AHEAD

ACTION FOR HEALTH AND EQUITY ADDRESSING MEDICAL DESERTS

NATIONAL POLICY DIALOGUE

ITALY

POLICY OPTIONS FOR ADDRESSING MEDICAL DESERTS

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Introduction

The project AHEAD addresses the challenge of medical deserts and medical desertification in Europe in an effort to help reduce health inequalities. The project is carried out in Italy, Moldova, the Netherlands, Romania and Serbia, with the aim to benefit health policymakers, patients' organisations, health professionals' organisations, affected communities and other relevant stakeholders. Further information about AHEAD's teams, mission and goals, and the activities conducted over the duration of the project can be found via the abovementioned links.

Our ultimate intended impact at society and EU level is better access to health services, especially in underserved areas, and more equitable access to sufficient, skilled and motivated health workers, starting with the countries involved in the project.

Purpose of this document

This policy brief is compiled on the basis of the activities carried out in Italy, under the responsibility of Cittadinanzattiva. This document is based on the ideas, opinions and suggestions collected during the process. It does not represent an official position of any institution or person taking part in the process, but contains recommendations for decision makers, who are in a position to implement policies for human resources for health and improve the national legislation regarding its governance, with the aim to address medical desertification.

The AHEAD country teams have compiled five of these policy briefs, one for each country. Every brief provides a short overview of medical desertification in each country, information regarding the adaptation of our consensus building methodology for each context (see next page), and the specific policy options, categorised where possible. The briefs include quotes from the national level events, conveying some opinions voiced by the participants and where acknowledged, their commitment to address this issue in their national contexts.

Methodology

Each country team organised one or more national policy dialogues, with key stakeholders from national and local levels, discussing the validated, context-specific, and feasible policy measures, thereby building momentum for actual policy change and effective action, and encouraging cross-fertilisation.

Policy dialogue can be valuable input on the demand side of health services and systems, depending on the degree to which it is truly participatory and inclusive, bringing enormous advantages to policy implementation and increasing the chances for positive results. Through policy dialogues, different stakeholders can better examine each other's perspectives whilst improving the general understanding of these policies and their impact in different frameworks. It promotes involvement in the policy-making process, can boost

commitment and lead to more responsive policies, engages diverse stakeholders from various sectors and gives people a say in the choices that will influence their lives and health.

Organizing policy dialogues: from the local to the national

Participation in policy dialogues is a win-win situation for both the community and policy makers. The process gives opportunity to the representatives of consensus building sessions to have direct access to the top decision makers. The dialogue gives opportunity to the decision makers to get input from people with lived experiences, and insights from experts like academics, health advocates and civil society members. The policy options discussed during the policy dialogues are not only backed by evidence but also represented by people who are affected by medical desertification in their daily lives.

Each member of the consortium has mapped and identified key stakeholders and actors at the national level, such as civic and patient organisations, healthcare providers and other health professionals (e.g. primary care physicians and specialists, paediatricians, nurses, pharmacists, etc.), and other relevant stakeholders, such as community representatives, trade unions working in the health sector, directors of health districts, etc. Project partners have conducted in-depth interviews with key stakeholders regarding the issue of medical desertification in their context, to gather experiences, perceptions and (possible and existing) measures to address the phenomenon of medical desertification.

In addition, each organisation's team conducted an analysis to identify key policy-makers involved in decision-making at the local level (e.g. local aldermen, mayors, regional council members, and actors standing for both majority and opposition groups). These key actors were invited to the consensus building sessions that aimed to discuss the most relevant issues about medical desertification in their local context and to build consensus on existing and possible new policy measures to prevent and mitigate medical desertification.

Our consensus building methodology

It is known from literature that successful implementation of health workforce policies requires strong inter-sectoral governance and consensus building among the different stakeholders involved. As a consortium, we have therefore set out to draft, test and validate a consensus building (CB) methodology, in order to increase the chances of successfully counteracting medical deserts.

The aim of this methodology is twofold:

- Implemented in the AHEAD partners' countries, it contributes to the identification and development of practical, feasible and context-specific policy options, that will support policy makers in their decisions on health workforce issues.
- Implemented, contextualised and evaluated across the AHEAD partners' countries, it will result in a validated methodology, that we will share in a practical guidance document,

so that other organisations (outside the consortium, and beyond the project timeline) can apply the same methodology in their own context.

This participatory consensus building method consists of two phases at local level and one at national level, all with facilitated dialogues. Further details about this methodology can be found via this link.

It is important to note that the methodology was contextualised to each country, following an extensive series of discussions with the country teams, to ensure its cultural and wider contextual appropriateness, tailoring it to the needs of the facilitators and participants.

Stakeholders

Very often, political representatives operating at the local level also play a role in national politics, and similarly, politicians operating at the European level also play a role at the national level. This means that many of these figures can be involved at multiple levels of the policy dialogue.

This is also true for other key stakeholders affected by the different phases of the project, e.g. a health worker may also be a spokesperson for a particular category at the national level. Or, the same civic or patient association may operate at both the local and national levels.

For this reason, it was very important to select the different stakeholders carefully and in advance in order to avoid their over-engagement.

The national consensus building session, also described as the policy dialogues, form the last phase of the AHEAD consensus building methodology. This step provides opportunity to ensure that the policy options developed in the multi-stakeholder consensus building sessions are carried forward and find their way in the menu of policy options to be implemented in each country.

The range of participants

The range of potential participants in the policy dialogues include the following:

- Politicians and policymakers:
    - Local level politicians, such as local aldermen, the Mayor, Council members as well as opposition leaders
    - National level politicians
    - Members of national Parliament and Members of European Parliament who are also active at national level
    - Regional level politicians
    - High level civil servants

- Representatives from the consensus building sessions

- Participants in earlier CB sessions, including those at local level
- Health advocates
- Academics
- Civil society members and other stakeholders

What are medical deserts?

In the initial stages of the AHEAD project, we carried out a literature review to better define the concept of 'medical desertification'. Based on a thorough review of scientific studies, we have concluded that the complex concept requires an elaboration of definitions to understand its multidimensional perspective. From the literature review, we derived a working definition to inform the development of research tools and validated this definition through the results of research tools. We also discussed this definition during the national dialogues.

Below is our final working definition of medical desertification.

*A medical desert is the **end point** of a complex **process** called 'medical desertification', that implies continuous and increasing inability of a given population to access health services in a timely and contextually relevant manner.*

An elaborate explanation of the definition can be found on the AHEAD website.

Potential solutions for counteracting medical deserts in Italy

Official data collected and analysed by Cittadinanzattiva during the different phases of the European project AHEAD "Action for Health and Equity: Addressing Medical Deserts" show an alarming fact that affects the entire Italian territory: from the north, to the south there is a shortage of doctors, both general practitioners and hospital doctors, as well as nurses and paediatricians. In particular, the effects of the so-called phenomenon of medical desertification are evident in the peripheral and ultraperipheral areas of the interior. This translates into widespread and serious difficulty for people living in these areas to access adequate care, due to the shortage of health personnel, inadequate and often long distances to health facilities and long waiting times.

Unfortunately, the problem is likely to go unaddressed by the funds made available by the National Recovery and Resilience Plan (NRRP): only 16-17 percent of the community homes and hospitals, in fact, will be built in these areas. Overcrowding in the offices of general practitioners and paediatricians is especially evident in the north of the country, while the shortage of hospital gynaecologists affects not only Caltanissetta, where there is one hospital gynaecologist for every 40,565 women, but also Macerata, Viterbo, La Spezia and three provinces in Calabria (Reggio Calabria, Vibo Valentia and Cosenza).

These are some of the data that emerged from the report that was presented in Rome on January 19, 2023 by Cittadinanzattiva during the conference "Health Needs in Inner Areas, Between Medical Desertification and NRRP," which was the final event of the national phase of the European project AHEAD. Further reading on the national event can be accessed here.

The project saw the implementation of a first phase at the local level in which two pilot projects were carried out: one in Piedimonte Matese in Campania and one in Avola-Noto in Sicily. In these two contexts, activities were conducted to collect testimonies and instances from the main stakeholders, such as: representatives of citizens and patients, health professionals, and local institutions at multiple levels. Through the realization of interviews, questionnaires and focus groups, it was possible to outline an illustrative picture of the difficult health situation in these territories, largely referable to the phenomenon of medical desertification.

The challenges that emerged were:

- The serious shortage of primary care physicians (general practitioners, free choice paediatricians[1]) and specialists;
- unacceptable service response times;
- lack of adequate facilities to cope with emergencies (emergency rooms and Level I DEA[2] hospitals), as well as
- the needs of territorial medicine (failure to reactivate closed outpatient clinics).

Starting with these, Cittadinanzattiva extended the research to the national level, with the aim of analysing these aspects throughout the country. This was faced with a few difficulties, given the scarcity of officially collected data that was publicly accessible.

The research led to the drafting of a report – which was presented during the national event - also containing specific regional focuses, elaborated by Cittadinanzattiva from the official data provided by the Ministry of Health from 2020, concerning 5 different healthcare figures (general practitioners, paediatricians of free choice, hospital gynaecologists, hospital cardiologists and hospital pharmacists) for each Italian province.

The national event made it possible to share the critical issues that emerged during the two local pilot phases and proposals to address them, but also to proceed to further analysis national data and to formulate concrete proposals to address medical desertification in the country.

In particular, thanks to the presence of representatives of the main national stakeholders, the conference provided an opportunity to:

- Report in a timely manner the health needs in the inner areas of the country, starting with the difficult access to care, also caused by medical desertification, which does not only affect the 5 professional categories highlighted by the project.

- To present an online tool - consisting of interactive maps and created as part of the AHEAD project - containing information, for each province, on certain categories of health professionals engaged in public hospitals (hospital gynaecologists, hospital cardiologists and hospital pharmacists) and primary care (general practitioners and paediatricians of free choice). This tool aims to make the collected data accessible and usable to all and, in particular, to institutions and the media.

- Reflect on how the resources provided by the NRRP can be an encouraging response to the needs of local communities.

- Discuss possible solutions on a national scale.

[1] In Italy, people have the right to have general practitioners and paediatricians working in the SSN who treat their patients free of charge. Besides them, there are also 'free-choice' paediatricians and specialists who work 'privately'. In these cases you pay (sometimes a lot) for all visits. They are called this way because in these cases you are free to choose them.

[2] Dipartimento di Emergenza Urgenza e Accettazione (Department of Emergency Urgency and Admission)

In this regard, in view of the complexity of the problem and taking into account the need to address the issue of care with a tailored and participatory approach, a **number of proposals** were made, and are listed below:

1) Allocate more resources for both health personnel and technological advancement (including the widespread diffusion of broadband), especially in inner and remote areas which present more critical issues.

2) Ensure the training and updating of digital skills of health personnel, including through ad hoc agreements and platforms to be developed in collaboration with professional associations (e.g. to ensure tele-counselling and tele-rehabilitation services).

3) Fundamental to dialogue among all stakeholders and implement a participatory approach (e.g. consensus building methodology) so as to ensure structural policies, co-design, and the organization of services that can respond to challenges in a coherent and informed manner.

4) Ensure annual census update, publication of data on health professionals (including data on municipal level, for in-depth analysis), and other indicators that can be used to define the stage of medical desertification in a region/locality, by the Ministry of Health and individual professional associations.

5) The growing inattention to the segments of the population that fall within the developmental age makes it imperative to collect and elaborate data and indicators that allow for the adjustment and planning of health care work dedicated to serve their needs.

6) It is necessary for LEAs (Essential Levels of Care) to measure the quality of territorial care provided, and it would be useful to develop an atlas of medical desertification that takes into account indicators developed for each ASL (Local Health Authority). This is necessary to be able to proceed with an extensive and concrete monitoring of the actions put in place.

It is important to highlight the impact of the national policy dialogues in Italy, which was documented in a series of published articles, which can be found here. Additionally, we want to note the important contribution of the vice president of the professional association of Surgeons and Dentists (OMCEO) from the largest province in Italy, Rome, in this article piece. It quotes:

"We do not think that the current idea of reforming territorial medicine, based on the creation of community homes, can be an answer,' the vice-president of the Rome Omceo emphasises, 'unless there is a major investment in the human capital of doctors and health workers, because otherwise there is only a risk of changing the name plate of health homes, then calling them community homes.

"The other danger,' De Lillo points out, 'is that of wasting NRRP money on real estate investments and not on the human capital made up of doctors who have to work in the area, whether they are general practitioners, continuity of care doctors, or specialist doctors who

can create the capillary territorial network that an efficient and modern healthcare system needs.

"All this," he also declares, "is certainly to the detriment of citizens, who risk having, especially in the next few years, difficulty in finding a free-choice doctor and, in any case, especially for those living in the province's smallest municipalities or in suburban areas, the greatest risk is that of having one at an ever greater distance, with territorial areas uncovered by the network of family doctors.

Yet there is a solution. "The recipe passes through the enhancement of the doctor, of the health worker as the cornerstone of the National Health Service. We need to invest more in the training of an increasing number of doctors, specialising more doctors, graduating more doctors, training more general practitioners, and above all - concludes De Lillo - making this profession attractive and preventing our young people from going abroad, where doctors have higher salaries'.

Final comment

As mentioned above, one of the major difficulties encountered in the progress of the work conducted under the AHEAD Project involved the lack of certain, up-to-date and easily available data related to the health workforce.

This, creates severe challenges with facilitation of planning of interventions and allocation of resources, and also creates issues related to the transparency of information that should be easily accessible, at least to relevant professionals and researchers.

In fact, the reforms also envisaged by the NRRP will be able to have the desired effects only if the investment on facilities - community homes and hospitals in the first place - is matched by an adequate investment in health personnel. Likewise, it is necessary to locate facilities dedicated to health by aiming to strengthen the weak areas of the country, taking into account the nature of the territories and not just an arithmetic logic that looks only at the number of inhabitants.

For this reason, on the occasion of the 17th European Patients' Rights Day, scheduled for April 18, 2023, Cittadinanzattiva will promote a national and local mobilization in support of the Italian National Health Care System and for a reform of territorial care that is truly tailored to the territories.