredited	430	35	465	14.041	3.474	17.515	64.168.350	8.195.085	72.363.435
Total	1.941	171	2.112	66.483	14.886	81.369	262.062.816	29.933.472	291.996.288

Source: Veneto Region

Today, in Italy, there are two main organizational models: the *sector-functional model* and the *divisional model*⁶². The first one is linked to the supply side and recommended specialist services into a single and coordinated process weighs entirely on the user, who to rebuild the path is forced to switch from one service to another because the services have the hierarchical power on the productive factors. In the second, the citizen is guided in the integrated paths because the District ensures the integration function between the services, as it is the structure that holds direct hierarchical power while the services have functional skills. The second model is the one that form the district in Veneto and in Ulss 6. The territory is currently subdivided into 5 social-health districts, coded according to the DGR 2174 of 2016⁶³, broken down by population resident on 1 January 2016, and in the Table 12 (Table 12: Population in the district⁶⁴) there is a broadly presentation of the division.

⁶² A. Madeddu and all, 2016

⁶³ Regional Decision, n. 2174/2016

⁶⁴ Veneto Region, 2017

The allocation of the districts is given by the number of inhabitants: ex-Ulss 16, with a population of 493.509 and its distribution, requires 3 districts in order to give the best and efficient answer to the needs of high number of persons. In the ex-Ulss 15 and ex- Ulss 17 there is only one district, which is enough for the implementation of the organizational activities on the community. All the districts help to manage and control the health services over an amount of 934.418 of persons.

DISTRICT	TERRITORY	POPULATION
District 1	Ex- Ulss 16	209.134
District 2	Ex- Ulss 16	117.339
District 3	Ex- Ulss 16	167.036
District 4	Ex- Ulss 15	258.039
District 5	Ex- Ulss 17	182.870
TOTAL		934.418

Source: Veneto Region, 2017

Directly connected and control by the districts are the *Territorial Operational Centres* (COTs), that must become the cornerstone of the territorial organization. It carries out coordination functions for the "*fragile*" users and the connection between the people in the care network: it represents the direction and guarantee of territorial hospital integration and is a strategic tool to guide the taking of the citizen according to specific needs or needs, ensuring uniformity in the collection and classification of the problem, activation of the most appropriate resources, and planning interventions by activating the people in the welfare network, protecting transitions from one place of care to another or from one clinical level to another. District and hospital services staff, the General Practitioner, the Paediatricians of Free Choice, and the Doctors of the Continuity Assistance may submit reporting of the socio-sanitary application. It is an experimental and innovative structure for short stays that are required to provide continuous care services under low and medium intensity care, created for the purpose of improving continuity of assistance, facilitate hospital discharge and avoid or delay the definitive entry of older people into residential facilities.

Another territorial structure, controlled by the district, that implement the full assistance of the patients is the "*Intermediate hospitalization facilities*" that can accommodate patients for which a home care path can not be pre-determined for a limited period of time (20 to 30 days), and hospitalization or institutionalization is inappropriate. In this context, there are, in particular, three specific supply units:

- *Community Hospital*: intermediate retirement structure, which is included in the network of services of territorial assistance;
- *Territorial Rehabilitation Unit (TRU)*: intermediate retirement structure with assistance goals, maintaining health and rehabilitation status;
- *Hospice*: residential facility, integrated into the palliative care network, intended for the care of illiquid patients at an advanced stage of illness or end of life.

In order to provide adequate support to the patient with special care needs (especially the elderly), at their home or near, is implemented the resources and the activities of the Primary Care, which becomes the main elements of the health organization. The districts, thus, have to manage over the territory not only the delivering of the services but also 626 Doctors of General Medicine and 103 Paediatricians of Free Choice. In compliance with the regional objectives, the last three years saw the evolution of basic healthcare, with the creation of Integrated Group Medicine. Group medicine will include specialists in chronic diseases such as heart disease, diabetes, and chronic lung disease and will help to better organize prevention activities and respond to patient needs. In the group medicine, in fact, the citizen will always find a doctor, from 8 am to 8 pm, and will no longer have to go to Emergency Room for common diseases. At 31/12/2016 there are 12 integrated group medicines in the Ulss 6 Euganea territory, with a further 4 being started. Due to the vastness of the Ulss Euganea, with strong population differences, the organization of the socio-sanitary area requires the whole range of services to be rethought by the citizen in the optics of equal access, best use of resources and better integration with highly complex structures. The main zones of interest are the fragile patients, children, mental health and dependencies, the area of prosthetics and the continuity of care. In each of these priority areas, it is necessary to review the processes and proceed towards homogenisation, the criteria for access to residential and semi-residential structures, to the child's management chain, to the prosthetic care. Strategic intervention also involves the better management and integration of the hospital with local structures, with the standardization of the resigned rescue, to provide easier pathways for the weakest patients, avoiding re-hospitalization, also with a view to improving in its target performance. The Regional Socio-Sanitary Plan 2012-2016 highlights the need to develop Primary Care, recognizing it as a central function of the Ulss. More in detail, the regional planning framework identifies as a strategic goal the spread across the regional territory of Integrated Group Medicine. In the Veneto model, the Integrated Group Medicines are multi-

professional teams, consisting of Family Physicians and Paediatricians, Specialists, Doctors of Continuity, nurses, study associates and social workers who:

- Provide global assistance, that is, from palliative prevention, continuous, fair and person-centred;
- Ensure h24, 7 to 7;
- They are a fundamental and essential part of the socio-sanitary district and assume responsibility for community health, addressing disease determinants and collaborating with local actors. For this reason, the Integrated Group Medicines must guarantee to assistants:
- Greater accessibility, ensuring h12 coverage through the presence of family medicine at home and structuring effective integration with Continuity Assistance to ensure effective coverage h24;
- Effective chronic disease delivery on the basis of PDTAs defined at regional level and contextualized in individual business realities. The Integrated Group Medicines, thus defined, are the focal point on which the whole set of territorial care needs to be reorganized in line with the strategic guidelines outlined in the Regional Health and Social Plan. The ultimate goal is to respond to the priority health needs that, with regard to primary care, are:
- Prevention and education of healthy lifestyles;
- High accessibility for acute problems;
- Taking care of chronic and non-dependable people;
- The guarantee of fairness and uniformity of services in the territory, including economic sustainability.

Provincial Companies, as defined in Regional Law No. 19 of 2016, art.14, paragraph 5, must ensure by December 31, 2017 the activation of at least 60% of general practitioners in integrated group medicine and activation by at least 80% by December 31, 2018. This process must be self-serving by achieving the peculiar goals of group medicine.

It is in this context that the Integrate General Medicine of Trebaseleghe is introduced, is defined and, at least, starts to work.

4.1: LOCATIONAL STRATEGY

A-Ulss 6 Euganea is the one in the Region with the highest number of MGI activated that actually working in the territory. In the Table 13 (Table 13: MGI activated in A-Ulss 6,

Euganea) there is a presentation of the situation in this areas, divided also between the ex A-Ulss. The MMG present in the A-Ulss 6 are 714 and, without considering the number in the MGI programmed, there are 132 GP that actually work inside the new structures. There are 13 MGI activated (5 in A-Ulss 15, 4 in A-Ulss 16 and 4 in the A-Ulss 17) and six that are attending the approval by the Region.

Table 13: MGI activated in A-Ulss 6, Euganea		
A-Ulss	MGI	n. MGG
A-Ulss 15	Casa della Salute, Medoacus Carmignano di Brenta	12
	L. Scimone, Trebaseleghe	7
	Amb. San Martino, Vigodarzere	10
	Vigoza	12
	Vivi in salute, Villanova	12
A-Ulss 16	Maserà	13
	Saonara	6
	Guizza	8
	Limena	8
A-Ulss 17	Due Carrare	10
	Pernumia	7
	Conselve	12
	Este	15
Total		132

Source: Veneto Region

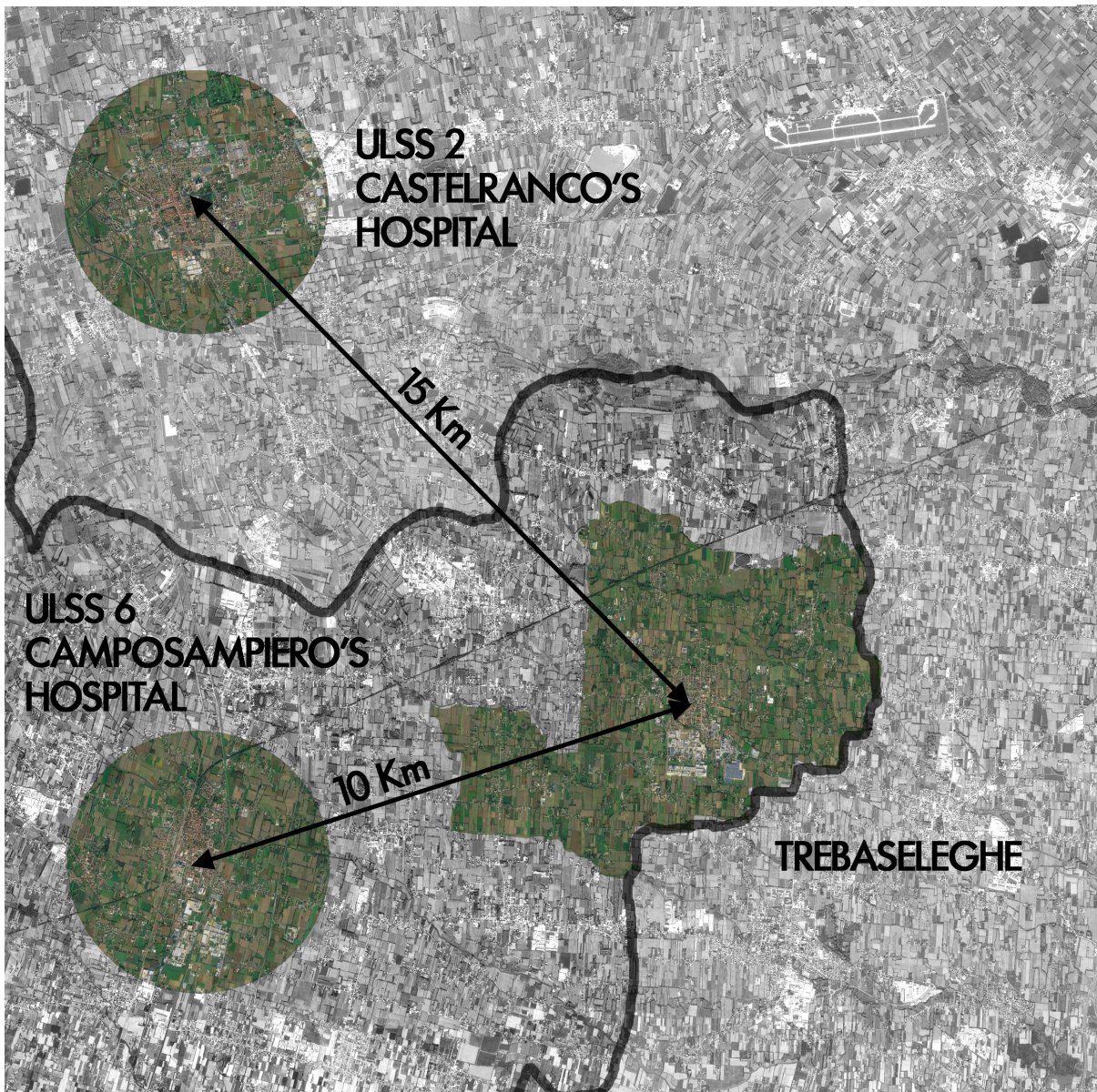
In this context was developed the MGI of Trebaseleghe. MGI in Trebaseleghe was born in May 2016, after about a year of negotiation and definition of the path to create this medical centre, which goes from the appointment of doctors, the choice of the right place in which put the building to the definition of the contract of exercise and the services card. However, as other integrated medicines already existed in the area, the route was, in certain aspects, facilitated by pervious experiences. The Health Plan 2017 expects the creation of this medicine group that foresees a strong intensification of territorial health activities, started already in previous years. All sites chosen for the development of integrated medicines are tactical sites, with the presence of healthcare facilities or hospitals that can supplement outpatient care. Trebaseleghe is one of these areas. In 1991 was build the “*Health district*” that managed the administrative, the home nursing care and the vaccination services and took

in care the delicate patients with the development of rehabilitation activities and employing social assistant and specialist outpatient clinics of gynaecology, cardiology, surgery and diabetes. However, the wish is that Trebaseleghe will become a “*real health citadel*”⁶⁵. Thus, there is in the last years an integration of all this services with the creation of the new integrated group medicine. Trebaseleghe is, in fact, a real strategic point. In addition to the sanitary districts, the ambulatory (located near the district’s venue) can take advantage of the services given by the two hospitals present in the Ulss 6: the Hospital of Cittadella and Camposampiero. Actually, the two structures offer different services and the doctors must be able to direct their patients to the most appropriate structure. In recent years, these two hospital districts have been upgrading thanks the team working whit specialist from Padua in some areas. In Camposampiero was implemented the activities related to the maxillofacial, vascular and neurological surgeries, while in Cittadella there was a strengthening of the activities linked to the cardiovascular disease and the treatment of breast cancer. However, there is another important hospital near to Trebaseleghe that is the hospital of Castelfranco. It belong to Ulss 2 and, according to the want to reduce the cost for Ulss, the MGI covers an important role to avoid the “*run*” of the patients out from the belonging one: in fact is the Ulss 6 that must pay the performance of the hospital out of the competences area. In the Figure 2 (Figure 2: Position of Trebaseleghe compared to the Camposampiero and Castelfranco hospital) is showed the distance between Trebaseleghe and the nearest hospital: it is difficult for the general practitioners reduce or control the affluence of the people in the good and efficient Castelfranco hospital, because it require a change in mentality and in the way in which people use and think the health system. Sometimes, people autonomously can choose to go in hospital for take appointments for some kind of visits or for use Emergency, taking advantage of the national health system, and this behaviour can lead the effectiveness and the proficient use of the scarce resource of the health system. In fact, the evidence shows that the cost of one bed in hospital is 500 € daily and thus it is not possible anymore sustain 30.000 access in emergency every years. It is entrusted to the A-Ulss the task of limiting the costs and, upon reaching the goals, every A-Ulss receives incentives related to them. Thus, the General Practitioners cover an important role in order to control these aspects and achieve the objectives set, directing the patients to the right path care in the right place and educating the patients to have the first access in primary care. In addition to this, the connection and the collaboration between GP and PDL and Hospital it is necessary for the activation of the palliative and home care. These services relieve the responsibilities of the territory, giving the

⁶⁵ Francesco Zuanon, Aprile 2014.

necessary instruments and with nurses with the right skills to implement the path cure, supervised by the family doctors, who control the right functioning and monitor the results of the cure. Also the hospitals grant the health services when the ambulatories are closed in Sunday and for the festivity and ensure the use of the radiology, that it is difficult to move in the surgery.

Figure 2: Position of Trebaseleghe compared to the Camposampiero and Castelfranco hospital



Source: Google street view

The other strategic aspect of Trebaseleghe position is related to the population. The municipality of Trebaseleghe counts 12.927 inhabitants, distributed in several fractions, and there are some other big parish, as Piombino Dese, with 9.534 inhabitants. The demographic

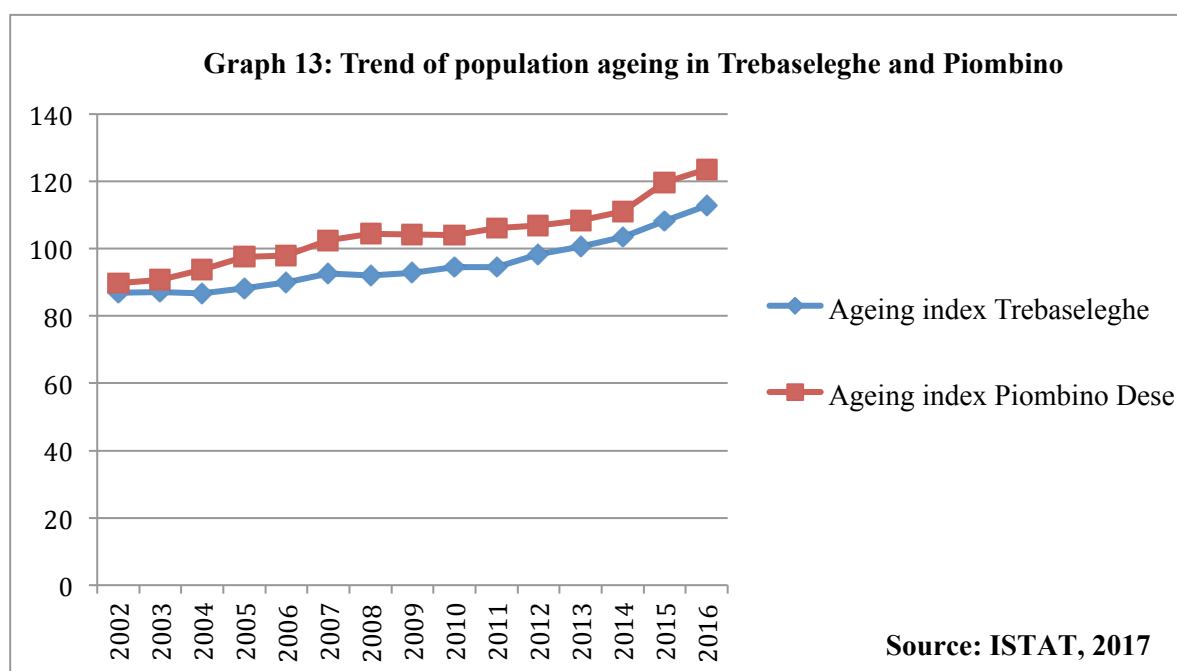
composition of the population, in both the city, is showing the same trends of the nation, with a progressive population ageing. In fact, as showed by the Table 14 (Table 14: Trebaseleghe and Piombino Dese main population indicators), the largest part of the population is composed by people between 15 and 64 years (66.6% in Trebaseleghe and 65,4% in Piombino Dese), the young and old people are, respectively, 17.7% and 15,7% in Trebaseleghe and 19.1% and 15,5% in Piombino Dese.

	0-14 population	15-64 population	+ 65 population	Ageing index	Dependency index
Trebaseleghe	17,7%	66,6%	15,7%	112,7%	50,2%
Piombino Dese	19,1%	65,4%	15,5%	123,6%	52,9%

Source: Veneto Region

Trebaseleghe, as the Nation, must face the problem of the population ageing, as show by the positive trend in the Graph 13 (Graph 13: Trend of population ageing in Trebaseleghe and Piombino) of the ageing index, with the relative issues as the increase in chronic degenerative disease and the noncommunicable disease, especially in the middle bands.

However, the largest part of the population is including between 15 and 64 years and this bundle is the old men of the near future and, for this reason, the ageing index is expected to increase. It means that, if the Ulss 6 wants to reduce the costs and continue to grant high quality of services and high level of individual health must develop a territorial web services,



that helps to take care of the people and that prevent the raising of expensive disease. Having a better control over the population means create adequate preventive actions to reduce the incidence of serious disease that, despite the increase in more percentage of elderly in population, can be translate in gain oh healthy life years.

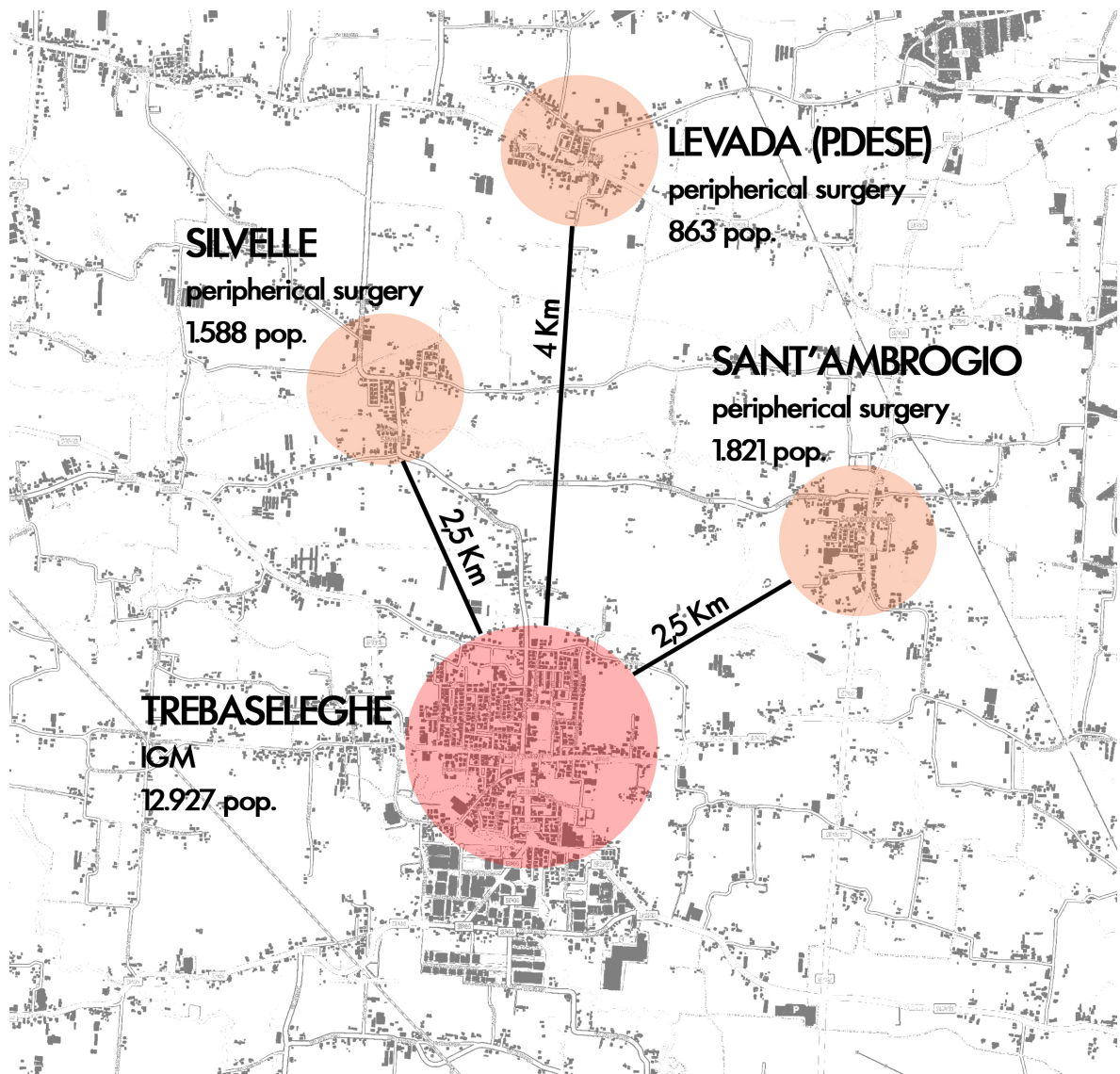
It is in this context that the Trebaseleghe IGM is born. In the Municipality of Trebaseleghe work 9 doctors: some of them, also before the integration, work in group, some other work in an alone surgery. To the project of the IGM have joined 6 doctors out of 9 and, actually, all of them work in the same structure and implement the activity expected by the Health Plan and the agreement signed. In this group, also, is added another General Practitioner, whose personal surgery is located in Levada, a fraction of the municipality of Piombino Dese. Hence, actually, in the ambulatory work together 7 doctors, 4 that make them main activities in this place and the other with a periferical surgery: the doctors offer their health services in Trebaseleghe and in three periferical areas that are Silvelle, Sant’Ambrogio e Levada. However, about the role ad the main function of them we talk in the second paragraph. Here we simply want to understand what is the coverture of their activities and how large is the part of the population that the IGM can involve in its health programs. As we said before, the population of Trebaseleghe is 12.927 inhabitants, which comprises the population of Silvelle (1.588), Sant’Ambrogio (1.821). Piombino Dese has 9.534, of which 863 live in Levada. The overall population to which IGM can turn is about 22.461, without considering the presence of other doctors in Piombino.

Table 15: Patients for GP in MGI L.Scimone	
IGM DOCTORS	NUMBER OF PATIENTS
GP1	1.641
GP2	1.462
GP3	1.585
GP4	1.543
GP5	1.525
GP6	1.256
GP7	1.161
TOT.	10.173
Source: Rimborso spese, Luglio 2017	

However, the coverture of Piombino Dese is granted by the presence of other professional (7) and the services of the IGM are addressed only to the patients of the professional that agreed to the contract. In the Table 15 (Table 15: Patients for GP in MGI

L.Scimone⁶⁶) we get the number of medical assistant. Considering the data, the entire population that can be reach by the IGM is 13.790 and the effective population recorded to the doctors inside the agreement is 10.173: the IGM can monitor, control and manage the 73,7% of the entire population of Trebaseleghe. Due to the vastness of the territory and to the high number of patients, in order to grant an efficient delivering of services, the General

Figure 3: Trebaseleghe IMG and peripheral surgery



Source: Open street map

Practitioner from Sant' Ambrogio, Silvelle and Levada keep active the peripheral surgery, ensuring services also in the head office.

⁶⁶ Information available in the monthly documents, called "rimborso spese", that the GP in MGI receive, within all the performance indicators.

As is possible to see from the Figure 3 (Figure 3: Trebaseleghe IMG and peripheral surgery), the distribution of peripheral surgery follow the dispersion of the population on the territory, in order to not harm the old persons and continue to offers concrete services even in the suburbs and not only in the centre of the city, following the pre-existent model. According to the law and to the principal scope of the reform, it is clear that the benefit made by the IGM of Trebaseleghe can be remarkable. The high coverture of the population, with the possibility to enlarge it on part of the nearest municipality, due to the portability of the borders, can ensure a good performance in the prevention activity an in the monitoring of the epidemiological situation. In addition, considering the composition of the population with a large part of old people and middle band, with high incidence of noncommunicable disease, this model can try to reduce the incidence of chronic degenerative disease and to give more healthy years to the old population.

4.2: MGI STRUCTURE AND FUNCTION

In primary care, MGI is responsible for responding to the health demand expressed by the territory, ensuring actions aimed at meeting the socio-health needs of the population residing through prevention, care and rehabilitation programs and providing territorial assistance. It has, as its purpose, the establishment of care pathways characterized by a multidisciplinary and multi-professional approach that will enable the integration of the territorial and hospital health and social services, thus contributing to the effectiveness of the continuity of care. The GPs are the only referents for the protection of the health of their assistants in the territory and provide the benefits of:

- Diagnosis, therapy and rehabilitation of the first level;
- Preventative medicine (individual and community);
- Health education in the field of health care, thus promoting the development and dissemination of healthcare culture and the knowledge of the Health Service National;
- Care for oncological and terminal patients;
- Assistance programmed at the domicile of the assisted;
- Integrated home help with the assistance specialist, nursing and rehabilitation services, if necessary with social assistance, according to a program agreed with the Socio-Sanitary District;
- Programmed assistance in protected residences and communities.

The main characteristics of the MGI in Trebaseleghe is described in the related “*Carta dei servizi*”, in which are presented the features of the surgery, as the name of the doctors that work inside and their turns, the way to enter and use the health services, the number of the secretary for make the reservation and the number to contact when the MGI is closed. The MGI L.Scimone is open 5 days a week, from Monday to Friday, according to a proper time set by the health care providers themselves and exposed at the entrance. On Saturday and in the day before national holidays, is granted the presence of, at least, one GP until 10 a.m., ensuring the domiciliary and ambulatory visits for the emergency and the urgent visits are met as soon as possible. The relationship between physician and assisted is based on trust and, according to the national agreement, and each MMG, with the exception of self-limitations or restrictions resulting from the carrying out of other compatible activities, can assist a maximum of 1500 assisted, plus temporary appointments and family reunions. However, inside the surgery and tanks the informatics system, the patients can receive performance from every doctors inside the MGI but there is the accordance that the patients cannot change their personal doctors and choose one of the other that signed the contract, with the only exceptions of deal between physicians. In addition to the family doctors and the principal ambulatory activities, in the MGI L. Scimone there are:

- *Study staff and personnel dedicated to secretarial activities*: that covers the role of administrative and appointment management. These ambulatory assistances allow the GP to concentrate their time and attention on the care needs and the citizen to receive a wide and accurate reception in the studio. More in detail the studio staff:
 - Welcome the patients;
 - Informs and directs users about the health services directly provided by MGI and other social health care facilities;
 - Establish appointments, collect requests, and deliver prescriptions prepared by the doctor and the continuity of care, as indicated in the electronic register;
 - Receive and filters phone calls for the reservation of outpatients visits, home and telephone consultations;
 - Archive documents.
- *Nursing staff* supports the doctors in:
 - The management of ordinary care by delivering nursing performance, after doctors decision and permission;

- Education, prevention and screening programs;
- Taking care of patients with chronic degenerative illnesses: recall patients to carry out periodic checks and provide them need for self-control and self-management of chronic conditions.

4.2.1: MGI SURGERY

The surgery of Trebaseleghe lodge the work of seven doctors that belongs from different part of the city in one building, that collect all the features for activate the MGI services. According to the DGR n. 751/ 2015, all the MGI surgeries programmed and planned must have:

- One personal office per 2 MMG;
- One office per 3 MMG that maintain the peripheral surgery;
- A multifaceted space;
- Nurse's office;
- Waiting room for the acceptance.

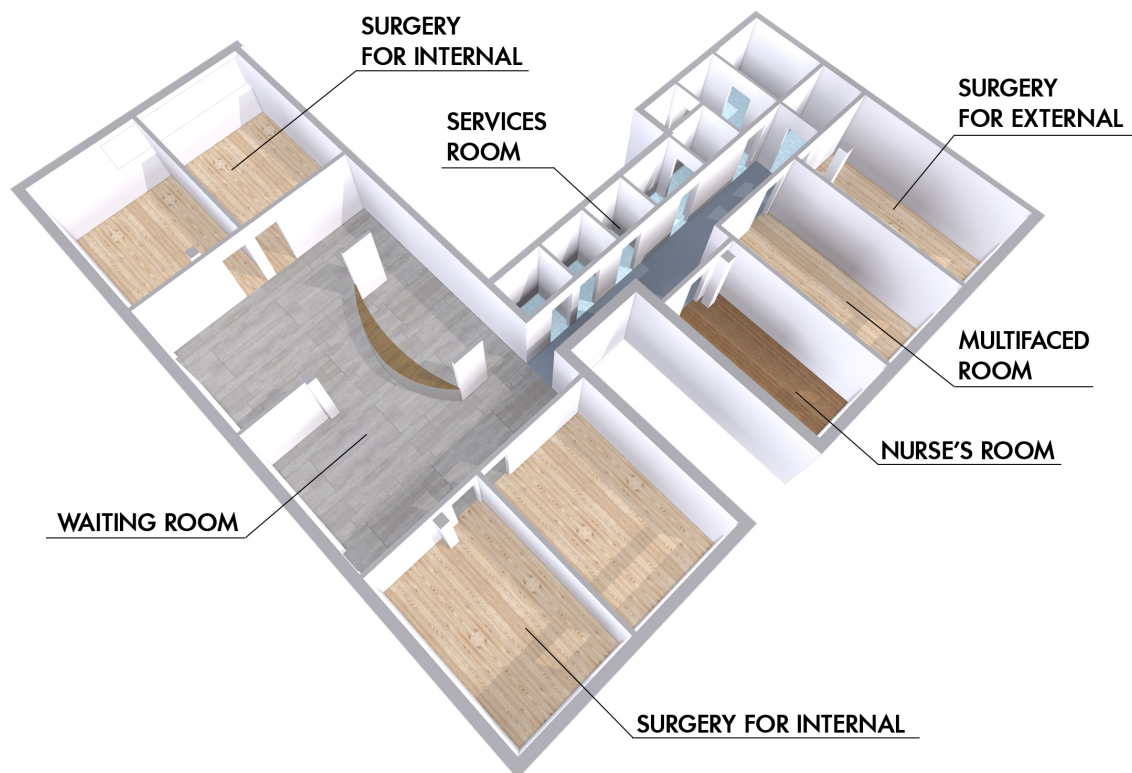
To obtain the Region approval and start to implement the integrate primary care activities in the territory, this is the first request to respect. The team of Trebaseleghe, in collaboration with a cooperative, that now assist the MGI, identify the right place near the pre-existent community district and with the necessary spaces in which set the different locales required. Hence, actually the edifice presents (Figure 4: MGI of Trebaseleghe map):

- *4 personal surgery for the internal MMG*: these office are dedicated for the activities of the four internal GP, that are so called the doctors that have before their personal private clinic in the near or in the centre of the city and had move their activities in this place;
- *1 surgery for the external MMG*: are the doctors that maintain the peripheral private clinic. They continue to work in their peripheral ambulatory, ensuring at least 4 hours of activities in the principal ambulatory;
- 1 nurse's office;
- 1 multifaceted space;
- 1 waiting room for the activities of the secretary and for the acceptance.

In this spaces the seven doctors implement their health services: the internal four doctors made their daily activities near the nurses and the three external medics grant the

health services in the farthest area, with the obligation to provide at least 4 hours at week in the principal surgery. For the maintenance of the ambulatory it is necessary the collaboration with an external services provider that helps the doctors in the management of the main administrative activities.

Figure 4: MGI of Trebaseleghe map



Source: made by Arch. Alberto Pedon

COOPERATIVA

The complexity of the activities implement in the surgery make impossible for the doctors to work alone. It is necessary the collaboration with other figure that attend the genera practitioners to the right functioning of the MGI. The current legislation provides that in the development of the new organization of the health system there are, at least, two actors that play together: who spends (family doctor) and who reimburses (the A-Ulss). However, in the creation of the MGI, there are almost always three actors: family physicians working in the MGI, the A-Ulss, which requires the MGI to carry out integrated health activities that

required the use of additional figures, and the cooperative, that furnish the additional staff. The cooperative, thus, cover an important role in the activation of the MGI structure in Veneto, but the MMG can decide to not use it for the recruiting of the staff.

MGI L. Scimone, instead, decides to take advantage of the third actor. The cooperative lightens the doctor's commitments because it pays attention to all the administrative and organizational aspects of the ambulatory: it must ensure the good functioning of all medical instruments and of the information system and it makes the inventory of all the medical tools necessary for the clinical activities. Again, the cooperative allow the doctors to find the nurses and secretarial staff: it ensure the training of the personnel, in order to offer a more appropriate services to the patients and to the GP, the valuation of the appropriateness of work made, the possible firing of not efficient staff and the hiring of new one. This are the main features theoretically describe in the DGR n. 751/ 2015, but in reality there are some new aspects to consider. In the decree was written down that the cooperative should only be linked to the deliver of the staff for the medical activities and in the administration of the ambulatory, but in the case of the MGI of Trebaseleghe, the organization provided also the edifice. In the initial agreement the Regional Health System pledged to provide the necessary spaces and environments, assuming the task of adapting the existing places or of creating new ones for the implementation of new delivering system. Instead, for the primary care of Trebaseleghe was the cooperative that assume this role, with the identification of the strategic area (near the District), the renovation of the building and the furnishing of the office with medical equipment. Thus, the team of doctors have to pay back to the cooperative an amount for cover the expense made for building, which in the original region deal is not present. As payment, the GPs of Trebaseleghe decide to correspond an usage fees to the cooperative: every MGI can decide autonomously how to give back the money, in relation to the hour of usage or linked to the number of patients. In Trebaseleghe was chosen the policy that the fee is established on the basis of the number of patients: it can be considered as an equity method because the doctors are paid, broadly specking, in relation to the number of assisted, and in this way the doctors who received a higher wage pays a higher fee. However, due to the fact that the agreement is changed and it is not the Region that pays the reorganization of the edifice, all the general practitioners must pay this tariff, also the external doctors that keep in addition the peripheral surgery. It is one of the issues that rise and that can discourage the MMG to implement the reform: for this, the Regional Health System, decide to correspond an amount of about 200€, that theoretically can reimburse the expenses that the doctors must support to maintain active peripheral outpatient clinics and cover the costs for the new central ambulatory.

The main role covered by the cooperative, the first designated by the deal, is related to the furnishing and payment of the staff. According to the regional decree the number of staff and nurses depends on the number of patients that receive services from the structure: 1 nurse per 3.600 patients and 1 studio assistant per 2.400 patients. In the MGI of Trebaseleghe there are 4 nurses and 7 secretaries, which work in turn and grant the coverage of the 12 hours of activities. The staffs perform duties in the studio, that complete the services offered by the doctors and facilitate their activities but they belong to the cooperative. In fact, because the benefits of work done by the personnel are entirely received by the community, the staff is completely paid by the Region Health System. For this reason, the MMG receive, monthly a reimbursement, called *MGI reimbursement*, which is a professional remuneration, which enters in the bill of the doctor's remuneration, and therefore constitutes, in all respects, income subject to contribution to ENPAM⁶⁷. Thus, in the original agreement, the reimbursement should not be subject to any taxation and it is an economic incentive for the general practitioners to enter in a MGI and to use the cooperative for hire the studio personnel: this collaboration, in fact, increase pension fund for 1/3 with funds raised from his salary and for 2/3 paid by AULSS. This is a very attractive aspect that boosts the creation of the MGI but, now, it becomes the first reason that block the approval of other and new MGI by the Region. For the existence of a third actor, which interferes between A-Ulss and doctors, the Veneto Tax Office has expressed the view that this MGI reimbursement, must incur as tax on income. Consequently, the Veneto Region has communicated its intent to comply with this provision with the Representative Trade Unions of the Family Physicians (FIMMG, SNAMI, SMI,) in order to overcome this discrepancy. It is currently being discussed that the staff costs is included in the doctor's monthly salary, subjecting such income to the withholding tax, as indicated by the opinion of the Veneto Tax Office. In this way, physicians would thus be forced to anticipate 20% of the IRPEF⁶⁸ tax due, but they would then be deducted at the "Declaration of Income" for the following year: this advance would have no negative effect on doctors but in reality it is inefficient because they would pay taxes 20% in advance month to month and not all in July. However, this reimbursement can be allocated by the A-Ulss 6 of the ENPAM contribution to doctors because is entered as a wage bill, and so can affect the pension fund: but actually it is not indicate to the A-Ulss payment of ENPAM contributions, but merely advises on the allocation of the relevant contributions to ENPAM. Despite this, the function of the cooperative of hiring and training the staff, helps the doctors to better implement the health reform. However, if it is not clear define the aspects of the agreement

⁶⁷ National Pension and Assistance Fund for MMG

⁶⁸ Personal income tax

can raise some issues. The staff, in fact, it is not directly hire by the doctors but from third party and the MGGs have little or no contractual power on the staff, which should act without observing the doctors' disposition, which would have no power to act on any inefficiencies in the staff. In the case of a this furnishing relationship, the decision-making power is in the hands of the cooperative and it is necessary to make a service contract between the parts, where it is clear that the doctor is the manager of the study activities and therefore also in the full right to influence the choices of staff and on any measures to make the staff closely related to the requests of doctors of the MGI. In MGI of Trebaseleghe between the referent and the cooperative there is a collaborative relationship and periodically meeting to analyse the performance of the staff. Both the part expresses their needs and tries to be satisfied. During this meeting the referent report the quality of the services made be the secretarial staff and the nurses, expressing if there is some problem or if someone needs more personal training for exploit better abilities. Together, also, define if the studio staffs are enough for make all the ambulatory's activities or if it is necessary to hire new people. Until now, the relationship between MGI and the cooperative is positive and make collaboration that grant the success of the primary care group in Trebaseleghe.

4.2.2: NURSE STAFF

One of the new features introduced by the reform is the collaboration between the nurses and the doctors. In the previous years, the districts offer always the integration of the medical activities within nurse's services, especially in the cure of patients with cancer or chronic degenerative illnesses, such as Alzheimer and dementia. However, with the new organization, the nurse's assistances it is not only disperse in the territory but the patients can use it with the simply access in the central ambulatory in Trebaseleghe. It is a very important and useful innovation of the system because, if the team will be able to work together, with the coordination of the GP and nurses activities can be created important synergies. The main occupations of the nurses in Trebaseleghe MGI are:

- Make the simple surgery control and dressing, avoiding the unnecessary access in Emergency;
- Accommodate patients who show signs of acute disease to give immediate relief, waiting for a doctor to decide whether or not the hospitalization is required or if it is enough ambulatory intervention and supervision for short period of time;
- Help in the collection of data from the patients;
- Make the inventory of the medical tools,

- Follow the preventive actions.

The creation of the MGI organization, from the main directives, serve to reduce the costs of unnecessary access to the emergency and in the hospital. For the National and Regional Health System the costs related to the Emergency activities are composed by fixed and variable costs. The fixed cost is linked to the administrative and equipment costs, while, the variable costs change from performance to performance. In the Italian system gathers the different performance through the “*triage method*”: the different interventions are divided within different codes, identified by the colour white, green, yellow and red, that describe the gravity and urgency of the intervention. Every performance has different weights in the composition of healthcare expenditure. From the analysis of the costs of the hospital in the A-Ulss 6 Euganea, emerge that, in average, the costs for one intervention for the different categories are:

	WHITE	GREEN	YELLOW	RED
COST	226€	240€	290€	354€

Source: Welfare minister

As we said before, MGI L.Scimone has a strategic position between two important hospital centres as Cittadella and Camposampiero. In 2016, the two hospitals have 70.066 accesses in Emergency: 33.049 in Cittadella and 37.017 in Camposampiero, composed by:

- *3% Red codes*, with situation in which people risks their life;
- *9% Yellow codes*, not immediately dangerous for the people, but that require urgent cure;
- *41% Green codes*, that identifies the necessity of intervention but without serious risks for the person;
- *47% of White codes*, that represent not urgent visit and it can be considered as unnecessary use of the hospital resources.

The intervention of the MGI and the presence of the nurses in the structure is necessary to intercept these white codes to reduce useless access that, as can be seen from the data collected in the years 2016, are almost half of the Emergency’s accesses. The right implementation of the nurses services and the re-education of the community to use before this near and comfortable resource and only after the Hospital, can reduce the health expenditure, of only two important hospital centres, of about 6.492.315 €. In the A-Ulss 6

Euganea, we get 8 Hospital, and some of them, as the one in Padua, cover a large part of the population and it is simply understandable that these costs can rapidly increase. In average, we can assume that the expenditure for the management of with codes in the entire Region is higher that 50.000.000€ per years. Thus, the nurse's staff in Trebaseleghe, as in the other MGI in the A-Ulss, cover an important role in educate the community to use before the MGI structure and the services inside for have a clear indication of what do after. In fact, both the nurses and the secretaries must perfectly know what are the health services delivered in the territory in order to give to the patients a complete information. However, this is only one part of the real importance of these new figures in the surgery.

PREVENTION

According to all the international literature, the challenges that the Govern must face is not viral disease that can affect the population but the average increase of the people ages and the higher incidence of chronic degenerative disease. Thanks an increase in the hygiene in the living spaces of the societies, better cure path and vaccines, the life expectancy of the people improve. But, the problem now is about the quality of life that people reach. The creation of the MGI, in fact, is necessary for the implementation of monitoring activities about the epidemiological status of the community but also for the implementation of preventive actions. Today, in fact, people died for disease that develops over time, starting with light symptoms or for wrong life style. In Trebaseleghe MGI the nurses, with the supervising of the doctors, make this important prevention and monitoring functions. The main performances implements are:

- Control of the cardiovascular disease;
- Control of the chronic bronchopulmonary disease (BPCO);
- Control of the patients with "Coumadin" cure;
- Follow of the PDTA.

The cardiovascular diseases are the first reason of death in the developed countries. It is due to several factors connected each other. The nurse's staff in the MGI find all the people that present, from the clinical records, some specific risks factors, as sedentary life style, overweight, smoking or some genetically conditions, and make the measures of the so called "BMI": control of weight, height and waist circumference. In this way it is possible intercept in the early stages people with high cholesterol or that can be affected by obesity, that are the first reason in raising of the cardiovascular disease. This is a very important action

implemented by the MGI because it can notably reduce the health costs: the region must face 10 million €, as direct costs, due to the illnesses and 5 million €, of indirect costs, that affect the assistance funds. The ability of the territorial health system in identifying and reduce this disease in the early stages it is real important also for the wellness of the nations: the seriousness of this chronic degenerative disease is responsible of the 22%⁶⁹ of loss in the national productivity. The monitoring activities made by the nurses, also in the MGI of Trebaseleghe, can helps the health system to have a clear pictures of the incidence and the costs supported and how are the pathway cure more effective for the reduction of the pathologies.

Another pathology that need periodical control and that are made by the nurses is the diabetes. This is a degenerative and debilitating illnesses that require constant control because the acuity of the symptoms does not follow an equal trend for every patient. Thanks the informatics system, autonomously, the nurses can fix control visits in order to monitoring the development of the pathologies and constantly suggest to the patients how to behave to avoid critical situation. In addition to this, another important role of the nurses is spend time in the education of the patients and their family in the management of the pathology, learning to identify critical signals and understand how to act in case of emergency. Thanks the use of the nurses, the doctors can follow the pathway cure, whit the prescription of the specialists visits and of the drugs but the other part of the follow up is made out from the ambulatory, giving them the possibility to make more visit in the day. In Italy the expenditure related to this disease are 7,92 million of € as direct costs, and 12.64 million related to the indirect costs, that linked the absence from the work, early-retirement and social benefit. The increase in the better control of the disease, again, means reduce the worst impact on the national fiscal aspects, giving the possibility to increase the richness. The high management of the disease in the territory means turn the health pathway more closer to the patients in a more comfortable situation and the same is for the patients that must follow the cure of “Coumadin”. Today, people that must take this drug must go to the hospital, at least, one time at week for make the blood donations and control the dosage. Now, with the nurse’s services, this is made directly in the ambulatory and with the laboratory activities, the patients can goes directly in ambulatory, avoiding long waiting times for established and programmed control.

The last important preventive action made by the nurses is related the respiratory illnesses. In Trebaseleghe, the nurses make the systematic monitor of all the people in the risky ages bounds and that presents the risky factors. It is made the spirometry to all the young and old smokers and for all people that are affected by bronchopulmonary diseases

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(BPCO). With recall, suggested by the informatics system, people in the *electronica* clinical register is periodically monitored in their health status, to avoid the hospitalization. In fact, according to the regional data, this disease, as BPCO and Asthma, are the causes of a higher number of sudden hospitalization, that is the most important aspects of disease related costs. Implement prevention activities over the Trebaseleghe territory means understand what is the incidence of the disease and also the main cause: becomes a useful tolls to understand what is the environmental factors that instigate the acute phases of the pulmonary disease and what is the incidence of cancer. Thus, the prevention activities of the ambulatory, like MGI L.Scimone with ARPAV, can map a clear situation of the risks factors, linked to the environment, pollution and to the personal behaviour.

The preventive actions in the MGI L.Scimone started its implementation only one year ago, but thanks the report send to the Region, is showing a good performance, that can really help to reduce the overall health expenditure.

4.4: ONE YEAR LATER

The MGI of Trebaseleghe celebrated in May a year of activities. The reform of the health system rethinks the territorial ambulatory as the first line in the distribution of the health in the community and, at the same time, the way to reduce the health spending. After only one year of occupations it is difficult to say if the organism can really helps the regional health system to have a reduction in the expenses. However it is possible to try to understand the costs of the MGI.

As we said, the budget related to the building of the edifice does not come from the health system but it is funding by the cooperative. Thus, the only expense for the health authorities is related in the payment of the personnel of the ambulatory, both doctors and staff. The cost of it is written in the “contratto d’esercizio” (Table 17: MGI L. Scimone “contratto d’esercizio”), which define all the contractual relationship between the parts. Thus, in addition to the normal wage, established on the number of patients for every doctors, for the general practitioners, inside the MGI, there is the possibility to achieve economic incentives, gain thanks the reaching of the goal describe in the deal. In this way, the doctors are motivated to obtain the specific results require. In order to demonstrate to the Region the obtainment of the outcomes, every GP must compile electronic documents that report the daily ambulatory activities, especially related to the fragile patients and to the domiciliary visits. However, it is a critical aspect of the reform. In fact, to the physicians is required a strong work in documentation and in send all available information to the health system. With the “*electronica flow*” and the *electronic prescription*, to the region comes all the information

related to the ambulatories activities of the doctors. Nevertheless, it is additional work for the general practitioners, which, between one patient and another, must complete this certification. For large part of the community of MMG, this is a excessive bureaucracy of the doctor's work, that have to spend more time to write down documents instead to visits people. This is one of the reasons under the strikers announced for the period between September and December 2017.

Table 17: MGI L. Scimone “contratto d’esercizio”

QUALITY FACTORS	OBJECTIVES	INCENTIVES (€/patient/year)
Equity	Prevention activity	1,50 €
	Chronic disease assistance	4,55 €
	Education and audit	1,00 €
Computerized individual health card	Use of informatics' system for the cooperation within the MGI	DGR n. 1753/2013
	IVAO index with the value of 0,50 for the first year and at least 0,65 in the years after	1,35 € (Quota B Paths)
Accessibility	MGI must ensure the daily assistance 12H, both physical and call centre, pre-holiday and Saturday, until 10 am.	3,05 €
Participation in governance	Participates in respect of the goals assigned to the A-Ulss	3, 10 € (Quota A paths)
Start-up and co-ordination benefits	Una tantum contribution for single doctors	1.000 €
	Identifying a MGI referent that cares for the relationship between the district and the group.	600 €/month + EMPAM (7-10 MMG)

Source: DGR 751/ 2015

In addition to these economic resources, the Regional Health System must finance the staffs that work inside the ambulatory with the MMG. The tariff is decided in accordance between the Health Authorities and the cooperative, while, the doctors have not authorities on this aspect but only, in accordance to the decree, in the decision of the needed number of them. In order to understand what is the expense in the Trebaseleghe MGI for the staff it is possible analyse the typical monthly prospect of the staff turn in the office (Table 18: monthly hours of the studio staffs and nurses⁷⁰):

⁷⁰ This information are related to the August month, and it is not the same for the other month.

Table 18: monthly hours of the staff and nurse			
STUDIO STAFF	TOT. MOUNTHLY N. HOURS	NURSES	TOT. MOUNTHLY N. HOURS
STAFF 1	615	NURSE 1	410
STAFF 2		NURSE 2	
STAFF 3		NURSE 3	
STAFF 4		NURSE 4	
STAFF 5		-----	-----
STAFF 6		-----	-----
STAFF 7		-----	-----

Source: final turn of August in MGI L.Scimone

The staff works in daily turn, with different remuneration for the turn in the morning, in the afternoon, in the evening and in Saturday, but, anyway, it is possible to identify an average of the monthly expenditure for the secretaries and nurses around 16.666.66€. To the MMG referent in Trebaseleghe, the Region correspond a quarterly fund of 50.000€ for the payment of the staffs, divided between the GPs in the MGI on the basis of the number of patients, as for the usage fee of the edifice: also for the payment of the personnel the MGI decide to use this equity method. Hence, the annual expenditure of the MGI in Trebaseleghe for the region it is foresee to be around 200.000 €: it is the sum that correspond to the maintenance of a primary care team that present the same or similar number of doctors an personnel in the MGI, without considering the personal wage of the singular doctors.

The regional decision establishes funding for 25.000.000 € per year for 4 years for financing the creation and maintenance of the ambulatories in the entire region. The initial investment is high but what is expected by the Health Authorities is an amortization of the costs over the years. The outcomes are not immediate and require long work in the ambulatories and in the community: the challenges, in fact, are not only to develop functional structure but insert this model in the mentality of the community. People must become familiar with the new delivering model and understand the new piratical organization of the health system, that allow on the basis the territorial structure, as family, home hospitals, community hospital, hospice, after the primary care team and only as last land of resort the emergency and hospital. Only through this change in mentality the health system can have a considerable resource saving, but it require long term, because change the way in which the people, especially the old one, see the health it is not immediate. The nurses and the secretaries in the ambulatory cover this important role to educate and inform the community about all the possible services available, without the use of the hospital costly resources.

At least, the preventive actions are another important elements that can optimize the outcomes expected. The high initial investment to furnish the ambulatories of the clinical equipment necessary for starting the program it is expected to be reimburse from the reduction in the worsening of some dangerous pathologies, with the consequent reduction in the use of hospital performance. In fact, every disease presents the risks to worst and make necessary the hospital intervention. However, a performance linked to the cardiovascular, pulmonary and chronic diseases present high costs if managed in Emergency:

- For the cardiovascular intervention in emergency the system must spend in average to 334,24€ to 2.243,04€, depending on the kind of performance and to the seriousness;
- For the pulmonary illness, BPCO and asthma: in average around 344,26 € (these are always disease in acute phases);
- Chronic condition: from 293,70€ to 353,15 €.

The role of the MGI is to control the incidence of these diseases and intercept critical situation and cure it at home, without the use of the hospitalization. It has double benefit, both from the economic and human point of view: create a cure path in the territory, more closer to domestic reality, is more comfortable for the patients, that can reach benefit from this situation and is less expensive for the region. However, if the hospital intervention become necessary for the health status of the individuals, the MGI must know what are the better structure that offer the better services and guide the patients to the right structure inside the A-Ulss 6, Euganea. In fact, the MGI has also the role to block the run of the people to nearest hospital but that belong from another A-Ulss.

The outcomes of this system should be appreciate only from years and the performance of the MGI in Trebaseleghe, with the other in A-Ulss 6, should be evident in the gaining of quality in the health services and in the satisfaction of the community but also in the reduction of the white codes and unnecessary hospitalization.

5: CONCLUSION:

Health, from the WHO, is considered as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. It is a fundamental human right and the attainment of the highest possible level of health is a most important worldwide social goal, whose realization requires the action of many of other social and economic sectors in addition to health sector. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life. Governments have the responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community, in the coming decades, should be the attainment, by all peoples of the world, of a level of health that will permit them to lead a socially and economically productive life. However, it is a tough challenge to sustain due to the several demographic condition that affect the world. The population ageing is a critical demographic aspect that touches all the nations: the fewer natiivities and the increase in the life expectancy lead the enlargement of the elderly part of the society. With the new medical technology, treatment and cure people can live longer than in the past and the viral disease are not mortal and the main treats are the chronic degenerative diseases. The population ageing and the linked consequences are the reason why it is necessary a change in the society organization, especially in the health system. The actual hospital centre model cannot sustain the new issues rising and it needs to be change with one that can absorb the new health demand and that can deliver it in the more efficient way. The chapter 1 shows what are the main reasons why it is essential create a new model that can sustain the dramatically change in the demographic conditions. The increase in the chronic degenerative diseases imply that people are affect by not mortal disease but they are afflicted with constant illnesses, which require continuous cure and that worsen over time. Hence, the health system organization must be modify to use in more effective and efficient way the scarce resource of the health system. In fact, sustain people with the, so-called, Non Communicable Disease (NCD) present high cost, not only from the health system point of view but also for the fiscal one. The health expenses, in fact, rise at different rate than the other economics' areas and it depends on the national and individual income but also from the size and the health status of the society. Due this, it is essential to have a healthier population in order to control the national spending. Thus, it is evident that change the health system with one that can contain the health spending but, at the same time, can sustain the increase in the

demand is necessary. However the transformation is not simply to make and presents a lot of obstacle and difficulties. In order to better realize the renovation, it is important develop a legal tolls that sustain it and motivate the main actors with some economic and non-economic incentives. But also, it is essential that the main actors, that in the health system are the General Practitioner (GP) and the patients, are well informed about the change and trained to implement it. In fact, the reform modifies the way in which the health is thought and delivered, giving more importance and relevance to the patients. The goal is to reduce the fragmentation of the cure received by the persons and increases their engagement in the cure. For this, it is extremely important to implement the informatics system to increase the connection between the different figures and to ensure continuity and comprehensiveness of the cure. In XXII century it is expected a variation in the population composition and the number of elderly became higher that the number of the child lower five years old. It is a noticeably situation, that displays the obligatory choice that the health system must take. To overcome this issues it is necessary change the way in which the old age is think: it is not more allow to think to the old people as inactive but free form disease, but as an active part of the society. Thus, gain more importance the concept of Healthy Life Years, that is the main focus of the governs: increase the level of this indicator means that not only the person live longer but that they live a long and healthy life, without serious illnesses, that limited their ability and their capacity. It is necessary rethink the organisation of the health system in order to achieve this goal and the primary health care is the key to attaining this strategic objective.

Primary health care is essential health care based on practical, scientifically and social acceptable methods and technology that want to make the health system universally accessible to individuals and families, to the community through their full participation. It forms an integral part both of the country's health system and the overall social and economic development of the community. It is the fist level of contract of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. Primary health care is deeply connected to the economic conditions and sociocultural and political characteristics of the country and its communities and it is based on the application of the relevant results of social, biomedical and health services research and public health experience. The innovation of the model is that it addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services. The integration between hospital and community is the key tools to create a health system able to cover all the needs of an ageing population, which require a complex set of cure. However, the role of the hospital become secondarily and the main role are implemented by the primary

care in the territory. Primary care, according to the analysis made in the chapter 2, is the way to grant high quality services and reduce the overall costs: the intervention of the family doctors with preventive actions and more comprehensive cure allow to reduce the unnecessary hospitalizations and contain the health spending. The development of the model is based in the Chronic Care Model (CCM) of Wagner and on the more realistic Expanded CCM: both describe the importance of the community and of the empowerment of the people but, in the second one, the porous border shows the flow of ideas and competencies between the different figures, displaying the importance in a higher collaboration between the different health actors. It represents the main aspects of the reform that is the new importance gaining by the patients, which are put in the centre of the health system, giving more attention to their real needs. Thus, these models, with the Patients Centred Care Model, are the theoretical aspects on which based the creation of the new organizational structure. To achieve the goals and create an effective system the health organization must grant: equity and universal access near to the people, comprehensiveness and continuity of the care, higher coordination between the different professionals, given by a empowerment of the technological communication. In the view of the patient centred care the patients need to be well informed about the treatment but also trained in the management of the disease, thanks the collaboration with the nurses and the doctors: the patients and their family become an active part in the pathway cure and in healing process.

However, as said in the chapter 1, in order to build an effective model it is essential have a solid legal base. From the National Health Plan 2006 there was the first hint to the necessity to implement a model that is based in the preventive actions and in a more engagement of the general practitioners in order to reduce the hospital's expenses. Thus, during the years, the regions, in different way (because of the Title V of the Constitution gives freedom to the region in the health area) try to implement this plan. In chapter 3, there is the description and the analysis of the main action implemented by the Veneto region. Balduzzi decree presents the necessity to transform the territorial organization of the health system, with the creation of AFT (Territorial Functional Aggregation) that helps to monitor the activities in the community. In Veneto, this reform starts with the rationalization of the number of A-Ulss, from 21 to 9, and with the empowerment of the territorial districts, which assume the role of the administrative centres in the territory. For controlling all the activities implemented in the community, there is a "headquarter" called Local Health Authority (Azienda Zero). This pyramidal allocation of the power is useful to distribute the administrative and monitoring actions in structures that are more near the real life of the community and the districts helps the general practitioners in the execution of their actions.

However, the main tools to reduce the health spending remain the preventive actions. Thus, the regional reform, forecast the reorganization of the territorial health in primary care teams, which are multiprofessional teams, that work together in the same surgery or in the peripheral one, that allow a continue and complete coverture of all the people's needs for 12h daily for 5 days at week. The regional reform forecasts that, to 2018 the 80% of the doctors will be grouped in the MGI. However, the actual situation is longer to achieve this goal: it is forecast that in Veneto will be more or less 400 MGI but, actually, only 90 are programmed and, of this, 62 are actually working. Only the 22% of the doctors now are grouped into an MGI and, in the regional declaration was foreseen that the 60% of the GP at the end of 2017 will work in this new primary care team. This deceleration is due to a block from the Region to the approval of the projects because there are some problems:

- The collaboration with the cooperative, that give some fiscal problem linked to the "MGI reimbursement";
- In receive the funds;
- Internal resistances from the doctors that see some difficulties in the application of the model, due to the scarce number of young doctors to grant the turnover; the risks to allow the passage from a privatistic health; less clarity in all the main aspects of the "operating contract".

Due to the complexity of the model and the high number of services offered, in the ambulatory's activities it is request staffs that cooperates with the doctors and help them in the daily performance. The collaboration with the cooperative becomes essential because it offers assistances to the GP in the administration of the surgery (inventory, cleaning, control of the state of all the medical equipment) but also hires the studio staff and the nurses. However, this relation is not always easy to create and can raise some issues: the MMG, in fact, cannot control directly the nurses and, if there is not a clear deal, can augment problem in the working relationship. But, every MGI lives a different situation and must be analyse case by case.

In the chapter 4, the analysis of the MGI in Trebaseleghe (PD) L.Scimone represents an example of how the MGI was implemented in the territory. This is one of the 13 MGI activated in the A-Ulss, Euganea, and give coverture in a boundary's area near to the A-Ulss 2 Marca Trevigiana. Due to the strategic location, the MGI has the important role to offer high quality services to the community and to control the run of them to the biggest near hospital of Castelfranco (PD), that belong from the other A-Ulss. In fact, one of the key functions of the primary care is to reduce the access in the emergency and the use of the hospital that do

not belong from the same A-Ulss. Hence, the surgery is equipped of all the necessary tools to give to the patients a total coverture, from the normal ambulatory's activities to the prevention programs. Thanks the work made in collaboration with the nurses, the patients are called to follow up and screening actions, especially if their presents some risks factors (as obesity) or if present chronic degenerative diseases. This is in line with what the Health Plan and regional declaration said but there are also some discrepancies. In the Balduzzi decree is said that the region finances the surgery and the personnel: in Trebaseleghe the staffs, because the benefits of their actions are received totally from the patients, is paid by the health system but the edifice is financed by the cooperative. Thus, the doctors must pay a usage fee to the cooperative to correspond part of the initial investment, also the GPs that have maintain the peripheral surgery. To overcome the problem the region gives 200€ to cover the expenses, but sometimes are not enough. However, in the ambulatory, with the collaboration between doctors, studio staff and nurses is started the deliver and the implementation of the preventive programmes, helped by an informatics system and the electrical personal record for patients, shared between the different MMGs.

The implementation of the MGI is just started and it is too early to understand the real benefit or if it represents an increase in expenses. However, the ideas on which it is based, it is showed by international evidence, should be an effective way to contain the health expenditure and deliver the needed services to overcome the population ageing issues and the chronic degenerative illnesses problem.

REFERENCES

- Allen J., Heyrma J., Svab I., Gay B., P. Ram, Crebolder H., Evans P., *La definizione europea della medicina generale/ medicina di famiglia*, 2011,
www.woncaeurope.org/sites/default/files/documents/Definizione%20WONCA%202011%20ita_A4.pdf
- Barr V.J., Robinson S., Marin-Link B., Underhill L., Dotts A., Ravensdale D. and Salivars S., *The Expanded chronic care model: an integration of concept and strategies from population health promotion and the chronic care model*, *Healthcare Quarterly*, 7(1) November 2003: 73-82, 2003. 16763.
- Bates D.W., Bitton A., *The future of health information technology in the patient-centred medical home*, *HealthAffairs*, April 2010, vol.29 no.4, 614-621
- Bellini M., *La sanità cambia, nuove strutture in Polesine*, 24 Aprile 2015, www.rovigooggi.it
- Blomqvist A.G., Carter R.A., *Is health care really a luxury?*, 1993, Western University, Department of Economics Research Report,
ir.lib.uwo.ca/cgi/viewcontent.cgi?article=1640&context=economicsresrpt
- Bodenheimer T, Wagner E. H., Grumbach K., *Improving primary care for patients with chronic illness*, October 9, 2002, American medical association, vol. 288, No.14.
- Bodenheimer T, Wagner E. H., Grumbach K., *Improving primary care for patients with chronic illness, part two*, October 16, 2002, American medical association, vol. 288, No.15.
- Buttura R., *Appunti per una storia della sanità italiana*, 2004,
www.societasalutediritti.com/documenti/20042705APPUNTIPERUNASTORIADEL LASANITAITALIANA.htm
- Cartabello A., *Gli incentivi economici migliorano la pratica professionale?*, 2012;4(6): e1000020, www.evidence.it/articoli/pdf/e1000020.pdf
- Cipolletta E., *Le medicine di gruppo integrate: quale future per l'assistenza sanitaria territoriale?*, 1 Settembre 2015, *Il sole24ore*
- Clerico G., *Spesa sanitaria, costi-efficacia e scelte strategiche*, Università del Piemonte orientale, facoltà di giurisprudenza, Dipartimento di scienze giuridiche economiche, 2016, www.coripe.unito.it/Portals/0/EeS/2_1_Clerico.pdf
- Cristini C., Rizzi R., Zago S., *La vecchiaia tra salute e malattia*, *Sentieri della mente*, 2005, Pendragon.
- C.M Kilo, 2005, *Transforming care: Medical practice design and informational technology*, *HealthAffairs*, September 2005, vol 24, no. 5, 1296-1301.

- Christopher J.L. Murray, Alan D. Lopez, *Alternative projections of mortality and disability by cause 1990-2020: Global Burden and Disease Study*, The Lancet, vol. 349, Issue 9064, 24 May 1997, Pages 1498-1504
- Costa C., *Sanità in Veneto: le novità della Legge Regionale 19/2016*, CGIL, www.spi.veneto.it/sanita-in-veneto-le-novita-della-legge-regionale-192016/
- Frontoni S., *Health policy in non-communicable disease-Diabetes*, March 2015, vol n.2, Italian barometer diabetes observatory
- Hunter D.J., *The health debate*, 2016, Policy press.
- Hurd M. D., *L'invecchiamento della popolazione. Conseguenze per l'individuo, la famiglia, la società*, Biblioteca della libertà, XXXIV (1999), settembre-ottobre, n. 151, pp. 3-14
- Il Mattino di Padova, *Camposampiero e Cittadella, presidi salvi e potenziati*, 21 Giugno 2013
- Jackson G.L., Powers B.J., Chatterjee R., Bettger J.P., Kemper A.R., Hasselblad V., Dolor R.J., Irvine R.J., Heidenfelder B.L, Kendrick A.S, Gray R., and Williams J.W.Jr., MD, 2009, *The Patient-Centred Medical Home. A systematic review*, iele.ch/pdf/ghc_Patient_Centered%20Medical%20Home%20Demonstration_%20A%20Prospective%20Quasi_Experimental%20Before%20and%20After%20Evaluation.pdf
- Keleher H., *Why primary health care offers a more comprehensive approach to tackling health inequities than primary care*, 2001, Australian Journal of primary care 7(2) 57-61.
- Lafratta M., *Rimborso spese per il personale delle MGI/UCCP/UTAL/Case della Salute*, 25 Giugno 2017, www.anmos.it
- Luzzi S., *Salute e sanità nell'Italia repubblicana*, 2004, Donzelli editore, Roma.
- McDaid D., Sassi F., Merkur S., *Promoting health, preventing disease. The economic case.*, 2015, Open University press, www.oecd.org/els/health-systems/health-publications.htm
- Mennini F., *I costi delle malattie cardiovascolari e l'importanza della prevenzione in termini di risparmio globale*, 2014, www.fondazionecuore.it
- Minelli M, Perucca A., *Un sistema che non sa guarire*, 2016, Giapeto Editore
- Ministero della Salute, *Piano sanitario 2016-2018*
- Montaguti U., *Lo stato della sanità italiana. Ageing society e sistema sanitario*, 2004, www.italianieuropei.it/i-libri/item/762-lo-stato-della-sanità-italiana-ageing-society-e-sistema-sanitario.html
- Nasmith L., Ballem P., Baxter R., *Transforming care for Canadians with chronic health conditions: put people first, expect the best, manage the results*, 2010 Ottawa, ON,

- Canada: Canadian Academy of Health Science.
- Pammolli F., Riccaboni M., Magazzini L., *The sustainability of European Health Care Systems: beyond income and ageing*, 2008, MPRA Paper N. 16026.
- Peikes D., Anglin G., Taylor E.F., Dale S., O'Malley A., Ghosh A, Swankoski K., Converse L., Heith R., Finucane M., Crosson J., Mutti A., Grannemann T., Zutshi A., Brown R., *Evaluation of the comprehensive primary care initiative: third annual report*, 2016, Mathematica policy research, www.mathematica-mpr.com/-/media/publications/pdf/health/2016/cpc-third-annual-report.pdf
- Poli P., *Il diritto alla salute, 1978-2004*, www.centroperidirittidelmalato.it/documenti/storia_ssn.htm
- Rebba V. (2012), *Evoluzione dei sistemi sanitari tra sostenibilità e promozione della qualità: alcune esperienze internazionali*, *Politiche sanitarie*, 13(3): 127-128.
- Regione del Veneto, *Gli accessi di pronto soccorso in Veneto*, 2013
- Reid R. J., Coleman K., Johnson E. A, Fishman P.A, Hsu C., Soman M.P., Trescott C.E., Erikson M., and Larson E.B., *The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers*, *Health Affairs*, May 2010, vol. 29 no 5, 835-843.
- Reid R.J., MD, Fishman P.A. ,Yu O., MS; Ross T.R., Tufano J.T., Soman M.P., Larson E.B., *Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation*, 2011, www.ahrq.gov/pepr/pubs/ghc_Patient_Centered%20Medical%20Home%20Demonstration_%20A%20Prospective%20Quasi_Experimental%20Before%20and%20After%20Evaluation.pdf
- Saltman R. B., Rico a., Boerma W., *Primary care in the driver's seat? Organizational reform in European primary care*, 2006, www.euro.who.int/__data/assets/pdf_file/0006/98421/E87932.pdf
- Schut E., Sorbe S. and Hoj J., *Health care reform and long-term care in Netherlands.*, 2013 Economic department working paper no. 1010, www.oecd.org/eco/reform/2013-2.pdf
- Simon J., and Powers M., *Chronic Disease Registries: A Product Review*, May 2004, www.chcf.org/documents/chronicdisease/ChronicDiseaseRegistryReview.pdf (2 May 2005).
- Spandonaro F., *Ecco perché il nostro universalismo sanitaria è diventato "diseguale"*, dall'introduzione all'11° Rapporto Sanità del Crea Tor-Vergata, 29 Ottobre 2015, quotidianosantà.it
- Starfield B., *Is primary care essential?*, www.sciencedirect.com/sdfe/pdf/download/eid/S0140673694906343/first-page-pdf

- Starfield B., Shi L., Macinko J., *Contribution of primary care to health systems and health*,
onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2005.00409.x/full
- Taylor E. F, Dale.S, Peikes D., Brown R., Ghosh A., Crosson J., Anglin G., Heith R., Shapiro
R., *Evaluation of the comprehensive primary care initiative: first annual report*, 2015,
Mathematica policy research, innovation.cms.gov/Files/reports/CPCI-EvalRpt1.pdf.
- Tobruk D., *Nascita del sistema sanitaria nazionale 833/ 78, un riassunto facile*, 2016,
www.dimensioneinfermiere.it/sistema-sanitario-nazionale-833-78/
- Wagner, *Chronic care model*, 1968, www.tpchd.org/files/library/b6e06d8cdc9ff4a7.pdf
- Wisnar M., Palm W., Figueras J., Ernst K., van Ginneken E., *Cross border health care in the
European Union. Mapping and analysing practices and policies*, 2011, Observatory
Studies, no 22, pag 49.
- Wonka, *La definizione europea della medicina generale/medicina di famiglia*,
www.med.unipg.it/ccl/Materiale%20Didattico/Medicina%20Generale%20-
%20canale%20A/Germini/core_wonca_it.pdf
- Zuanon F., *Al distretto debutta la medicina integrate e l'Usl risparmio*, Il Mattino di Padova,
29 Aprile 2014.

SITOGRAPHY

- AAFP, *Joint Principles of the Patient-Centred Medical Home*, March 2007, www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf
- Epiprev, *Sustainability of the Italian National Health Services and need of change*, 2013, www.epiprev.it/attualità/la-sostenibilità-del-servizio-sanitario-nazionale-e-la-necessità-di-cambiamento
- Eurostat, *People in the Eu: Who are we and how do we live?*, 2015, ec.europa.eu/eurostat/documents/3217494/7089681/KS-04-15-567-EN-N.pdf/8b2459fe-0e4e-4bb7-bca7-7522999c3bfd
- FVG, *Salute: Siglato accordo integrativo con i medici di famiglia*, 2015, www.regione.fvg.it
- Health Policy, *Priority actions for the non-communicable disease crisis*, 2011, www.oecd.org/els/health-systems/47531330.pdf
- Il giornale di Vicenza Regione, *Ok l'accordo per la medicina di gruppo*, 14 Maggio 2015, www.ilGiornalediVivenca.it
- Il Ministro della Salute, *Atto di indirizzo per l'anno 2017*, 2017,
- La Tribuna di Treviso, *Medicine integrate, piano in Regione*, 17 Gennaio 2017, www.LaTribunadiTreviso.it
- MetaSalute, *Guida 2017, Piano Sanitario. Fondo MetaSalute*, 2017, www.fondometasalute.it/cms/resource/259/guida-piano-base-2017.pdf
- Ministero della Salute, *Pronto soccorso e sistema 118. Proposta metodologica per la valutazione dei costi dell'emergenza, Progetto Mattoni SSN*, 2003, www.mattoni.salute.gov.it/mattoni/documenti/11_Valutazione_costi_dell_emergenza.pdf
- Ministero della Salute, *Piano sanitario 2003-2005*, www.salute.gov.it/imgs/C_17_pubblicazioni_654_allegato.pdf
- Ministero della salute, *Piano sanitario 2006-2008*, ape.agenas.it/documenti/Normativa/PSN_2006-08.pdf
- OECD, *Conceptual framework for exploring primary care quality variation, 3° meeting of the OECD HCQI subgroup on health promotion, prevention and primary care*. www.oecd.org/health/health-systems/48264717.pdf
- OECD, *Developing a Health Care System Benefiting ALL*, www.oecd.org/health/developingahealthcaresystembenefitingall.htm
- OECD, *Health at a Glance 2015 How does the United States compare?*, 2015,

www.oecd.org/.../Health-at-a-Glance-2015-Key-Findings-UNITED-STATES.pdf
 OECD, *Improving health system performance in OECD countries*, 2002, www.oecd-ilibrary.org/social-issues-migration-health/measuring-up_9789264195950-en
 OECD, *Improving lifestyle, tackling obesity: the health and economic impact of prevention strategies*, 2009, OECD Health Working Papers, no. 48, [www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?doclanguage=en&cote=delsa/hea/wd/hwp\(2009\)6](http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?doclanguage=en&cote=delsa/hea/wd/hwp(2009)6)
 OECD, *Improving value in health care. Measuring quality*, 2010, *OECD Health Policy Studies*, www.oecd.org/health/health-systems/improving-value-in-health-care-9789264094819-en.htm.
 OECD, *Reviews of health care quality, Italy 2014. Raising standards*, 2014, OECD Publishing, www.dx.doi.org/10.1787/9789264268128-it.
 OECD, *What future for health spending?*, 2013, www.oecd.org/economy/health-spending.pdf
 OECD, *Work on health*, 2015, www.oecd.org/health/Health-Brochure.pdf
 Regione Veneto, Ulss 6 Euganea, *Piano delle performance 2017-2019. Direttive 2017*, www.aulss6.veneto.it/index.cfm?method=mys.apridoc&iddoc=41
 RovigoOggi, *La medicina integrate partirà anche qui, 15 gennaio 2012*, www.rovigo.it
 RovigoOggi, *Una rivoluzione per 9 medici e 8.000 pazienti, 7 Maggio 2017*, www.rovigooggi.it
 RovigoOggi, *Sette poliambulatori di medicina integrate in arrivo in Polesine, 3 Gennaio 2017*, www.rovigooggi.it
 SISAC, *Accordo collettivo Nazionale, 29 Luglio 2009, Medicina Generale*, www.sisac.info/antepriamaNewsHome.do?idArea=201011221610481056&idNews=201012212148298322.it
 Studi, ricerche e documenti, *Il medico condotto, precursore dimenticato e talvolta anche misconosciuto della sanità moderna*, 2012, www.eupolis.regione.lombardia.it/shared/ccurl/669/408/14_Studi_Ricerche_03.pdf
www.salute.gov.it/imgs/C_17_pubblicazioni_2528_allegato.pdf
 Tuttitalia, *Statistiche demografiche provincia di Padova*, 2016, Wwww.tuttitalia.it/veneto/provincia-di-padova/statistiche/
 VeneziaToday, *In Veneto orientale nasce la Ulss 4, l'azienda a vocazione turistica più grande d'Europa*, 2 Gennaio 2017, www.veneziatoday.it
 WHO, *From primary health care to universal coverage-the affordable dream*, www.who.int/publications/10-year-review/universal-coverage/en/index1.html

WHO, *Global action plan for the prevention and control of noncommunicable diseases, 2013-2020*, 2013, apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf

WHO, *Global Status Report on noncommunicable disease 2014. Attaining the nine global noncommunicable disease targets; a shared responsibility*, World Health Organization, apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua

WHO, *International conference on primary care, AlmaAta, 6-12 September 1978*, www.who.int/publications/almaata_declaration_en.pdf?ua=1

WHO, *Non communicable disease. Country profile 2014*, World Health Organization, 2014, apps.who.int/iris/bitstream/10665/128038/1/9789241507509_eng.pdf?ua=1

WHO, *Patient engagement, technical series on safer primary care*, WHO, 2016, apps.who.int/iris/bitstream/10665/252269/1/9789241511629-eng.pdf?ua=1

WHO, *Primary care. Putting people first, the world health report*, 2008, www.who.int/whr/2008/08_chap3_en.pdf?ua=1

WHO, *The Ottawa Charter for Health Promotion. First International Conference on Health Promotion*, Ottawa, 1986, www.who.int/healthpromotion/conferences/previous/ottawa/en/index1.html

What is the Patient-Centred Medical Home?, 2011, www.acponline.org/system/files/documents/running_practice/delivery_and_payment_models/pcmh/understanding/guidelines_pcmh.pdf

LEGISLATION AND REGULATIONS

- Bollettino Ufficiale della Regione Veneto, Decreto Governativo Regionale n. 41, 18 Gennaio 2011, *Progetto Cure Primarie 2011/2012*, www.bur.regione.veneto.it
- Bollettino Ufficiale della Regione Veneto, Decreto Governativo Regionale n. 1666 del 7 Agosto 2012, *Progetto per lo sviluppo dell'assistenza primaria approvato con DD.G.R. n. 41 e n.1666 del 2011*, www.bur.regione.veneto.it
- Bollettino Ufficiale della Regione Veneto, Decreto Governativo Regionale n. 751, 14 Maggio 2015, *Accordo tra la regione e le OO.SS della medicina generale convenzionata*, www.bur.regione.veneto.it
- Bollettino Ufficiale della Regione Veneto, Deliberazione della Giunta Regionale N. 3499 del 18 Novembre 2008. *Centro Unico di Riferimento Regionale di genotipizzazione per la diagnostica microbiologica e virale. Anno 2008/2009. Impegno di spesa*, www.bur.regione.veneto.it
- Bollettino Ufficiale della Regione Veneto, Deliberazione della Giunta Regionale n.953 del 18 Giugno 2013, *Progetto assistenza primaria*, www.bur.regione.veneto.it
- Bollettino Ufficiale della Regione Veneto, Deliberazione della Giunta Regionale n. 2174 del 23 dicembre 2016, *Disposizioni in materia sanitaria connesse alla riforma del sistema sanitario regionale approvata con L.R. 25 ottobre 2016, n. 19*, www.bur.regione.veneto.it
- Bollettino Ufficiale della Regione Veneto, Legge Regionale n.23, 2012, *Norme in materia di programmazione socio sanitaria e approvazione del Piano socio-sanitario regionale 2012-2016*, www.bur.regione.veneto.it
- Bollettino ufficiale della Regione Veneto, Legge regionale n.19, 2015, *Istituzione dell'ente di governance della sanità regionale veneta denominato "Azienda per il governo della sanità della Regione del Veneto - Azienda Zero". Disposizioni per la individuazione dei nuovi ambiti territoriali delle Aziende ULSS*, www.bur.regione.veneto.it
- Bollettino Ufficiale della Regione Veneto, Legge Regionale n.19 del 25 Ottobre 2016, *Istituzione dell'ente di governance della sanità regionale veneta denominato "Azienda per il governo della sanità della Regione Veneto- Azienda Zero". Disposizioni per l'individuazione dei nuovi ambiti territoriali delle aziende ULSS*, www.bur.regione.veneto.it
- Conferenza Stato-Regioni , 113/CSR del 02-07-2015, *Intesa tra Governo, Regioni e Province autonome di Trento e Bolzano concernente l'individuazione di misure di*

razionalizzazione e di efficientamento della spesa del Servizio Sanitario Nazionale,
www.regioni.it

Gazzetta Ufficiale, Decreto Legislativo 30 Dicembre 1992, n. 502, Riordino della disciplina
in materia sanitaria, Legge e Decreti Nazionali, 1992, www.gazzettaufficiale.it

Gazzetta Ufficiale, Decreto Legislativo 19 Giugno 1999, n. 229, *Norme per la
razionalizzazione del servizio sanitario nazionale*, www.gazzettaufficiale.it

Gazzetta Ufficiale, Decreto-Legge 13 settembre 2012, n. 158: *Disposizioni urgenti per
promuovere lo sviluppo del paese mediante un più alto livello di tutela della salute*,
www.gazzettaufficiale.it

Gazzetta Ufficiale, Legge 23 dicembre 1978, n.883 *“Istituzione del servizio sanitaria
nazionale”*, www.gazzettaufficiale.it

Gazzetta Ufficiale, Legge 28 Dicembre 2015, n.208, *Disposizioni per la formazione del
bilancio annuale e pluriennale dello Stato (legge di stabilità 2016)*,
www.gazzettaufficiale.it