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Community Care Homes
in Italy’s Primary Healthcare Reform

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Alla mia famiglia

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Introduction

The progressive ageing of the population, the rising prevalence of chronic and multi-morbid conditions, and the increasing complexity of health needs are exerting unprecedented pressure on healthcare systems worldwide. These structural dynamics are further intensified by persistent economic and social crises, which constrain public resources and amplify concerns regarding the long-term sustainability of health expenditure. In the Italian context, these challenges have acquired constitutional relevance following the reform introduced by Constitutional Law No. 1/2012, which amended Article 81 of the Constitution by embedding the principle of a balanced budget. This reform has significantly reshaped public financial governance, requiring a stricter alignment between expenditure commitments and available resources, and thus imposing new constraints on the organisation and delivery of healthcare services.

Within this evolving institutional and socio-economic landscape, traditional hospital-centred models of care appear increasingly inadequate. Originally designed to address acute and episodic conditions, such models are poorly suited to managing chronic diseases, which require continuity, integration, and long-term patient engagement. Moreover, hospital-based care is often associated with higher costs and inefficiencies when used to address conditions that could be more appropriately managed in community settings. As a result, the progressive de-hospitalisation of care has emerged not only as a clinical necessity but also as a strategic response to sustainability constraints.

Territorial and community-based healthcare settings provide a viable pathway to address these challenges. By bringing services closer to patients, enhancing accessibility, and fostering multidisciplinary collaboration, these settings enable a transition from reactive, hospital-based care to proactive, integrated, and patient-centred models. This transformation has the potential to simultaneously improve health outcomes and optimise resource allocation, thereby reconciling effectiveness and efficiency within public healthcare systems.

Italy represents a particularly relevant case for analysing this transition. Despite early efforts to strengthen primary care—such as the introduction of *Case della Salute*—the Italian National Health Service (Servizio Sanitario Nazionale, SSN) has historically remained characterised by a hospital-centric orientation and significant regional disparities in the development of territorial services. The COVID-19 pandemic exposed the structural weaknesses of this model, highlighting the limited integration between hospital and community care, the fragmentation of service delivery, and the inadequacy of territorial infrastructures.

In response, Italy launched a comprehensive reform through the National Recovery and Resilience Plan (PNRR) and Ministerial Decree No. 77/2022 (DM77), which together define a new organisational architecture for territorial healthcare. At the core of this reform lies the establishment of Community Care Homes (*Case della Comunità*, CCHs), conceived as integrated hubs for the delivery of multidisciplinary, proximity-based care. These structures are intended to coordinate health and social services, strengthen prevention and chronic care pathways, and leverage digital technologies to enhance accessibility and continuity.

However, the implementation of this reform unfolds within a highly decentralised system, where regional and local contexts significantly influence its trajectories. In particular, late-adopter regions—characterised by weaker territorial infrastructures—face substantial organisational, technological, and professional challenges. In such contexts, Community Care Homes represent not merely an incremental development but a radical organisational innovation, requiring the creation of new infrastructures, the reconfiguration of professional roles, and the development of integrated governance mechanisms.

Research Gap and Contributions

Despite the growing body of literature on primary care reform and the reorganisation of territorial healthcare systems, several critical gaps remain.

First, existing studies have predominantly focused on regions with relatively mature territorial infrastructures, while the implementation dynamics in **late-adopter contexts**—where Community Care Homes must be developed from the ground up—remain underexplored. These contexts are particularly relevant, as they reveal the organisational and institutional challenges associated with radical, rather than incremental, transformations.

Second, although digitalisation is widely recognised as a key enabler of healthcare reform, the literature has primarily addressed its technological dimension, often overlooking the interplay between **digital innovation and organisational readiness**, including issues related to professional skills, interoperability, and governance.

Third, the **role of healthcare professionals**, and particularly General Practitioners, has not been sufficiently investigated in the context of territorial reform. While policy frameworks assign them a central role, limited empirical evidence exists on their perceptions, levels of engagement, and capacity to act as promoters of organisational change.

Finally, theoretical contributions conceptualising Community Care Homes as **integrated innovation ecosystems**, combining organisational, technological, and professional dimensions, remain scarce and fragmented.

Against this background, this dissertation contributes to the literature in several ways.

From a **theoretical perspective**, it advances the conceptualisation of Community Care Homes as multi-level innovation ecosystems, highlighting the interdependence between structural, digital, and professional components.

From an **empirical perspective**, it provides original evidence from a late-adopter context, offering insights into the challenges and dynamics of implementation where territorial infrastructures are still under development.

From a **policy and managerial perspective**, it identifies the conditions under which territorial healthcare reforms can be effectively implemented, emphasising the central role of professional engagement, organisational alignment, and participatory governance processes.

Research Questions

Against this background, this doctoral thesis aims to investigate the implementation of Community Care Homes within the Italian healthcare reform, conceptualising them as complex innovation ecosystems and analysing the conditions under which they can effectively function.

To address this overarching aim, the study is guided by the following research questions:

RQ1. How are Community Care Homes conceptualised within the Italian healthcare reform, and to what extent can they be understood as innovation ecosystems integrating organisational, technological, and professional dimensions?

RQ2. What misalignments emerge between policy design and local implementation in the development of territorial healthcare services, particularly with regard to digitalisation and organisational readiness?

RQ3. How do healthcare professionals—especially General Practitioners—perceive and interpret the ongoing reform, and what factors influence their engagement in the implementation process?

RQ4. What organisational, institutional, and professional conditions enable or hinder the effective functioning of Community Care Homes in late-adopter contexts?

Methodological Approach

This doctoral research adopts a **mixed-methods research design**, combining qualitative and quantitative approaches to capture the complexity of territorial healthcare reform and to provide a comprehensive understanding of both policy design and implementation processes.

The choice of a mixed-methods approach is grounded in its suitability for addressing complex, multi-dimensional research questions, particularly in contexts characterised by institutional plurality, organisational diversity, and professional heterogeneity. Following established methodological frameworks, the research design integrates different methods to achieve multiple purposes, including **triangulation**, **complementarity**, **development**, and **initiation**. In this sense, qualitative and quantitative methods are not treated as alternative strategies but as complementary tools that allow for a richer and more nuanced analysis.

The research unfolds through a sequential and iterative process.

The first phase consists of an extensive **desk analysis** of policy documents, legislative frameworks, institutional reports, and academic literature. This phase aims to reconstruct the design of the reform, identify its underlying assumptions, and conceptualise Community Care Homes within the broader framework of healthcare innovation ecosystems.

The second phase adopts a **qualitative exploratory approach**, based on semi-structured interviews with key informants and focus groups with General Practitioners. This phase is informed by a case study methodology and relies on purposive sampling to identify knowledgeable actors involved in the implementation of the reform.

The qualitative data are analysed through **thematic content analysis**, using a theoretically informed coding scheme derived from the literature on healthcare innovation, organisational change, and digital transformation.

The third phase consists of a **quantitative survey**, developed on the basis of insights emerging from the qualitative analysis. The questionnaire is administered to General Practitioners within the Local Health Authority of Pescara, ensuring a high level of representativeness. The survey aims to operationalise key constructs—such as professional engagement, perceptions of the reform, organisational readiness, and prior aggregation experiences—and to statistically assess their relationships.

This sequential design reflects a **developmental logic**, where qualitative findings inform the construction of the quantitative instrument, and where the integration of results allows for a more comprehensive understanding of the phenomenon under investigation.

Structure of the Thesis and the Four Empirical Studies

The dissertation is structured around four empirical chapters, each addressing a specific dimension of the research questions and collectively contributing to a comprehensive understanding of the implementation of territorial healthcare reform.

Chapter 1 develops the conceptual foundations of the study by analysing Community Care Homes as healthcare innovation ecosystems, with particular attention to the evolving role of General Practitioners.

Chapter 2 examines the digital transformation of territorial healthcare, focusing on the alignment between national policy design and local implementation practices.

Chapter 3 investigates the gap between service design and actual implementation, highlighting the organisational, infrastructural, and cultural barriers that emerge in practice.

Chapter 4 presents a quantitative analysis based on a survey of General Practitioners in the Local Health Authority of Pescara, exploring perceptions, levels of engagement, and determinants influencing attitudes towards the reform.

Development of the Research Questions within the Structure of the Thesis

The four empirical chapters are closely interconnected and collectively contribute to addressing the research questions.

Chapter 1 addresses **RQ1** by developing the conceptual framework of Community Care Homes as innovation ecosystems.

Chapters 2 and 3 address **RQ2** and partially **RQ4**, by identifying misalignments between policy design and implementation and analysing the organisational and contextual barriers that shape reform trajectories.

Chapter 4 addresses **RQ3** and **RQ4**, by providing empirical evidence on General Practitioners' perceptions, engagement, and the conditions influencing their participation in the reform process.

Taken together, the chapters provide a multi-level and integrated perspective, combining conceptual, qualitative, and quantitative insights to explain how territorial healthcare reforms are implemented in practice.

CHAPTER I

Community Care Homes in Italy. An analysis upon possible different trajectories and the key role of GPs¹

Chapter 1 provides the conceptual and institutional foundation of the dissertation by analysing the transformation of primary healthcare in Italy within the framework of Ministerial Decree 77/2022 and the establishment of Community Care Homes (CCHs). The chapter contextualises the shift from hospital-centred models toward integrated and community-based care, framing CCHs as complex organisational innovation ecosystems characterised by the interaction between structural, technological, and professional dimensions.

Within the overall structure of the research, the chapter primarily addresses RQ1 by developing the theoretical framework of the study and exploring how Community Care Homes can be conceptualised as integrated healthcare innovation ecosystems. At the same time, it introduces the organisational and governance challenges that are further investigated in the subsequent empirical chapters.

The chapter highlights that the effectiveness of territorial healthcare reform depends not only on the creation of new infrastructures, but also on the capacity to promote professional integration, organisational alignment, digital interoperability, and participatory governance mechanisms. The findings emphasise the relevance of local implementation dynamics and territorial heterogeneity, particularly in late-adopter contexts where Community Care Homes represent a radical organisational transformation rather than an incremental evolution of existing services.

¹ D'Andreamatteo A., Antonucci G., Arquilla P. (2023). "Community Care Homes in Italy: An Analysis of Possible Trajectories and the Key Role of GPs." Presented at XL AIDEA National Conference, 2023.

1.0 Introduction

In the last years, healthcare systems have been asked to re-design their service delivery processes. Important steps in this direction are represented by the frame of reference on Primary Care by the EU Commission in 2014 (EC, 2014), and specially by the 2018 Astana Declaration by the World Health Organisation (WHO, 2018), which states the necessity to strengthen health systems by investing in Primary Health Care.

The Covid health crisis contributed to accelerating the transformation towards the creation of health value to patients within the entire value network (Stabell, 1998) of professionals, organizations, and institutions involved in the service supplying within a specific geographical area. It is indeed clear now, that the shaping of the post pandemic period is in our hands (Katzourakis, 2022) and specially in the way in which we are getting out of it and its legacies. In many countries, the way to overcome Covid-19 and re-set the public sector system has been largely considered as the “hardest challenge of the century” (OECD, 2021a).

Consequently, the worldwide general regard of public health services and the consideration of medical research have changed (Bargain and Aminjonov, 2020). Healthcare systems have been indeed asked to totally re-design their service delivery processes by disrupting the “in-hospital” paradigm of service providing. This is because it has been demonstrated the importance of placing primary health care at the core of the caring system, both to manage an unexpected surge of demand and to maintain continuity of care for all (OECD, 2021b).

In Italy, the National Plan of the European Union Programme “Next Generation EU” (PNRR) is strategic in this process of healthcare innovation. A specific pillar of Mission 6 of the PNRR (M6-PNRR) allocates approximately € 15,6 billions to support asset investments in Proximity Assistance and Telemedicine (7.0 billions for strengthening and reorienting the Healthcare System towards a model centred on local areas and social and healthcare networks) and Healthcare Innovation,

Research, and Digitisation (8.6 billions for disseminating telemedicine strengthening the healthcare system's information and digital tools) (PNRR, 2021).

Among the others, it has been found the necessity of innovating the first access point, by redesigning the system towards an effective gatekeeping, with the involvement of GPs and the reengineering of the territorial health system (AGENAS, 2022).

Starting from the above considerations, this Extended Abstract reports about an ongoing research, run upon the fundamental role of the so-called “Case della Salute” that is Community Care Homes (CCH). Considering the theories on ecosystem innovation in healthcare, we aim at investigating the gaps between the different ideas and design by the policymakers and the correspondences by the side of health operators, concentrating our analysis upon the different possible roles of General Practitioners (GPs). We decided to use a mixed methods approach, starting from a desk analysis to then run semi-structured interviews to high-qualified experts and finally the submission of a questionnaire to GPs, to understand which are the distances, and thus which are the problems, in the actual implementation of a new (or reengineered) health service through the development of CCHs. Our results so far are depicting the crucial role of GPs in defining what kind of service might be implemented. We particularly consider the relevance of the full involvement, of all the health operators, since the preliminary phases, before the actual implementation, as a guarantee for a more effective health service execution, really able to create public value for users.

2.0 Theoretical Background

Since the beginning of the 2010s (if not even before) western countries’ governments have been looking for a way to improve quality and efficiency of health systems. The strategy of this decade mainly tries to support and ‘modernise’ the primary care sector, to better engage with the rest of the health care system (Armitage et al. 2009). This change should be based on unification / integration of care among sectors, continuity of chronic care for patients and families, community-based health

services (Rosen et al., 2011). But if the aim and the outputs are clear, the way to achieve them is not easy to be determined (Nicholson et al., 2017), especially if we consider different specific traditions and cultural aspects.

It has been indeed noted that the need of these reforms, especially in countries with Public National Health Services, arrives after decades in which public health systems were permeated by reforms inspired by New Public Management theories and principles (Cairney, 2002) whose efficacy, in such a peculiar system as healthcare, has not been really a success (Andrews et al., 2019). In these years, on the contrary, instead of an increase in efficiency and effectiveness, we have been witnessing a fragmentation of health services which created a complex, rapidly changing, and often impersonal health system, difficult to be managed for the well-being of citizens (Jackson et al., 2010).

It must be also noted that the demand of healthcare services is changing a lot. Indeed, on one side, the aging of the population is increasing patients with multi-pathological chronic conditions (Hajat & Stein, 2018). Moreover, most of the patients are, nowadays, more informed thus leading to a rise of expectations from public health care systems (Parker, 2006). On the other hand, there are, anyway, financial pressures which require public healthcare organizations to provide more and better services with equal (if not decreasing) resources (Gabutti et al., 2017). Healthcare systems are therefore destined to change, requiring outstanding levels of performance in terms of quality, efficiency, as well as equity and appropriateness (Zaadoud et al. 2021).

In the last years, several studies have been increasing our knowledge and understanding about the notion of public value (Bracci et al., 2019) and the aspects related with public value in healthcare (Heath et al., 2021) deepening, among the others, aspects related with co-production in public services and health organisations (Loeffler and Bovaird, 2019; Cluley and Radnor, 2020). Moreover, several researchers investigated the upshots of the Covid 19 pandemic. This aspect has been mostly investigated at level of government initiatives (Ferry et al., 2021; Wang et al., 2021) as well as a

“booster” of innovation, both of services and strategies (Cepiku et al., 2021) especially linked with digitalization in healthcare and telemedicine development (Agostino, et al., 2020; Leite, et al. 2020).

Being in this streamline, we intend to investigate both role and importance of the CCHs as “re”-formulated in the PNRR, thus intended as nodes for the creation of public value in the Italian health caring system.

CCHs are indeed not a novelty in the Italian National Health Service. Although having different names, and different regional planning and actual implementations, they have been present in Italy for more than 10 years (Del Vecchio et al., 2016; Morando et al., 2017).

A preliminary definition of CCHs can be found in the Law 296/2006 (Art. 1, section 806, point a), where they are defined as multipurpose facilities, capable of providing all the health and socio-healthcare services in the same physical space, promoting, through the spatial contiguity of services and operators, the unity and integration of the essential levels of both health and socio-health services. Along the years several interpretations have been designed and implemented in the different Italian regions (Camera dei Deputati, 2021).

The ‘renovated’ view of the CCHs sees them based on three distinct pillars, within an overall territorial reform (PNRR, 2021): CCH and the taking in charge of the person; the ‘Home’ as the first place of care and telemedicine; the strengthening of intermediate care and its structures. Accordingly, and differently from what happened in the past, a national scheme (Ministerial Decree 77/2022) states common structural and organisational standards for the whole national territory.

Starting from the above “new” definition of both the structure and especially the role of the CCHs, we decided to analyse them within the studies upon innovation in health care (Flessa and Huebner, 2021) taking in particular consideration aspects regarding the health innovation ecosystems framework (Iyawa, Herselman and Botha, 2016; Lepore et al., 2023).

Innovations in healthcare represents any improvement in the quality of services and/or life, being indeed a continual challenge to existing health care providers and systems (Flessa and Huebner, 2021). This implies technologies, procedures, as well as forms of organisation. Paradoxically, a huge problem in the health sector is not innovation per se, but the dissemination of innovative concepts (Berwick, 2003). Service innovation in healthcare implies new forms of logistics, advice, etc., and it is successful only if it can satisfy users' needs (Flessa and Huebner, 2021). The so-called promoters cover a fundamental role in this sense: they are key persons who allow the implementation of the change, contributing to overcoming its barriers (Gemünden et al., 2007).). They can do that because they know “how things work” and thus comprehend the innovation and perceive its perspectives (Goduscheit, 2014).

Innovation ecosystems in healthcare can be seen as the full potential, especially given by new technologies, to tackle unmet needs (Javaid and Haleem, 2019) by timely addressing patients' situations and thus being able to perform correct diagnosis, analysing plentiful variables (Frontoni et al., 2020). A great impulse in the development of innovations based upon these schemes was given by the research of solutions to fight Covid outbreak. The pandemic crisis led to the search for an ecosystem approach for new solutions, thus raising the competences of different stakeholders for achieving common important outcomes (Arribas-Ibar et al., 2021).

All the above considered, we decided to analyse the CCHs, looking at them as an innovation which could be probably effective if developed with a healthcare ecosystem approach, and we decided to particularly address, in our investigation, the role of health operators, first of all GPs, as innovation promoters for an effective development of CCHs according to their foreseen outcomes.

3.0 Methodology

Considering both the relevance and specially the multipurpose of our investigation, we decided to construct our investigation using a mixed method approach (Schoonenboom and Johnson, 2017)

particularly for aspects regarding its purposes (Greene et al., 1989; Greene, 2007) in order to look for triangulation (for convergence and corroboration) and complementarity (for enhancement, illustration, clarification); and especially for both development (to use the results from one method to help to develop or inform the other ones) and initiation (to discover paradoxes and contradictions).

The first step was represented by a desk analysis upon laws, rules, and regulations, as well as published studies and reports on CCHs. The aim, of this first part of the analysis, was to investigate design, expectations, first realisations, and preliminary analysis. All read to see if, and especially how and for what, CCHs could be seen as health innovation ecosystem.

In the second step, coherently with the qualitative explorative case sampling (Patton, 2002), we inquired the potential impact of CCHs within its real-life context, by intercepting information from rich key informants, i.e. well-situated and competent people involved in critical issues (Yin, 2014). Particularly, in this further stage of investigation, we executed exploratory targeted qualitative interviews (Bailey, 1987) with privileged witnesses, who were able to be informative as experts in the area (Weiss, 1995).

We developed the theoretical rationales for the interview protocol by drawing, first of all, items regarding literature on community health services facilities (Winpenny et al., 2016) and then, considering the relevance of digitalisation, some aspects from digital transformation literature, particularly on the pillars of digital portfolio for digital innovation framework (Schreckling and Steiger, 2017). We therefore enucleate the following items to be investigated: 1) setting; 2) facility type; 3) expected outcomes; 4) staffing; 5) role of nurses; 6) collaboration and integration with other services; 7) users centricity; 8) people mindset for digital adoption; 9) skills and obstacles for developing such a context.

A last step, coming from the analysis of the results derived from the interviews to experts, is constituted by the submission of a survey to GPs. This further step arrived after the emerging results about GPs as strategic actors for being innovation promoters for a proper implementation of CCHs.

At this stage of our research, while submitting this extended abstract, we are still working on the construction of the specific questionnaire to be submitted to GPs.

4.0 Findings

We present below some preliminary findings, from step 1 of methodology and from first elaboration of the high exploratory targeted qualitative interviews with privileged witnesses.

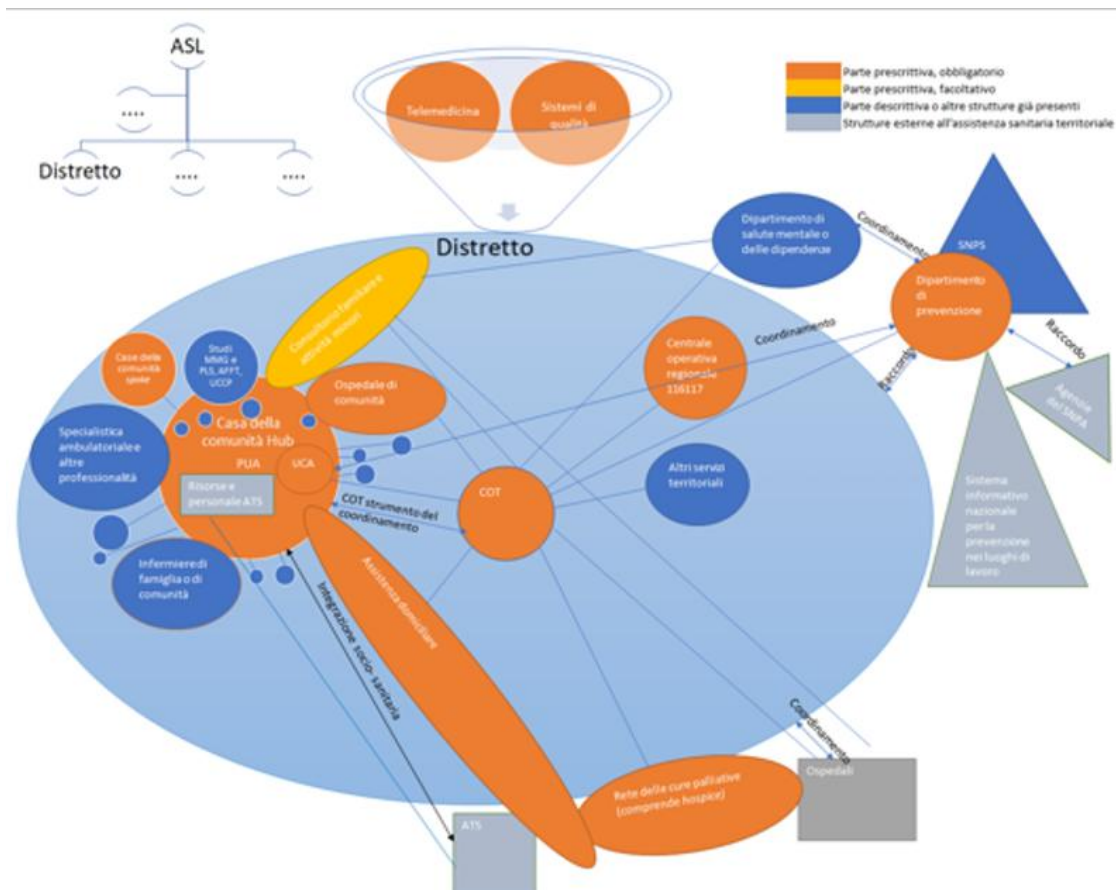
4.1 Community Care Homes as a healthcare innovation ecosystem

According to the results of our desk analysis, the CCHs can be fully considered as strategic health innovation ecosystems. Within the M6 PNRR panorama, the 1.1. refers to “Community Home and taking charge of the person”. It is therefore an investment aiming at the “territorialisation” of health care to face the demographic and epidemiological trends of the country.

CCHs aim at strengthening and reorganizing the services offered in the area, by increasing their accessibility, and consequently, improving the quality of healthcare intervention. Each CCH should be a health service access point, as designed for coordinating all the services offered in the area, with a particular focus on chronic diseases. To this end, it should be equipped by a multidisciplinary team composed by GPs, paediatricians, specialist physicians, nurses and other health professionals, being also in coordination with city hall welfare workers.

In this context a CCH should be seen as a node of a health ecosystem, being a reference point for its target population which, also through an IT infrastructure, should be able to guarantee the promotion and prevention of health as well as the continuity of cares within the specific targeted geographical area. Figure 1 shows how the scheme should be considered.

Figure 1 Model of the redesigned territorial health assistance



Source: Ufficio Parlamentare di Bilancio (2023) pag 46

In this complex scheme, CCHs are characterised by the following aspects (Del Vecchio et al., 2022):

- Physical dimension (health center) and organizational setting (service model);
- Multi-disciplinary and multi-professional integrated approach;
- Hub & Spoke logic with the provision of mandatory, optional, and recommended services and thus personnel availability;
- Nursing, health care, social, and administrative personnel standards;
- Network logic between intra CCH networks and integrated Community Hospital networks;
- Forecast of 1 CCH Hub per 40/50 thousands inhabitants;

- Distinction between regulatory requirements (no. of Hubs, personnel standards, and services to be provided) and descriptive (everything else).

To favour the accessibility to services all along the country, in particular in rural areas, it has been thought a “Hub & Spoke” scheme, thus enlarging the network of territorial care. The PNRR envisages the realisation of 1 hub and at least 3 spokes connected to it, for each Health District (1 every 30/35,000 inhabitants in metropolitan areas; 1 every 20/25,000 in urban and sub-urban areas; 1 every 10/15,000 in inland and rural areas).

In the policy-maker intentions, CCHs ought to represent an adequate response to health and social health needs of citizens. They should be organized as polyvalent and functional structures which host primary cares, by guaranteeing continuity of care and prevention activities, through the work of multi-professional staff. In particular, they are focused on taking care of chronic pathologies, in connection with other territorial providers, to increase the cost-effectiveness of cares through integration of out-of-hospital paths. In synthesis, CCHs will have to be the physical place of proximity, where the community can access, to enter in contact with the health and social-health care system (AGENAS, 2021). This is the great relevance of the “new” vision given in the PNRR, but it is, at the same time, the greatest challenge because CCHs (and other similar structures with different denominations) have been hitherto conceived and created as physical containers and “isolated” dispensing places compared to the territorial health service delivering system (Giudice et al., 2021).

A strategic component to reverse the past trend of different regional CCHs developments, is represented by the fact that extended consensus conference processes should be implemented (as made in the leading experiments in Emilia Romagna and Tuscany regions) to share the elements that should characterize the CCHs trend model. This is important for significantly diversifying them from “simple” polyclinics or district offices (Brambilla, 2021).

4.2 The GPs' strategic role and its uncertainties

Considering that CCHs ought to represent a new scheme of territorial intervention within a health innovation ecosystem, and especially considering the challenges to be afforded, we decided to investigate some aspects through interviews to the actual implementers. The aim was to collect several indications about tasks, duties, risks, etc. Primary results suggest the role of the GPs as change promoters.

This aspect is emerging not so much in the role of CCHs as reference point for the care of chronic and semi-chronic patients, rather than in the challenge of implementing them as a reference point for its target population. Particularly, we found as strategic and challenging the actual realisation of CCHs as the physical place of proximity where the community can access to enter in contact with the health and social-health care system. In other words, the comprehension of them, by the population, as polyvalent and functional structures which host primary cares and prevention activities through the work of multi-professional staff. Indeed, our investigation is confirming the relevance of addressing a more advanced realization, to be known by the whole population insisting on that territory, in order to win the challenge of identity and to enhance the effectiveness of communication to users (Giudice et al., 2021).

5.0 Conclusions

In the last years, healthcare systems have been asked to re-design their service delivery processes. Particularly, they should totally re-design their service delivery processes by disrupting the “in-hospital” paradigm of service providing. They ought to do it predominantly placing primary health care at the core of the caring system.

In Italy, this need for change, passes through the use of the PNRR funds, which foresee a specific pillar in Proximity Assistance and Healthcare Innovation, Research, and Digitisation. Within this framework a pivotal role is played by the redesigning of CCHs.

Although reporting only the preliminary results of an ongoing investigation – designed according to a mixed methods approach (which, at the moment of this submission, is concluding its second phase and planning the third one) – this extended abstract presents some relevant insights.

CCHs should be designed considering the whole health ecosystem to be developed, especially considering that previous experiences conceived and created them as physical containers, “isolated” from the territorial health service delivering system. This is the real challenge for permitting that CCHs really achieve their mission.

The analysis we are conducting through high qualified targeted qualitative interviews with privileged witnesses is revealing a risky situation. It is emerging the relevance of the full involvement, of all the health operators, since the preliminary phases, before the actual implementation, as a guarantee for a more effective health service execution, really able to create public value for users. Among the others it is particularly highlighted the strategic role of GPs as change promoters. That is why, in proceeding with our investigation, we will submit a questionnaire to them in order to look for their thoughts and considerations for an actual proper implementation of the CCHs as the fulcrum of complex but effective territorial health ecosystems.

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CHAPTER II

Misalignments in the digitalization of proximity health care services. A case study upon reforms in Italy²

Chapter 2 analyses the digital transformation of territorial healthcare within the implementation of Ministerial Decree 77/2022, focusing on the relationship between national policy design and local implementation practices. The chapter examines the role of digital technologies as enabling factors for integrated and proximity-based care, particularly in supporting coordination between healthcare professionals, continuity of care, and the integration of health and social services within Community Care Homes. At the same time, the study explores the organisational and institutional conditions required to effectively support digital innovation processes in territorial healthcare settings.

Within the overall structure of the dissertation, the chapter primarily addresses RQ2 by investigating the misalignments emerging between the strategic objectives of the reform and the operational realities of local implementation. In particular, the chapter analyses how differences in organisational readiness, technological infrastructures, governance capacity, and professional competencies influence the implementation of digital healthcare models across territorial contexts.

The findings highlight that digitalisation alone is insufficient to ensure effective territorial healthcare transformation. Rather, successful implementation depends on the alignment between technological innovation, organisational processes, and professional engagement. The chapter identifies persistent barriers related to interoperability, fragmented digital infrastructures, limited coordination mechanisms, and uneven levels of digital preparedness among healthcare organisations and professionals. These results demonstrate how digital transformation in territorial healthcare

² Antonucci G., D'Andreamatteo A., Arquilla P. (2024). "Misalignments in the Digitalization of Proximity Healthcare Services: A Case Study on Reforms in Italy." Presented at ITAIS Conference (2024); and published in M. Cipriano, A. Lazazzara, L. Caporarello, Technologies for Organizations and Society, Springer, (2025)

represents not only a technological challenge, but also a broader organisational and governance process that significantly shapes the effectiveness of Community Care Homes and the broader primary healthcare reform.

1.0 Abstract.

The use of ICT resources in healthcare has been growing since the 2000s because can lead to cost saving, time saving, errors reduction, improvement of medical practice. In Italy, Mission 6 of the National Recovery and Resilience Plan (M6-PNRR) allocates 8.6 billions for disseminating telemedicine strengthening the healthcare system's information and digital tools. Considering the theories on ecosystem innovation in healthcare, this study, using a mixed-method approach, investigates the gaps between ideas and design by the policymakers and the correspondences by the side of health operators. Our results confirm that, a huge problem in the health sector is not innovation per se, but the dissemination of innovative concepts. Service innovation in healthcare is successful only if it can satisfy users' needs. A fundamental role has been found in the GPs, seen as strategical promoters. Another important aspect has been found in Covid health crisis as a buster of digitalization, thus confirming previous research. But another important aspect has been found in the need of “educating/training” patients, thus revealing the importance of really creating a co-production scheme for developing a real effective digitalized system. The commitment and active participation of patients represents indeed a prerequisite for obtaining high adherence, but if users are culturally not keen in contributing to the process, the potential of digitalization remains unexploited.

Keywords: Digitalization, Telemedicine, Ecosystem Innovation, Health policy

2.0 Introduction

Healthcare systems, and public ones in particular, require nowadays a reform focused on Primary Care, as highlighted by the frame of reference on Primary Care by the EU Commission in 2014 [1], and by the 2018 Astana Declaration by the World Health Organisation [2]. Yet, adjustments in public healthcare systems seem to be insoluble, especially considering their persistent resistance to reforms [3 4 5].

Indeed, since the beginning of the 2010s (if not even before) western countries' governments have been looking for a way to improve quality and efficiency of health systems [6], but the different ways for optimisation, such as cost control and quality management, have been challenged by several tensions [7].

To overcome the difficulties for the actual implementation of the needed changes, a great role has been now allocated to Information and Communication Technology (ICT) and to digitalization [8]. The use of ICT resources in healthcare has been growing since the 2000s [9], given that digitalization can lead to cost saving [10], time saving [11 12], errors reduction [13 14], improvement of medical practice [15 16]. Nowadays digitalisation of healthcare constitutes a central component of pervasive healthcare and represents an important instrument to increase health promotion, disease prevention, provision of care, and monitoring [17].

Moreover, the Covid health crisis challenged this ongoing progression, clarifying that the determination of the post pandemic is in our hands [18] as the reset of public sector system, after Covid, has been deemed the “hardest challenge of the century” [19]. Particularly, within public healthcare systems, the pandemic had two important effects. First, it led a positive change on the esteem of public health services and the respect of medical research [20]. The Covid19 crisis is indeed contributing, in requesting a tailored assessment of the value-based healthcare creation [21], necessitating the involvement of professionals, organizations, and public institutions in charge of the service supplying, together with an active role by the patients [22]. Secondly, the pandemic led to an increased use of digital tools, thus transforming our working arrangements as well as our interactions

[23] and it was also a “booster” of innovation in the whole public sector [24 25 26] and in the healthcare in particular [27].

Consistently, among recent endeavors of improving healthcare systems, governments have launched policy initiatives to foster digitalization in healthcare (e.g. [28], even more in the post-pandemic era [29]. Health policy design and implementation have a relevant role in improving the performance of healthcare systems. Scholars recognize the power of policies to enhance the health and well-being of a population [30 31], although not all the policies are implemented successfully [32]. Concomitantly, a growing body of research related to policy analysis has been developing to ascertain strength and pitfalls of such policies, both in the design and implementation phases. Health policy analysis is understood as <<a multi-disciplinary approach to public policy that aims to explain the interaction between institutions, interests and ideas in the policy process>> [33:308], an approach that goes far beyond the mere technical content of the policy [30]. At present, the prevalent method of research used for such an analysis is the case study methodology [33].

Accordingly, this study investigates the alignment issues between policy-driven digital healthcare reforms and their practical implementation in a mainly public healthcare system: what are the challenges and barriers that could potentially impede the implementation of policy-driven digital healthcare reforms? In synthesis, we run our investigation with the aim of exploring and understanding possible causes and risks of misalignment between the reform plan on health digitalisation and its actual implementation in the field, especially at local level where primary proximity cares are delivered.

Rooting in the tradition of qualitative studies, we used case study research [69]. We chose the Italian National Health Service (INHS) as unit of analysis, essentially because the central Government has recently launched the massive Plan of investments of the EU Programme Next Generation EU, Mission 6 of the National Recovery and Resilience Plan (M6-PNRR), with the aim of strengthening the healthcare system's information and digital tools [30]. The plan allocated approximately € 15.6 billion to support asset investments in Proximity Assistance and Telemedicine, having 8.6 billion for

disseminating telemedicine. Further, the INHS has specific features that make it an interesting unit of analysis. First, Italy is one of the countries with the most aged population and with the necessity to modify its public National Health Service [35]. Second, it is a decentralized public health system, a setting which has great disparities among the territories in terms of quality and expenses [36]. Despite these disparities and problems, the systems had the potential to reach significant outcomes for its population. During Covid pandemic peaks, for example, the local branches of Italian National Health Services reacted promptly through a community co-production approach [25]. Third, the central Government recently launched a major reform redesigning primary healthcare in all the country, in which digitalization is one the levers to implement the reform.

To achieve our research aim we decided to focus on digitalization at the level of proximity caring, within a larger ongoing research upon Community Care Homes in Italy, and started from a desk analysis [34] to then run semi-structured interviews to high-qualified experts and finally managing two focus groups with GPs. To design our research and interpret results, we deemed useful to apply the theories on ecosystem innovation in healthcare [38 39], searching for possible gaps between the different ideas and design by the policymakers and the correspondences by the side of health operators who actually deal with the proper digitalization of the public primary system, being in direct contact with their users.

Next section informs about the theoretical background, while section 3 describes the research methodology. In section 4 findings from the desk research, interviewees and focus group are presented. Section 5 contains discussion and conclusion.

3.0 Theoretical Background

In order to completely reform Healthcare systems, especially public ones, we ought to overturn the “in-hospital” paradigm. It is necessary to place primary health care as the core service of each caring system. For this reason we ought to manage the flows of the demand being able to maintain continuity of care for all [40]. It is therefore necessary to integrate caring among sectors, maintaining continuity of chronic care, and community-based health-services [43]. The point is that this target cannot be settled easily [44].

This is particularly factual in contexts having Public National Health Services which had, in the last years, reforms inspired by New Public Management theories and principles [43] whose effectiveness, in such a unique context as healthcare, has been contested [44]. This is because, especially since the new millennium, we are witnessing a ruining of public health services rather than their increase in efficiency and effectiveness, leading to an always changing complex, and thus impersonal, health system, not able to respond to citizens’ needs and also difficult to be managed [45].

Indeed, the demand of caring services is transforming a lot because the aging of the population, particularly in more developed countries, is increasing the number of multi-pathological chronic diseases [46]. Moreover, nowadays most patients are more informed, thus claiming for better and personalized caring services according to advancement in medical knowledge [47]. The demand for more and better services has, on the other hand, to cope with financial sustainability, in a context of limited public resources [48]. It is therefore necessary to change public healthcare systems, aiming at both quality and efficiency, as well as equity and appropriateness [49].

In recent years, many studies have been increasing our knowledge and understanding about the notion of public value [50] and public value in healthcare [51] developing, issues concerning co-production in public health services [52 53]. Additionally, many researchers are investigating the consequences of Covid 19 pandemic as a “booster” of innovation, both of services and strategies [25] especially linked with digitalization and telemedicine [24 27].

Following this path, we aim at investigating both role and importance of proximity healthcare digitalisation and telemedicine implementation as planned within Italian healthcare reforms linked to PNRR.

Digitalisation and telemedicine services implementation had a fast growth during Covid crisis [54]. All healthcare systems are moving towards a setting with an intensive presence of virtual components in caring systems, modifying completely health services provision [55 56]. This happened also to the Italian Public National Health Service that, before Covid, had “simply” formally transposed national guidelines launched in 2014 as a first attempt to give a “glossary” in a common national scheme [57]. Since Covid crisis, several regions (being Italian NHS governed at regional level) launched specific norms and regulatory statements to activate tele-examinations as interaction at distance between MD and patient [57].

This innovation is in line within the PNRR Mission 6 devoted to the primary care reorganisation, innovation, and implementation (M6-PNRR). It foresees, among the others, “Telemedicine to a better support to patients” allocating 1B€ (1.2.3 M6-PNRR) divided in 250 M€ to implement a national Platform for Telemedicine and 750 M€ to design and implement regional projects of telemedicine (Ministerial Decree 01/04/2022) meanwhile, with the Law 25/2022 (which modified previous Legislative Decrees) the National Agency for Regional Health Services [58] was attributed of the further role of National Agency for Digital Health (ASD) thus ratifying an evolution also in the governance of the regional health systems.

Starting from the above “new” definition of both the structure and especially the role of telemedicine within the Italian health service, we decided to analyze it within the studies upon innovation in health care [59] taking in particular consideration aspects regarding the health innovation ecosystems framework [38 39].

Innovations in healthcare represents any improvement in the quality of services and/or life, being indeed a continual challenge to existing health care providers and systems [59]. This implies technologies, procedures, as well as forms of organization. Paradoxically, a huge problem in the

health sector is not innovation per se, but the dissemination of innovative concepts [60]. Service innovation in healthcare implies new forms of logistics, advice, and reporting, and it is successful only if it can satisfy users' needs [59]. The so-called promoters cover a fundamental role in this sense: they are key persons who allow the implementation of the change, contributing to overcoming its barriers [61]. They can do that because they know "how things work" and thus comprehend the innovation and perceive its perspectives [62].

Innovation ecosystems in healthcare can be seen as the full potential, especially given by new technologies, to tackle unmet needs [63] by timely addressing patients' situations and thus being able to perform correct diagnosis, analyzing plentiful variables [64]. A great impulse in the development of innovations based upon these schemes was given by the research of solutions to fight Covid outbreak. The pandemic crisis led to the search for an ecosystem approach for new solutions, thus raising the competences of different stakeholders for achieving common important outcomes [65].

All the above considered, we decided to analyze the ongoing modifications of Italian public health systems looking at them as an innovation which could be probably effective if developed with a healthcare approach, and we decided to particularly address, in our investigation, not the digitalization and telemedicine design per se, rather than the path for its actual implementation, thus investigating the role of health operators as innovation promoters for an effective development of digitalization and telemedicine according to their foreseen outcomes.

4.0 Research design and method

Considering the multipurpose aim of our research, we chose to frame it using a mixed-method approach [66, 67 e 68] informed by case study research [70]. We chose the INHS as a unit of analysis, on which we focused on two different steps.

The first step was represented by a desk analysis, i.e. a <<research strategy of using existing data sources>> [34:103], such as laws, policy briefs, commentaries, literature reviews, etc. Desk analysis is useful when trying to understand the context of the investigated phenomenon. Accordingly, we searched for laws, rules, and regulations, as well as preliminary possible published studies and reports regarding the digitalization and telemedicine within the reforms of the Italian Public Health Service stated in the PNRR. All read to see if, and especially how and for what, the ongoing process of digitalization could be seen as a health innovation ecosystem.

The second stage saw a qualitative explorative case sampling [69]. We investigated the prospective effects of digitalization in a proper reforming context, by collecting information from key informants involved in critical issues [70], through both semi-structured interviews and focus groups. Specifically, we managed exploratory targeted qualitative interviews [71] with privileged witnesses who were experts in the area [72].

We sketched the theoretical rationales for the interviews depicting the issues from the literature regarding community health services facilities [73]. We based our construct on the work by Srinivasan and Chandwani [74] who studied managers' role in an evolving health organization domain. We had as reference point also the research by Mergel et al. [8] upon digital transformation processes in public service facilities. We therefore create a specific questionnaire based on the following questions:

- Is the Italian public health sector changing? And how?
- What is the degree of digital skill in Italian public community services?
- Is there a positive attitude toward digital transformation?
- After the reform did your organization digitally transformed itself?

Within a larger, still ongoing, research upon Community Care Homes in Italy, we had the possibility to interview personnel belonging to two different Italian regions and to 4 different Local Public Health Territorial Services (ASL), in order to gather insights, not only for a specific case, but also about general indications coming from different contexts. Being the basic elements of a healthcare innovation ecosystem, we decided to select, for our interviews, personnel belonging to key roles in the implementation of the change. In other words, if GPs were found as promoters of the change (and therefore object of the two focus groups as showed later on in this section) we decided to interview the different points of entry of the change, that is those covering key roles in the management of local Italian NHS services.

In particular we interviewed:

- A Head of a unit of coordination and management of public primary care and local territorial services
- A Responsible for public psychiatric territorial services
- A Head of a public General Medicine Operating Unit.
- A MD and President of a Conference of Mayors for public local health services.

Moreover, considering the fundamental role of the promoters of the change, we run two focus groups with 9 GPs who represented the whole spectrum of the unions in Local Public Health Territorial Services (ASL). In other words, managing two focus groups with the different representatives of the category, we had the possibility to cover ideas, sentiments, experiences of the GPs of a whole local unit (ASL).

Interviews took place between June and November 2023 and were conducted (as well as the focus groups) in both the interviewers' and interviewees' native language (Italian). The average interview lasted about 20 min each.

Focus group one – dedicated to acquire information about the process services innovation – was managed in January 2024, lasting 85 min, while the Focus Group 2 – specifically devoted on

telemedicine issues as a deepening of previous investigation – took place in May 2024, lasting 40 min.

The records were firstly transcribed and then analyzed thanks to a content analysis [75], framed on deductive thematic analysis, obtained by theoretically-driven coding [76]. Specifically, the works by Winpenny et al. [73] and Srinivasan and Chandwani [74] allowed us to define the following items: 1) facility type; 2) expected outcomes; 3) staffing; 4) collaboration and networking among services; 5) users' centricity. Considering that we had no previous data to assist with coding, we opted not to use any specific computer-assisted software. The final results were translated in English to allow the final editing of this work.

5.0 Findings

Our investigation, in confirming that the ongoing reforms and digitalization of Italian public health system can be seen as a healthcare innovation ecosystem, showed also a kind of misalignment between policy-driven digital healthcare reforms and their practical implementation in a mainly public healthcare system. Particularly, we found a detachment between the reform plan on health digitalization and its actual implementation on the field, especially at local level, where primary proximity cares are delivered.

The findings show indeed that the real problem is not innovation per se, but the dissemination of the basic innovative concepts, those able to modify health services delivering in a successful way, namely really able to satisfy users' needs. In this sense we found the GPs as the crucial link, being them the strategical promoters of the change. A full commitment of them is essential, but if you want to have their commitment you first need to have their understanding of the change, and to have it you need to inform them. In synthesis without involvement, you cannot have commitment. On the contrary we discovered, for instance (see following paragraphs) that no GP knew that the electronic health record was already developed and that they could use it in assisting patients.

Moreover, our research found that you cannot see only at one side, but you need also to consider the other one, that is those of the recipients. Such a change, as a service digitalization, cannot indeed be unidirectional, but needs also an active role by the users' side. In this sense we found that an important aspect regards the need of “educating/training” patients, thus disclosing the relevance of creating a co-production scheme for really implementing operative digitalized systems. Indeed, the engagement of patients is important to have collaborative users, but if they are traditionally not keen in being part of the change, the potential of digitalization remains in name only.

This section about findings consists of two parts. We first present the results coming from the desk research, that is, as initially thought and designed by the policy makers. We then illustrate those coming from the content analysis of the interviews and the focus groups.

5.1 Digitalisation and telemedicine in the PNRR as a healthcare innovation ecosystem

The prominent result of our desk analysis regards the fact that, the ongoing reform, can be fully considered a strategic health innovation ecosystem. As previously mentioned, within the M6 PNRR panorama, there is a specific measure entitled “Telemedicine to a better support to patients”. Furthermore, the National Agency for Regional Health Services (AGENAS) entrusted the additional role of National Agency for Digital Health (ASD), thus sanctioning the digitalized change, at national level, of the governance of the regional public health systems.

There is furthermore the clear aim to improve regional assistance in the area of primary and intermediate care, through technological and digital transformation [77]. This modernization aspires to define a strategic vision for telemedicine. It indeed starts giving a clear definition of regional strategies on digital health and governance of the relevant ecosystem [78]. Within this definition there is the implementation of a digitalized renewed information system in health service facilities to adapt and homogenize the that already in use, where territorial health services (maybe for the first time) are the core elements of these reforms [79].

A first important step can be found in the agreements between national Government and the different Regions, in December 2020. They clearly defined both the rights and responsibilities of the parties respecting the relevant general framework of the homogeneity of basic services within all the Italian territories, stating that [80]:

- the doctor is responsible for deciding in which situations tele-consultations can be employed in favor of the patient
- during the tele-consultation it must always be guaranteed the ability to exchange on time real clinical data, medical reports, images, audio and video
- the activation of the service requires a prior intention of the patient that must be preceded by adequate information in so that the patient is aware and well informed about the visit methods, advantages, risks, and protection of his/her personal data.

Another relevant aspect is represented by the clear definition, at national level of the different assisted ICT interventions and caring both by a single specialist and by a team. This aspect has been stated at national level through the definition of a proper “glossary” of interventions [57] as reported in the following table:

Table 1. Glossary of the implemented digitalized health services

Tele-examination	medical procedure in which the professional interacts remotely in real time with the patient, even with the support from a caregiver
Medical teleconsultation	medical procedure in which the professional interacts with one or more doctors/specialists to discuss the clinic situation of a patient, via video call or even in asynchronous mode
Medical-care teleconsulting	healthcare activity, not necessarily medical, which takes place remotely and is performed by two or more persons who have different responsibilities with respect to the specific case. It can be provided in the presence of the patient or in a deferred manner.
Teleassistance	professional act based on remote interaction between professional and patient/caregiver
Telemonitoring	telemedicine operating mode that allows continuously remote detection and transmission of vital and clinical parameters
Tele-control	remote control of the patient through a regular series of contacts with the doctor, by means of video-call in association with the sharing of clinical data

In brief, the programme “Telemedicine to a better support to patients” within M6 of the PNRR – as it has been thought and designed by the policymakers – can be definitively viewed as a relevant health innovation ecosystem, as it has been defined above. It can be seen at its full potential, given by new technologies, to tackle unmet needs [63].

But our investigation intended to deeper the analysis, taking into account the possible gaps between the planning, of an innovation in health services delivering, and its actual implementation. Particularly, we addressed the crucial role of the promoters of the change, that is the personnel working in public territorial health services, as illustrated hereafter.

5.2 The role of the personnel and the misalignments and gaps in the innovation governance

In this second part, we present the outcomes of the analysis upon the different items regarding the relevance of the personnel as change promoters in the implementation of the health innovation ecosystem, underlining the gaps between the two parties in governing this change.

Facility type

The design of healthcare facilities should see the involvement of different stakeholders, being able to align clinical as well as operational and organizational objectives. This is because it ought to consider the dynamic and complex nature of public healthcare systems, which need an equilibrium, able of both improving population health and reducing costs, trying also to improve staff work life [81].

It is anyway evident the presence of a misalignment between what thought and designed in terms of infrastructure creation and the real implementation of the reform by those who should be the promoters of the change. All the interviewed people feel they tasks as “detached” from the current system modernization stimulated by the PNRR. One of the GPs, in the first focus group, even affirmed

that “there continue to be parallel tracks and we do not know how to interact properly”. Another one stated “They do not put the pieces together. There is no unique process line: the anamnesis is “productive” not detached”. Lastly more than one highlighted referring to lack of tools: “It seems that everyday everything is urgent and must be done in extraordinary ways”.

On the other hand, by the side of the service managers, it has been underlined the strategical importance of preliminary analysis of present pathologies in order to have different planning in different realities. Thus, being in line with the impossibility of implementing a telemedicine service if not tailored according to pathologies to then obviously tailor value-based interventions for any specific case. An example in this case was given by the following statement by the responsible for public psychiatric territorial services “Yes I know, it is easy for her (referring to another interviewed person) she is an oculist, but how could you think we might develop telemonitoring with people with psychiatric disorders?”

We found also territorial differences in our investigation, highlighting different stages of implementation as a consequence of different starting points, even in the same region. In one case local services had even implemented the so called “Unique medical electronic record”, that is a virtual record which allows, all interested parties, to have a clear illustration of the actual medical situation of each patient, independently from the specialists that might have to intervene according to both previous and ongoing pathologies. But, nevertheless the system appeared implemented at the 90% at least, according to AGID, [88], that remained the only one we found, being, in all the other cases far from being activated.

Expected outcomes

This revealed itself really a contested item. This was firstly because of a different interpretation, by interviewers and interviewee, of the word “outcome”. Indeed, we designed our analysis, intending outcome as achievement of deliberated impacts, in line with the planned innovation. We therefore assumed to analyze aspects such as the extent of goals, level of accessibility by the target population, and the efficiency in the implementation [82]. But instead, by the side of health personnel, the

meaning was specifically connected to health outcomes. They therefore initially intended the effects given by a proper cure and or medication delivered by the healthcare system [83].

This initial misunderstanding can be read positively, considering that, also taking a managerial position, health personnels focus on medical results for patients. Therefore, they consider digitalization and telemedicine as tools for achieving patients' wellbeing, and only secondarily as instruments to better manage health services in terms of cost and time efficiency.

Once clarified this aspect it has been possible to collect specific insights. The first important one, on which all the interviewees agreed, is that digitalization and telemedicine are opportunities, but much will depend on how the PNRR innovation will be actually implemented. In this sense some claims by our interviewees were indicative: “for having a result you need precise protocols, not just definitions!”; “there is nowadays what I named ‘health consumerism’ that is a misperception of the aims with the goals on one side and the “measured” interventions on the other one”.

Moreover, the managers highlighted the need of a “different vision”, stating that if it is true that digital innovation is an opportunity, it cannot be seen as the panacea for solving health local services problems. In other words, monitoring and caring of patients, especially those with chronic diseases, can be better assisted, but if you still have a system which remains linked to “old processes”, innovations cannot be achieved nevertheless the expenditure in digitalization. This distrust in innovation is strictly linked to the staffing and collaboration items as illustrated hereafter.

Staffing

This item proved to be easily to be interpreted, but really sensitive. Indeed, it is absolutely not easy to handle a digitalized and telemedicine caring system, it is complicated because it must be cooperative and organizationally embedded at the same time. This means that it is necessary to correctly develop non-didactic training [83]. But the digitalization reform financed by the PNRR seems to be unreceptive to this aspect. Our analysis disclosed a lack of information and a complete absence of training.

We found that no GP knew that the electronic health record was already available to allow them to exchange information about patients' conditions. But above all, none of the interviewees had basic knowledge about telemedicine, starting from not being able to give a basic definition of it, as provided by the Ministry and presented in in 4.1. They had no information about the progress in the ongoing reform process. In this sense, a GP, in the second focus group declared "We are ill-informed, we have no capabilities, we don't know". Our analysis shows a peculiar misalignment: thanks to the PNRR funds technical tools were acquired, but the reform did not foresee proper training for the personnel. In this sense an interviewed GP claimed "it is not a matter of having inter"NET", you need a "NET"work of minds before technology"; another one stated "You first of all need to reorganize the operational system, otherwise, without knowing the process we will repeat twice or three times the same exam".

Lastly, most of the interviewees stressed on the persistence of digital divide problems, especially in aged workers, and this was linked to a lack of experience. One GP even affirmed "Before starting a battle, you have to know what forces you have, and it is not sufficient to have tools, you need personnel".

Collaboration and networking among services

To be effective, a digitalized health system must consider: health data, electronic health record system, tele-health service [84]. The PNRR health reform appears not taking into account the relevance of designing and implementing a health innovation ecosystem as described above. On the contrary it look as if in the relevance of telehealth service quality is not properly taken into account. This last aspect points out that health providers ought to give an equal quality of care, according to the same principles, regardless of the type (i.e. at-distance or in-person visits) thus being always compliant with current protocols and procedures [84]. Unfortunately, our analysis uncovered some criticalities.

If it is true that both GPs and managers declare positively about having teleconsultations and telemonitoring to interact with specialists, even if staying far away, it is also true that they see its

actual effective implementation as a utopia. This is due not only to the already described lack of retraining, but especially in the persistence of a bureaucratic system, nevertheless the reform designed by the PNRR. One GP affirmed “It would be great to have the possibility to interact at distance with specialists for a teleconsultation, but do you know that at the moment, if we want to prescribe a home assistance, we still have to fill specific forms which are given to us on printed on paper? What are you talking about? We dream simplification but we still have bureaucracy”. Still a GP maintained “We’d like to exchange information, but the daily reality is that there are no specific protocols and especially no knowledge by the side of the personnel, and I’m referring to administrative ones. I saw screens left open with all sensible data while none was working in that specific moment!”. Lastly, the majority of the interviewees stressed on the fact that “one thing is to work in urbanized areas, another is to assist people in internal ones (especially near mountains) where you would use more the possibility of teleconsultation, but you don’t even have a stable connection”.

But the crucial criticality was found in the system interoperability. We found that, there were still different operating software, not only among the regions, but even in local organizations of the same territory. One GP affirmed “They talk about the possibility of having interaction among the territories, but then my organization [referring to his one of GPs] suggested me a good management software, then the ASL [the territorial administrative branch of NHS] has another one, and the region another more! To account for our work and to allow the analysis of epidemiological data a good spreadsheet was more than enough. On the contrary we have to be linked to three licensed software providers! Where is the connection? How could we do networking?”

Users’ centrality

In drafting this item, we referred to the definition given by the EU Commission that is “putting users’ needs at the centre when determining which public services should be provided and how they should be delivered” [85]. In contrast we discovered that the interviewees, especially the GPs, were bearing in mind the issue from another point of view.

They stressed about the need of “coaching” their patients. We actually collected several statements about uninformed and “demanding” patients. “Their expectations, in such a free of charge public system, as the Italian one, made the system inefficient. In several cases there are excessive requests”; “It is a cultural aspect. With the improper use of internet, a kind of ‘self-diagnosis’ is growing and if you say them they don’t need that medical examination they tell you that you don’t know your work”; “You are talking about monitoring at distance, but do you know that we spent hours answering to telephone calls that ask what to do if they have cold or cough”. Initially we did not understand why they were portraying these criticalities while talking about telemedicine. We later comprehended that all these statements arrived at the same conclusion: “Can you imagine a patient to use a device to be monitored at distance?”. In short, the interviewees intended to stress on the fact that, apart from retraining health personnel, it is fundamental to “educate” the users. Furthermore, they explained that telemonitoring might be really useful in assisting patients with chronic diseases, but most of these needing patients, being old, have serious digital divide problems. “They call me at the telephone because they forgot the posology... How could you think I might interact with them if SMS is the only way to remotely transmit information and only few can use WhatsApp?” and another added “And those who can use it are a problem. They send pictures of the results of their self-monitoring of blood pressure being worried. On the contrary, in the majority of the cases, this is due to an incorrect use of the machine. Could you imagine them having constant telemonitoring tools?”

6.0 Discussion and conclusion

With the aim to study strengths and challenges of current policy driven digital healthcare reforms, we focused on the INHS as a unit of analysis, since two recent major reforms are reshaping the Italian context: fostering digitalization and reorganizing primary care.

A digitalization of the health system and the implementation of telemedicine services can contribute directly toward achieving 1) better health outcomes, 2) improved patient experience, 3) lower costs, and 4) improved clinician experience [86]. Telemedicine saves both the patient's and the healthcare providers' time and the cost of the treatment. Furthermore, due to its fast and advantageous characteristics, it can streamline the workflow of hospitals and clinics, thus being able to create a win-win situation [87].

Although one limit of case study analysis is the difficulty of generalizing results, our study confirms that a huge problem in the health sector is not innovation per se, but the dissemination of innovative concepts [60]. In the context of territorial services, a level of lack of homogeneity and fragmentation emerges of enormous services, recognizing the presence of a multiplicity of actors and care settings, equipped with different information and procedural tools, developed and used according to a performance logic, for activation and delivery of a specific health and social service [79].

Our investigation seems to show that the PNRR reform, regarding digitalization and telemedicine, is going on in a kind of double track. On one hand the technical components are going to be fully implemented [88 51], on the other hand health personnel seem not to be involved in this change thus resulting in a not implemented reform. Our results, although having the limit of being based only on few interviews and two focus group, confirm that a full reflection of a strategic nature aimed at defining the objectives to be pursued through the implementation of telemedicine it is still immature [50].

Policy makers and practitioners should be aware that service innovation in healthcare is successful only if it can satisfy users' needs [59]. According to the conceptual model by Lepore et al [39]

designed to capture the key variables of a healthcare innovation ecosystem, some aspects are crucial. Particularly the way in which the key variables interact “investigating the emergence and evolution of focal actors and relationships among governmental institutions, academia and firms” [39] According to our analysis, while left part, according to the scheme reported in Figure 1, as been developed, and it represents a central focus of the already ongoing strategy foreseen in the PNRR strategy, the other part seems, at least at the moment, set aside. Indeed, while the transformation of AGENAS has been realized and the different software by the companies have been developed, there has not been any involvement of the Academia, but most of all there is no investment yet on workers capabilities, first of all the GPs. In such a situation the success of the reform cannot be assured.

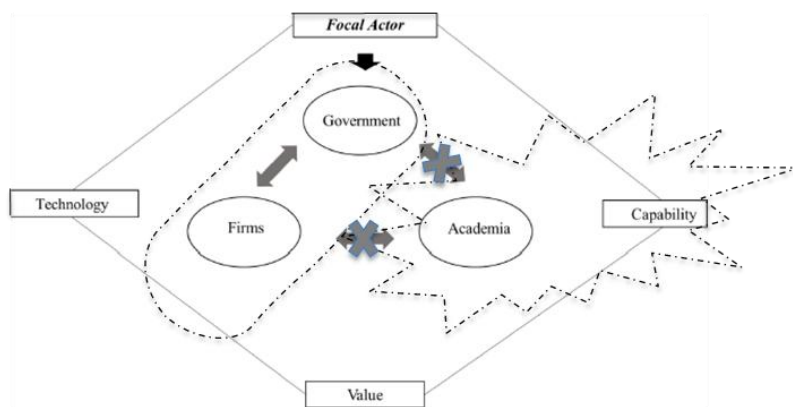


Fig. 1 Key variables in involvement in the ongoing innovation ecosystem reform
Source: Adapted from [39]

A fundamental role has been found in the importance to inform and retrain medical personnel (and GPs in particular) as strategical promoters of the change. But another important aspect has been found in the need of “educating/training” also patients, thus revealing the importance of really creating a co-production scheme for developing a real effective digitalized system. The commitment and active participation of patients represents indeed a prerequisite for obtaining high adherence, but if users are culturally not keen in contributing to the process, the potential of digitalization remains unexploited. New policies should be designed thanks to a wider use of co-production approaches, whose solutions

could be further adapted at the point of use according to the characteristics of the end user and/or the setting. Future policies should not underestimate the role of education and training, as well.

Moreover, in this sense our results are in line with the paradox according to which a huge problem in the health sector is not innovation per se, but the dissemination of innovative concepts [60]. The so-called promoters cover a fundamental role in this sense: they are key persons who allow the implementation of the change, contributing to overcoming its barriers [61]. Accordingly, policy makers should design policies first identifying key change agents. To design new plans, they should also adopt an ecosystem approach properly considering all its subsequent steps, and ought to rise the competences of different stakeholders for achieving common important outcomes [65]. But according to our results the above reported issues have not been taken into account by the ongoing reform, thus leading to the risk of spending PNRR money to implement a telemedicine system which few health personnel know, and no users are aware of.

Further research is needed. Comparative studies among different healthcare settings (secondary and tertiary care) and systems (intercountry comparison) could be useful to confirm our findings or highlight other issues in the design and implementation of policy driven digital healthcare reforms. Other studies could explore specific cultural factors and resistance patterns that hinder the adoption of digital healthcare tools among end-users. Further studies are needed to find strategies for better engagement of healthcare staff in digital initiatives. Finally, longitudinal studies of the implementation of such reforms could offer deeper insights on criticalities and the way to solve them.

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CHAPTER III

The Gap between Service Design and Actual Implementation. A case study upon the Community Care Homes in Italy³

Chapter 3 investigates the gap between the formal design of territorial healthcare reform and its practical implementation within local healthcare contexts. Focusing on the development of Community Care Homes and the reorganisation of territorial services, the chapter explores the organisational, infrastructural, and cultural barriers emerging during the implementation process, with particular attention to late-adopter contexts characterised by weaker territorial healthcare infrastructures.

Within the overall structure of the dissertation, the chapter primarily addresses RQ2 and RQ4 by analysing the misalignments between policy objectives and operational conditions, as well as the organisational and institutional factors influencing the effective functioning of Community Care Homes. The study specifically examines how governance arrangements, interprofessional coordination, resource availability, and local organisational cultures shape the implementation trajectories of territorial healthcare reform.

The findings reveal the existence of persistent tensions between the strategic vision promoted by DM 77/2022 and the concrete realities of local healthcare organisations. In particular, the chapter highlights uncertainties regarding professional roles, limited integration between services, insufficient organisational coordination, and uneven infrastructural and technological capacities. The

³ Antonucci G., D'Andreamatteo A., Arquilla P., Berardi G. (2024). "The Gap Between Service Design and Actual Implementation: A Case Study on Community Care Homes in Italy." In Pfannstiel, M. A. (Ed.), *Service Design, Creativity and Innovation in Healthcare*, published by Springer in 2025

results further demonstrate how the implementation of Community Care Homes is strongly conditioned by pre-existing organisational configurations and by the capacity of local actors to manage complex change processes. Overall, the chapter shows that the effectiveness of territorial healthcare reform depends not only on formal policy design, but also on the ability to adapt organisational models to local contexts through integrated governance, professional collaboration, and participatory implementation mechanisms.

1.0 Abstract

In the last years, healthcare systems have been asked to re-design their service delivery process, towards the creation of health value to patients, within the entire value network of professionals, organizations, and institutions involved in the service supply within a specific geographical area. In Italy, a specific pillar of the Next Generation EU Programme is indeed dedicated to healthcare innovation, proximity assistance and telemedicine. Among others, it has been found that the necessity of innovating the first access point, by redesigning the system towards an effective gatekeeping, with the involvement of GPs, together with a reengineering of the territorial health system. Starting from the above considerations, this chapter focuses on the fundamental role of the so-called Community Care Homes. In particular – considering the theories about the inertia and resistance to change in public organisations – it investigates the gaps between the idea and design formulated by the policymakers and the correspondences received by the side of health operators. We interviewed health to understand which distances exist and thus which problems arise in the actual implementation of a new (or reengineered) health service that appears definitively appropriate in its design but encounters obstacles in achieving the aims for which it is implemented. On the basis of our research results, we therefore suggest a few indications for more effective planning and design of health services, specially considering the full involvement of the operators since the preliminary phases, before the actual implementation, as a guarantee for a more effective health service execution.

2.0 Introduction

In the last years, healthcare systems have been asked to redesign their service delivery processes. Important steps in this direction are represented by the frame of reference on Primary Care by the EU Commission in 2014 (EC, 2014), and especially by the 2018 Astana Declaration by the World Health Organisation (WHO, 2018), which states the necessity to strengthen health systems by investing in Primary Health Care.

The Covid health crisis contributed to accelerating the transformation towards the creation of health value to patients within the entire value network (Stabell, 1998) of professionals, organizations, and institutions involved in the service supplying within a specific geographical area. It is indeed clear now that the shaping of the post pandemic period is in our hands (Katzourakis, 2022) and especially in the way in which we are getting out of it and its legacies. In many countries, the way to overcome Covid-19 and reset the public sector system has been largely considered as the “hardest challenge of the century” (OECD, 2021a).

Consequently, the worldwide general regard of public health services and the consideration of medical research have changed (Bargain and Aminjonov, 2020). Healthcare systems have been indeed asked to completely redesign their service delivery processes by disrupting the “in-hospital” paradigm of service providing. This is because it has been demonstrated that importance of placing primary health care at the core of the caring system, both to manage an unexpected surge of demand and to maintain continuity of care for all (OECD, 2021b).

In Italy, the National Plan of the European Union Programme “Next Generation EU” (PNRR) is strategic in this process of healthcare innovation. A specific pillar of Mission 6 of the PNRR (M6-PNRR) allocates approximately € 15,6 billion to support asset investments in Proximity Assistance and Telemedicine (7.0 billions for strengthening and reorienting the Healthcare System towards a model centred on local areas and social and healthcare networks) and Healthcare Innovation,

Research, and Digitisation (8.6 billions for disseminating telemedicine strengthening the healthcare system's information and digital tools) (PNRR, 2021).

Among other things, it has been found the necessity of innovating the first access point, by redesigning the system towards an effective gatekeeping, with the involvement of GPs and the reengineering of the territorial health system (AGENAS, 2022).

Starting from the above considerations, this chapter reports on the first results of a still ongoing research, undertaken upon the fundamental role of the so-called “Case della Salute” which is Community Care Homes (CCH). Starting from consideration of the theories on ecosystem innovation in healthcare, we aim to investigating the gaps between the different ideas and design formulated by the policymakers and the correspondences received by the side of health operators, concentrating our analysis upon aspects related to the resistance to change. We decided to use a mixed methods approach, starting from a desk analysis to then conduct semi-structured interviews with high-qualified experts and finally a focus group with GPs, in order to understand which factors are the distances, and thus identify the problems, in the actual implementation of a new (or reengineered) health service through the development of CCHs. Our results so far are illustrating the crucial role of the GPs in determining what kind of service might be implemented. We particularly consider the relevance of the full involvement of all the health operators since the preliminary phases, before the actual implementation, as a guarantee for a more effective health service execution, truly able to create public value for users. Indeed, our investigation shows that not fully involved, since the preliminary phases, might lead to an increase in the gaps between the design formulated by the policymakers and the idea (or even the lack of any idea) that the promoters of the change (in our case the health operators) have.

3.0 Theoretical Background

Since the beginning of the 2010s (if not even before) western countries' governments have been looking for a way to improve quality and efficiency of healthcare systems. The strategy of this decade mainly tries to support and 'modernise' the primary care sector to better engage with the rest of the health care system (Armitage et al. 2009). This change should be based on the unification/integration of care among sectors, continuity of chronic care for patients and families, and community-based health services (Rosen et al., 2011). But if the aim and the outputs are clear, the way to achieve them is not easily to be determined (Nicholson et al., 2017), especially if we consider the different specific traditions and cultural aspects.

It has been indeed noted that the need for these reforms, especially in countries with public National Health Services, arises after decades in which public health systems were permeated by reforms inspired by New Public Management theories and principles (Cairney, 2002) whose efficacy, in such a peculiar system as healthcare, has not really been a success (Andrews et al., 2019). On the contrary, since the beginning of the new millennium, instead of an increase in efficiency and effectiveness, we have been witnessing a fragmentation of health services that created a complex, rapidly changing, and often impersonal health system, difficult to be managed for the well-being of citizens (Jackson et al., 2010).

It must also be noted that the demand for healthcare services is changing significantly. Indeed, on one side, the aging of the population is increasing the number of patients with multi-pathological chronic conditions (Hajat & Stein, 2018). Moreover, most of the patients are, nowadays, more informed thus leading to a rise of expectations for public healthcare systems (Parker, 2006). On the other hand, there are, nonetheless, financial pressures that require public healthcare organizations to provide more and better services with equal (if not decreasing) resources (Gabutti et al., 2017). Healthcare systems are

therefore destined to change, requiring outstanding levels of performance in terms of quality, efficiency, as well as equity and appropriateness (Zaadoud et al. 2021).

In the last years, several studies focused upon the notion of public value (Bracci et al., 2019) and the aspects related with public value in healthcare (Heath et al., 2021) deepening, among the others, aspects related with co-production in public services and health organisations (Loeffler and Bovaird, 2019; Cluley and Radnor, 2020). Moreover, several researchers investigated the upshots of the Covid 19 pandemic. This aspect has been mostly investigated at level of government initiatives (Ferry et al., 2021; Wang et al., 2021) as well as a “booster” of innovation, both of services and strategies (Cepiku et al., 2021) especially linked with digitalization in healthcare and telemedicine development (Agostino, et al., 2020; Leite, et al. 2020).

Being in this streamline, we intend to investigate both role and importance of the CCHs as “re”-formulated in the PNRR, thus intended as nodes for the creation of public value in the Italian health caring system.

CCHs are indeed not a novelty in the Italian National Health Service. Although having different names, and different regional planning and actual implementations, they have been present in Italy for more than 10 years (Del Vecchio et al., 2016; Morando et al., 2017).

A preliminary definition of CCHs can be found in the Law 296/2006 (Art. 1, section 806, point a), where they are defined as multipurpose facilities capable of providing all the health and socio-healthcare services in the same physical space, promoting, through the spatial contiguity of services and operators, the unity and integration of the essential levels of both health and socio-health services. Along the years several interpretations have been designed and implemented in the different Italian regions (Camera dei Deputati, 2021).

The ‘renovated’ view of the CCHs sees them based on three distinct pillars, within an overall territorial reform (PNRR,2021): CCH and the taking in charge of the person; the ‘Home’ as the first

place of care and telemedicine; the strengthening of intermediate care and its structures. Accordingly, and differently from what happened in the past, a national scheme (Ministerial Decree 77/2022) states common structural and organisational standards for the whole national territory.

Starting from the above “new” definition of both the structure and especially the role of the CCHs, we decided to analyse them within the studies upon innovation in health care (Flessa and Huebner, 2021) taking in particular consideration aspects regarding the health innovation ecosystems framework (Iyawa, Herselman and Botha, 2016; Lepore et al., 2023).

Innovations in healthcare represents any improvement in the quality of services and/or life, being indeed a continual challenge to existing health care providers and systems (Flessa and Huebner, 2021). This implies technologies, procedures, as well as forms of organisation. Paradoxically, a huge problem in the health sector is not innovation per se, but the dissemination of innovative concepts (Berwick, 2003). Service innovation in healthcare implies new forms of logistics, advice etc., and it is successful only if it can satisfy users’ needs (Flessa and Huebner, 2021). The so-called promoters cover a fundamental role in this sense: they are key persons who allow the implementation of the change, contributing to overcoming its barriers (Gemünden et al., 2007). They can do that because they know “how things work” and thus comprehend the innovation and perceive its perspectives (Goduscheit, 2014).

Innovation ecosystems in healthcare can be seen as the full potential, especially given by new technologies, to tackle unmet needs (Javaid and Haleem, 2019) by timely addressing patients’ situations and thus being able to perform correct diagnosis, analysing plentiful variables (Frontoni et al., 2020). A great impulse in the development of innovations based upon these schemes was given by the research of solutions to fight Covid outbreak. The pandemic crisis led to the search for an ecosystem approach for new solutions, thus raising the competences of different stakeholders for achieving common important outcomes (Arribas-Ibar et al., 2021).

All the above considered, we decided to analyse the CCHs looking at them as an innovation which could be probably effective if developed with a healthcare ecosystem approach, and we decided to particularly address, in our investigation, not the service design per se, rather than the path for its actual implementation thus investigating the role of health operators as innovation promoters for an effective development of CCHs according to their foreseen outcomes.

4.0 Methodology

Considering both the relevance and especially the multipurpose of our investigation, we decided to construct our investigation using a mixed method approach (Schoonenboom and Johnson, 2017) particularly for aspects regarding its purposes (Greene et al., 1989; Greene, 2007) in order to look for triangulation (for convergence and corroboration) and complementarity (for enhancement, illustration, clarification); and especially for both development (to use the results from one method to help to develop or inform the other ones) and initiation (to discover paradoxes and contradictions).

The first step was represented by a desk analysis of laws, rules, and regulations, as well as published studies and reports on CCHs. The aim of this first part of the analysis was to investigate the design, expectations, first realisations, and preliminary analysis. All read to see if, and especially how and for what, CCHs could be seen as an health innovation ecosystem.

In the second step, in line with the qualitative explorative case sampling (Patton, 2002), we explored the potential impact of CCHs within their real-life context, by gathering information from knowledgeable key informants, that is, well-situated and competent people involved in critical issues (Yin, 2014). Particularly, at this further stage of investigation, we conducted exploratory targeted qualitative interviews (Bailey, 1987) with privileged witnesses, who were able to offer insights as experts in the area (Weiss, 1995).

We developed the theoretical rationales for the interview protocol, by drawing on themes regarding literature on community health services facilities (Winpenny et al., 2016) and considering aspects concerning the path to analyse changes in health public services and managers' role in an evolving domain (Srinivasan & Chandwani, 2014).

We therefore identified the following items to be investigated: 1) setting; 2) facility type; 3) expected outcomes; 4) staffing; 5) collaboration and integration with other services; 6) users centrality.

We interviewed personnel belonging to two different Italian regions and to 4 different Local Public Health Territorial Services (ASL), in order to gather insights not only for a specific case, but also about general indications coming from different contexts. In particular we interviewed:

- A Head of a unit of coordination and management of public primary care and local territorial services
- A Responsible for public psychiatric territorial services
- A Head of a public General Medicine Operating Unit
- A MD and President of a Conference of Mayors for public local health services

Moreover, we conducted a focus group with 9 GPs from a Local Public Health Territorial Services (ASL).

Interviews were conducted between June and November 2023 and were conducted in both the interviewers' and interviewees' native language (Italian). The average interview lasted about 40 min each.

The focus group was held in January 2024 and lasted 85 min.

The transcriptions of the records were analyzed through content analysis (Bauer and Gaskell, 2000), which was developed through deductive thematic analysis, guided by theoretically-driven coding (Braun and Clarke, 2006), in line with the previously mentioned items. Considering that we had no

previous data to assist with coding, we opted not to use any specific computer-assisted software. The content analysis results were then translated into English and finally re-analyzed for the redaction of this work.

5.0 Findings

In reporting our findings, we divide this section into two parts. We firstly illustrate the results coming from the desk research, namely those corresponding to the design and intention of policy makers. We then report on those regarding the analysis of the interviews and the focus group.

5.1 Community Care Homes as a healthcare innovation ecosystem

According to the results of our desk analysis, the CCHs can be fully considered as a strategic health innovation ecosystem. Within the M6 PNRR panorama, the 1.1. refers to “Community Home and taking charge of the person”. It is therefore an investment aiming to “territorialization” of healthcare in order to face the demographic and epidemiological trends of the country.

CCHs aim to strengthening and reorganizing the services offered in the area by increasing their accessibility, and consequently, improving the quality of healthcare intervention. Each CCH should be a health service access point, designed for coordinating all the services offered in the area, with a particular focus on chronic diseases. To this end, it should be equipped with a multidisciplinary team composed of GPs, paediatricians, specialist physicians, nurses, and other health professionals, and also in coordination with city hall welfare workers.

In this context a CCH should be seen as a node of a health ecosystem, serving as a reference point for its target population which should be able to guarantee the promotion and prevention of health as well

as the continuity of care within the specific targeted geographical area. Figure 1 illustrates the scheme that should be considered.

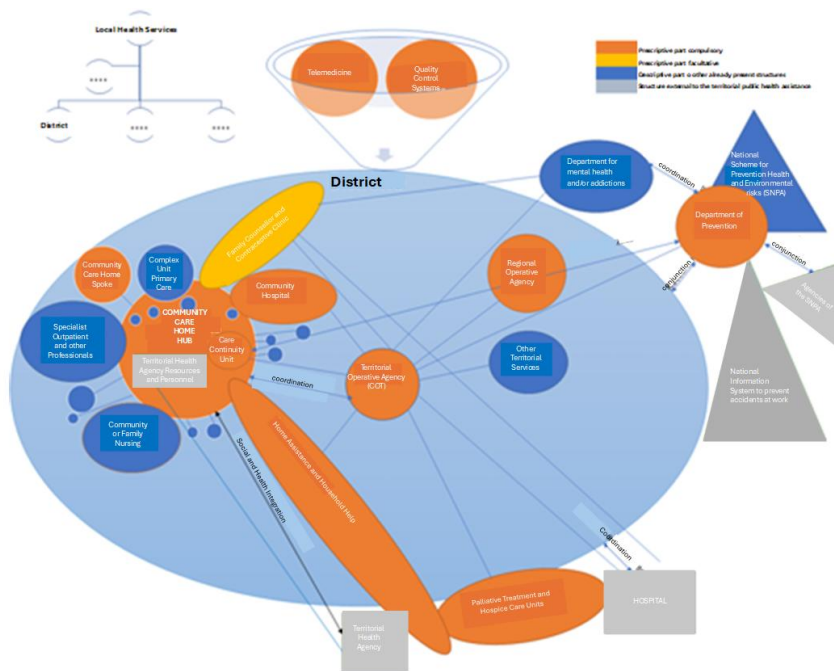


Fig. 1 Model of the redesigned territorial health assistance
Source: Adapted from Ufficio Parlamentare di Bilancio (2023) p. 46

In this complex scheme CCHs are characterised by the following aspects (Del Vecchio et al., 2022):

- Physical dimension (health center) and organizational setting (service model);
- Multi-disciplinary and multi-professional integrated approach;
- Hub & Spoke logic with the provision of mandatory, optional, and recommended services and thus personnel availability;
- Nursing, health care, social, and administrative personnel standards;
- Network logic between intra CCH networks and integrated Community Hospital networks;
- Forecast of 1 CCH Hub per 40/50 thousands inhabitants;

- Distinction between regulatory requirements (no. of Hubs, personnel standards, and services to be provided) and descriptive (everything else).

In order to allow accessibility to services also to people living in rural areas it has been thought a "Hub & Spoke" scheme, thus enlarging the network of territorial care. The PNRR envisages the realisation of 1 hub and at least 3 spokes connected to it, for each Health District (1 every 30/35,000 inhabitants in metropolitan areas; 1 every 20/25,000 in urban and sub-urban areas; 1 every 10/15,000 in inland and rural areas).

In the policy-maker intentions, CCHs ought to represent an adequate response to health and social health needs of citizens. They should be organized as polyvalent and functional structures which host primary cares, by guaranteeing continuity of care and prevention activities, through the work of multi-professional staff. In particular, they are focused on taking care of chronic pathologies, in connection with other territorial providers, to increase the cost-effectiveness of cares through integration of out-of-hospital paths. In synthesis, CCHs will have to be the physical place of proximity where the community can access to enter in contact with the health and social-health care system (AGENAS, 2021). This is the great relevance of the "new" vision given in the PNRR, but it is, at the same time, the greatest challenge, because CCHs (and other similar structures with different denominations) have been hitherto conceived and created as physical containers and "isolated" dispensing places compared to the territorial health service delivering system (Giudice et al., 2021).

A strategic component to reverse the past trend of different regional CCHs developments, is represented by the fact that extended consensus conference processes should be implemented to share the elements that should characterize the CCHs trend model. This is important for significantly diversifying them from "simple" polyclinics or district offices (Brambilla, 2021).

In synthesis, according to what has been planned by the policy-makers, CCHs can be really considered an important strategic health innovation ecosystem. But our investigation intended to deeper the analysis, taking into account the possible gaps between the planning of an innovation in health services delivering, and its actual implementation. Particularly – as shown in section 2 when presenting the background of our research – we addressed the crucial role of the promoters of the change, that is the personnel working in public territorial health services, as illustrated in the following paragraph.

5.2 The strategic role of the personnel and its uncertainties

In the following sub-sections, we illustrate what emerged from the analysis of the considered items about the relevance of the personnel role in developing and implementing the health innovation ecosystem.

5.2.1 Setting

A first analysed item was the setting. As presented in 4.1, the planning of the new system is conceived as an integrated system which starts with prescriptive obligatory units arriving up to exchanges with structures operating outside the public territorial system. Such a plan clearly responds to the necessity of putting primary care at the core of the health assistance. Now, all the interviewees agree in the necessity of such an integrated scheme. The point is that, according to the results of our investigation, they rarely know the basic of the system and they talk about it as a nebulous setting that should be concretized. For instance, GPs taking part to the focus group, were questioning bout aspects like “Should we guarantee some hours and days per week in the CCH?” “How could we integrate our service in the CCHs with the continuity in our medical studios?” “Would be shifts impacting also on weekends?”

On the other hand, the President of a Conference of Mayors for public local health services was already saying about inefficiencies which, according to him, were present in the planning about the different sites in which they were planning to insert the different units. The Responsible for public psychiatric territorial services, was instead underlining which were, according to her experiences, the risks, in terms of security and safety, of the dedicated places.

In synthesis, our interviews reaffirm that “it is not possible to understand a specific action (...) without understanding the setting itself” (Dixon & Shofer, 2006, p. 1619), thus the nebulous idea they all have, according to the different specific roles, seems to be at the base, at least at this stage, an important aspect to be tackled for having a proper implementation of the system.

5.2.2 Facility type

The design of healthcare facility is a multifaceted process, which should involve different stakeholders, aiming at aligning operational, clinical, and organizational objectives. It should indeed be considered the dynamic and complex nature of healthcare itself, and the necessity of finding an equilibrium able of both improving population health and reducing costs, trying also to improve staff work life (Halawa et al., 2020). In this case our results show a misalignment among the different involved components. By the side of the GPs, our focus group resulted in the statement that they perceive their role as “detached” from the other public health services within public structures. One of them even affirmed that “there continue to be parallel tracks and we do not know how to interact properly with the services”. Moreover, they were also wondering about the equivalent of each intervention made by them within the system, considering the differences between urban areas and internal ones. On the other hand, by the side of the service managers of territorial services, it has been underlined the importance and strategic role of preliminary territorial analysis. That is the analysis of present pathologies in order to have different planning in different territories. In this case we also

found huge differences among the different territories involved in our investigation, showing that, there are different stages of implementation of the reform which are due to the fact that there were different starting points even within the territories of the same region.

An aspect which was found relevant for a great improvement of the integrated work, was found in enhancing the use of digitalisation. In one case local services were already experimenting what they called “Unique medical record” that is a virtual record which allows all interested parties to have a clear illustration of the actual medical situation of each patient, independently from the specialists that might have to intervene according to both previous and ongoing pathologies.

5.2.3 Outcome

This item resulted really as a contested one. A first misunderstanding came out from the different indication given to “outcome”. Indeed, our analysis was given in terms of achievement of intended impacts, according to the foreseen innovation, thus considering aspects such as the extent of goals, level of accessibility by the target population, and the efficiency in the implementation (World Bank, 2003). On the contrary, by the side of our interviewees, the indication was given properly to health outcomes, that is to the consequences brought by the treatment of a health condition or as a result of an interaction with the healthcare system (Lee & Leung, 2014).

This misalignment can be seen as an indicator of the fact that, even if covering managerial roles, health personnel are keen on medical results for patients and see the general management of the structure, including the achievement of its aims, as a secondary component.

Nevertheless, some important aspects, after appropriate clarifications, came out. The first important one on which all the interviewees agreed is that a first outcome ought to be the reduction of avoidable readmissions and the improvement of care coordination. Moreover, the GPs highlighted the importance of a reorganisation of the “operating machine”, as they indicated it, intending the way in

which the system functions with “stop and go” together with possible reiteration of medical examinations as well as the necessity of streamlining the screening and preventive exams. In this sense one GP stated the necessity of having precise, but at the same time easy, procedures, able to tackle what he defined “the territorial bureaucracy of the exams”. By the side of the managers, it has been highlighted the importance of preventive interventions, but most of all the necessity of a “different vision” in terms of health local services planning. A last important component they found, was the possibility of having a completely different management in the caring of patients with chronic diseases, which now have, in too many cases, several periodical occurrences of risky acute phases, due to a lack in daily monitoring, caring, and prevention assistance.

5.2.4 Staffing

The aspect regarding staffing was easy to be decrypted from our content analysis, but at the same time was really a worrying one. All the interviewed people agreed upon the necessity of having specialised nurses. They recognised that, nowadays, the university masters for nurses are able to educate and train such a crucial figure. Indeed, according to the planned reforms, in most of the activities to be implemented in the CCHs, there should be specialised community nurses, able to run shifts upon 24 hours, thus being the real personnel to assure the continuity of caring, as well as monitoring and surveillance. In two cases, some interviewees made a kind of similitude stating that “in CCHs nurses should not be considered as ‘attendants’, but as real ‘paramedic personnel’”.

In synthesis, we confirmed that, although primary care organization in Italy is still based on a dated physician-centric care model, the positive attitude of MD towards nurses, for a more collaborative model is definitively a promising starting point (Gualano et al., 2018).

Unfortunately – together with the statements about the crucial role of nurses and the praise of the Italian university system for educating and training new nurses – our interviewees also dreaded a lack

of them, confirming the ongoing trend of the last decade which sees a lack of nurses as well as a poor recognition of their work within the Italian public health system (Sansoni et al., 2016).

5.2.5 Collaboration with other services

According to what emerges from the analysis of CCHs as important strategic health innovation ecosystems, as reported in 4.1, the partnership among the different structures within a territory (arriving even to collaborations with social caring local units) appears to be fundamental. On the contrary, according to our investigation this collaboration seems not easy to be achieved. Particularly we found a kind of dichotomy between the personnel working within the structures (hospitals, territorial services) and the GPs. The former appear in many cases, not recognizing the role of the latter.

While discussing about the statement (by the way agreed by all the interviewees) regarding the crucial role of GPs for a proper development of CCHs, some interviewed persons even affirm: “They do not work on weekends and nights and they earn much more than us” “They will never accept to be involved in the CCHs because they are used in covering their role, with their patients, without caring about the generality of the health system” “They have been reduced to bureaucrats who just prepare medical prescriptions and medical examinations by specialists”.

On the other hand, the GPs involved in the focus group highlighted their full availability but raised some issues. Apart the already mentioned doubts (the hours to be dedicated to CCHs and the way to combine the continuity of their medical studios) they highlighted the necessity of a proper network as well as a full recognition of their role. They made affirmations such as “In our system we are, nowadays, losing the importance of an overall view in doing a diagnosis” “We are witnessing a kind of ‘hyper-specialization’” “Nowadays patients might come in our offices asking for medical prescriptions saying: ‘the specialist I consulted told me what I need and what you have to prescribe

to me””. Moreover, the GPs – confirming the already mentioned points regarding the necessity of proper protocols and an excess of bureaucratization – pointed out some incongruences of the system making affirmations like: “You have to networking also the mindsets, not only structures and offices” “If you want the system to run, you have to cancel double prescriptions and requests. I did twice the same practices and my patient had to present documents three times to have a home care service for an old woman” “You are in a system in which, especially after COVID19, the requests are growing but the quality is decreasing. We worry about meaningless aspects instead of solving problems”.

In synthesis, our results, although coming from an investigation upon a specific innovative service, confirmed that the role of GPs still needs a radical change to be abreast with the times and Italian ones are probably those who needs it more than others (Garattini et al., 2023).

5.2.6 User centrality

When considering this final item we started our investigation having in mind the EU Commission definition which sees it as “putting users’ needs at the centre when determining which public services should be provided and how they should be delivered (EU). On the contrary we found that the health operators, and GPs in particular were considering it by a completely different point of view.

They highlighted the necessity of in some sense “educating the patients”. Indeed were made affirmations such as “Their expectations, in such a free of charge public system, made the system inefficient. In several cases there are excessive requests which even arrive to improper claims for hospitalisation because several patients don’t realise” “With the improper use of internet a kind of ‘self-diagnosis’ is growing and if you say them they don’t need that medical examination they tell you that you don’t know your work” “It is a cultural aspect, in Sweden you see your GP if you are ‘really’ ill. Here, especially after COVID19 we spent hours answering to telephone calls that ask what to do if they have cold or cough”.

But apart from these statements, a really worrying one, expressed not only by GPs but by most of our interviewees, regards what they defined as “defensive medicine. In this case we are talking about an aspect completely different from the notion of user centricity, that is the necessity by MDs to do several acts and exams, although completely useless, to avoid any risk of being involved in a trial by the relatives of patients, thus having to spend time and money (although within their professional insurances) to defend themselves from the accusation of wrong conduct in doing their profession.

In synthesis, the personnel we interviewed, who has to cover the role of promoter of the change, in considering the item about user centricity, instead of thinking about the relevant role of putting the patient at the centre of the intervention, sees him/her as a possible risk and consider that, before putting him/her at the centre, the health public system should work on changing the ongoing cultural consideration of the system itself.

6.0 Conclusion

In the last years, healthcare systems have been asked to re-design their service delivery processes. Particularly, they should completely redesign their service delivery processes by disrupting the “in-hospital” paradigm of service provisioning. They ought to do it predominantly by prioritizing primary health care at the core of the caring system.

In Italy, this need for change, passes is addressed through the use of the PNRR funds, which envisage a specific pillar in Proximity Assistance and Healthcare Innovation, Research, and Digitisation. Within this framework a pivotal role is played by the redesigning of CCHs.

Our investigation, designed according to a mixed methods approach, although having its limits, first of all the few number of interviews in the qualitative part presents some relevant insights.

CCHs should be designed considering the entire health ecosystem to be developed, especially considering that previous experiences conceived and created them as physical containers, “isolated” from the territorial health service delivering system. This is the real challenge for permitting that CCHs really achieve their mission.

The analysis we conducted through highly qualified targeted qualitative interviews with privileged witnesses is revealing a risky situation. It is emerging that relevance of the full involvement of all the health operators from the preliminary phases, before the actual implementation, is crucial as a guarantee for a more effective health service execution, truly able to create public value for users. Among others, the strategic role of GPs as change promoters is particularly highlighted.

Considering that CCHs ought to represent a new scheme of territorial intervention within a health innovation ecosystem, and especially considering the challenges to be addressed, our results suggest the role of the GPs as change promoters is crucial, but it is full of risks unless the system can reconsider their role changing the way in which they are conceived and especially considered now.

This aspect is emerging not so much in the role of CCHs as reference point for the care of chronic and semi-chronic patients, but rather than in the challenge of implementing them as a reference point for their target population. Particularly, we found the actual realisation of CCHs to be strategic and challenging in serving as the physical place of proximity where the community can access them to enter in contact with the health and social-health care system. In other words, the comprehension of them by the population as polyvalent and functional structures which host primary care and prevention activities through the work of multi-professional staff. Indeed, our investigation confirms the relevance of addressing a more advanced realization, to be known by the whole population residing on that territory, in order to win the challenge of identity and to enhance the effectiveness of communication with users (Giudice et al., 2021).

On the basis of our results, we therefore suggest to policymakers that for a more effective planning and design of health services, it is fundamental to fully involve the operators from the preliminary phases before the actual implementation, as a guarantee for a more effective health service execution. Otherwise, gaps between the planning vision of policymakers, and the intention of the real involved personnel in its implementation might lead to unexpected and undesirable results.

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CHAPTER IV

Community Care Homes in Italy: evolution of territorial care paradigms and the role of general practitioners. The case of ASL Pescara⁴.

Chapter 4 presents the quantitative component of the research through a survey administered to General Practitioners within the Local Health Authority of Pescara. Building on the findings emerging from the previous qualitative analyses, the chapter investigates healthcare professionals' perceptions of territorial healthcare reform, their levels of engagement in the implementation process, and the organisational factors influencing attitudes towards Community Care Homes and new primary healthcare models.

Within the overall structure of the dissertation, the chapter primarily addresses RQ3 and partially RQ4 by providing empirical evidence on how General Practitioners interpret the ongoing reform and which organisational, professional, and experiential variables shape their willingness to participate in the transformation of territorial healthcare services. Particular attention is devoted to the role of previous aggregation experiences and to the perceived opportunities and criticalities associated with integrated and multidisciplinary organisational models.

The findings show that healthcare professionals generally recognise the strategic importance of strengthening territorial healthcare services and improving multidisciplinary collaboration. However, the results also reveal significant concerns related to increased organisational complexity, higher workloads, coordination difficulties, and the lack of clear operational frameworks. The analysis

⁴ The present paper has just completed and is ready for submission.

further demonstrates how previous experiences of professional aggregation significantly influence perceptions of the reform, often generating ambivalent attitudes towards new organisational models. Overall, the chapter highlights the central role of professional engagement and organisational support in determining the effective implementation of Community Care Homes and the broader territorial healthcare reform.

1.0 Abstract

This paper examines the evolution of territorial care models in Italy following Ministerial Decree 77/2022, with a particular focus on the role of General Practitioners (GPs) in implementing the newly introduced Community Care Homes (“Case della Comunità”, CCHs). Drawing on lessons from previous experiences—such as the Case della Salute—and on the challenges encountered in various forms of primary-care aggregation across Italian regions, the study investigates the centrality of these professionals in ensuring the effectiveness of the new organizational model. The analysis is especially relevant for regional health systems that lack significant past experiences of professional aggregation, where integrating contracted General Practitioners (GPs) within CCHs structures is essential to operationalize the territorial-care paradigm envisaged by DM 77 and financed through the NRRP. Through an empirical inquiry conducted within the Local Health Authority (ASL) of Pescara—an emblematic case of “radical innovation” due to the limited diffusion of structured aggregative models—the study provides insights into the opportunities and criticalities perceived by GPs, shedding light on the organizational, professional, and infrastructural conditions that underpin successful implementation of the reform.

Keywords: Community Care Homes; Ministerial Decree 77/2022; General Practitioners; organizational model; Abruzzo Region; complexity.

2.0 Introduction

The “*Case della Salute*” (CdS) and “*Case della Comunità*” (CCHs) are not exactly the same, although the two expressions are often used interchangeably. While they share similar goals, they represent two entirely different worlds: Italy in 2007 on the one hand, and post-Covid Italy on the other — a generational gap comparable to that between parents and children. This distance reflects the diverse trajectories followed by regional health systems: in some regions, the introduction of CCHs constitutes a **radical innovation** in territorial healthcare; in others, it represents a more **incremental evolution** of pre-existing structures.

Building on the results of the Case della Salute and on the challenges encountered in various forms of primary-care aggregation implemented elsewhere, this paper focuses on the role of the key actors whose participation is essential for the success of the new organizational model: **General Practitioners (GPs)**.

The purpose of the study is to provide guidance especially for those territories that lack significant prior aggregative experiences, in order to facilitate the integration of contracted General Practitioners (GPs) within the CdC. This integration is necessary to ensure the functioning of the new territorial-care paradigm defined by DM 77 and financed through the National Recovery and Resilience Plan (NRRP) — a topic currently at the center of national political debate and negotiations with union representatives of the concerned categories.

3.0 Context analysis: associative experiences in primary care and the innovation introduced by Ministerial Decree 77/2022

The Community Health Centres (Case della Comunità) established by Ministerial Decree 77/2022 represent, from an organizational standpoint, the evolution of the earlier model of the *Case della*

Salute, which had been introduced experimentally by the 2007 Finance Act (Law No. 296/2006 – Art. 1, para. 806, lett. a) and defined in Annex A of the Ministry of Health Decree of 10 July 2007 as “*multifunctional facilities capable of delivering, within the same physical space, the full range of health and social care services, fostering—through the spatial proximity of services and professionals—the unity and integration of essential socio-healthcare services*”, with the objective of “*representing the reference structure for the provision of primary care*”.

This model, however, did not achieve uniform implementation across regional health services. Indeed, of the 493 Case della Salute reported as active by the end of 2020, more than half (56.18%) were concentrated in three regions: Emilia-Romagna (124), Veneto (77), and Tuscany (76) (Servizio Studi Camera dei Deputati, 2021).

Nevertheless, the model has demonstrated its effectiveness, as evidenced by a study conducted in Emilia-Romagna (Nobilio L., Berti E., Moro M.L. et al., 2020): the presence of a Casa della Salute in a territory resulted in a reduction in inappropriate emergency department visits (white codes) by 12.0% when the general practitioner (GP) operated outside the facility, rising to 25.7% when the GP had an office within the Casa della Salute.

These findings provide unequivocal support for the following claim: **the less fragmented the provision of primary care, the more effectively territorial medicine can intercept the health needs of citizens.**

These considerations—widely shared across the sector—constituted the premise from which Ministerial Decree 77/2022 began when redefining the territorial care model through the introduction of the Community Health Centres. The Decree adopted the original objective of aggregating services and professionals that had informed the Case della Salute while maintaining, for the time being, the organizational instruments introduced by the 2012 Balduzzi Reform (Decree-Law 13 September

2012, No. 158): the *Aggregazioni Funzionali Territoriali* (AFTs) and the *Unità Complesse di Cure Primarie* (UCCPs).

AFT stands for *Aggregazioni Funzionali Territoriali*, whereas UCCP refers to *Unità Complesse di Cure Primarie*. These are organizational models introduced pursuant to Art. 1 of the Balduzzi Decree, in which AFTs and UCCPs constitute the forms of organization of contracted primary care, insofar as they “*deliver primary care through personnel contracted with the National Health Service*” (Art. 1, para. 2 of the Decree), namely general practitioners, paediatricians of free choice, and outpatient specialists.

More specifically, AFTs are associations of professionals described as “*monoprofessional organizational forms*” (Art. 1, para. 4, lett. b, which introduced lett. b-bis into para. 1 of Art. 8 of Legislative Decree 502/1992), aimed at “*ensuring care activities throughout the entire day and on all days of the week, as well as an integrated offer of services provided by general practitioners, paediatricians of free choice, out-of-hours services, public health services, and outpatient specialists*”. UCCPs, in contrast, are defined as “*multiprofessional organizational forms*” (Art. 1, para. 4, lett. b) that “*deliver—in accordance with regional planning—healthcare services through the coordination and integration of doctors, other contracted professionals of the National Health Service, nurses, midwives, technical professionals, rehabilitation professionals, prevention professionals, and social services with health relevance*”.

The Balduzzi Reform represented an attempt to promote bottom-up aggregation within primary care by fostering the creation of professional associations. This attempt, however, did not materialize on the scale envisioned by the legislator, partly because the ACNs (National Collective Agreements) of 21 June 2018 and 18 June 2020 systematically neglected the issue of professional associationism. A shift occurred with the ACN signed on 20 January 2022, whose Art. 8 entrusted the regions with defining programming instruments “*aimed at establishing monoprofessional organizational forms*

(AFTs) and the modalities for physicians' participation in multiprofessional forms". The most recent ACN of 4 April 2024—the first signed after the introduction of Ministerial Decree 77/2022—set out in Art. 29 the general characteristics of AFTs and assigned to Districts, pursuant to Art. 3-quater, para. 3 of Legislative Decree 502/1992, the task of defining the activities, objectives, and performance levels of AFTs. It also allowed Regional Integrative Agreements (AIRs) to expand their functions in line with regional planning.

Until last year, therefore, health authorities lacked instruments enabling the organization of primary care independently of the willingness of contracted professionals. The National Collective Agreements (ACNs) in fact constitute binding limits for regions and local health authorities in planning primary care, as underscored by Constitutional Court ruling No. 157/2019.

Even today, given the autonomy of contracted professionals, their integration within the Community Health Centres—when not voluntarily pursued—poses significant challenges for regions and health authorities. Consequently, a reform of general practice is currently under discussion, based on a proposal from the regions that includes, among other elements: *"legally binding obligations for current contracted physicians, where necessary, also for the purpose of ensuring compliance with the provisions already contained in the 2024 ACN—such as required working hours, services to be guaranteed, primary workplace settings, and digital tools to be adopted—removed from national and local collective bargaining, so as to ensure the effective implementation of the structures and organizational model envisaged by the PNRR, pending the introduction of a model allowing for the employment of GPs as salaried staff, through the creation of the position of Primary Care Medical Director, trained through a dedicated university specialization programme (in place of the current regional training course), with eligibility extended also to current GPs"* (Confidential document of the Regions, cited in *Quotidiano Sanità*, 29 May 2025).

Regardless of the contractual instruments that will ultimately be available following the reform, the integration of contracted primary care into the Community Health Centres has now entered its operational phase. The goal is to establish CCHs not only as physical healthcare buildings but also as fully functional service hubs, in line with the definition set forth by DM 77/2022: *“a physical and easily identifiable place where citizens can access healthcare and social-health services with health relevance, and the organizational model for proximity care for the reference population”*. CCHs thus serve as the territorial equivalent of hospital facilities for needs characterised by lower clinical complexity.

However, lower clinical complexity does not imply lower organizational complexity. This is due, among other factors, to the contractual status of GPs/PLS, whose relationship with the National Health Service is described as a *“private-law professional self-employment relationship with the public administration... which, owing to its specific regulatory framework, is configured as a form of quasi-subordinate employment”* (Constitutional Court ruling, 3 July 2019, No. 157). This makes contracted professionals a structurally independent variable within the system.

The territorial care model is therefore characterised by significant complexity, arising from the particular status of the general practitioner, the nature of the doctor–patient relationship, and the autonomy with which GPs organise themselves and aggregate in diverse forms within a historically heterogeneous system. These include:

- associative forms integrated within the “Case della Salute”;
- medical practices located within the facilities but not part of associative models;
- associative forms developed independently of the facilities;
- territories lacking both associative models and “Case della Salute”.

This situation leads to territorial care being conceptualised as a **hyper-complex system**, combining the complexity typical of any organisational system, the specific complexity of the healthcare sector,

the administrative complexity of public sector organisations, and the additional complexity arising from the plurality of contractual models governing healthcare professionals operating within the new structures.

4.0 Research question: how to integrate contracted primary care?

The issue of integrating general practice into the territorial healthcare delivery system has already been examined from a systemic perspective (Noto G., Noto A., Borgonovi E., 2022) and is crucial to the functioning of Community Health Centres (CCHs).

It has been observed that regional health systems display markedly different levels of development in territorial care, due to the heterogeneity of planning instruments (Cinelli et al., 2023), the varying degrees of aggregation within primary care (Barzan et al., 2019), and the fact that the *Case della Salute* model was implemented only in specific and limited territorial areas (Servizio Studi Camera dei Deputati, 2021): of the 493 Case della Salute active at the end of 2020, more than half (56.18%) were located in just three regions—Emilia-Romagna (124), Veneto (77), and Tuscany (76).

As a result, the activation of services within the CCHs has progressed in a highly uneven manner. By the end of 2024, some regions had not activated almost any service in the planned CCHs; others were more advanced, although even among these only a minority of facilities had activated all mandatory services except medical and nursing care; and only four regions had activated all mandatory services in at least five facilities (13 in Emilia-Romagna, 10 in Lombardy, 8 in Lazio, and 7 in Tuscany) (Agenas, 2024).

On 26 May, AGENAS published the national report providing detailed monitoring of the services active in CdC as of the end of 2024. This report offered a homogeneous baseline for constructing the index of mandatory services active across the different regional health systems.

This synthetic tool illustrates the degree of implementation of mandatory services in CCHs relative to those that must be active by the first half of 2026, in the CCHs planned for implementation by regional health systems. It is expressed as a percentage that describes the extent to which planned targets have been achieved.

The analysis of these data shows an unexpected result for Lombardy, which ranks first despite not having had Case della Salute in the past, although it has historically maintained a highly developed system of territorial care.

In the rest of the regions, it is clear that not all “Case della Salute” —where they existed—were equivalent: some regions with well-resourced “Case della Salute” appear in the upper part of the ranking (Emilia-Romagna and Veneto), whereas others remain far from the target (Sardinia, Sicily, and Calabria, which collectively had 83 Case della Salute active in 2020 (Servizio Studi Camera dei Deputati, 2021) and now place only marginally ahead of regions that did not have such structures at all).

Below are the revised data for all regional health systems. They should be interpreted as a synthetic snapshot of the situation, not exhaustive due to two simplifications: first, the services considered are only those common to both Hub and Spoke CCHs; second, services with differing impacts on citizens’ well-being were assigned equal weight.

Table 1. Implementation of mandatory services in Community Health Centres (CdC) across Italian regions

Region	CdC planned	Total mandatory services active	Total mandatory services planned	Index of active mandatory services
Lombardy	207	1005	1656	60.69%
Emilia-Romagna	177	840	1416	59.32%
Marche	29	107	232	46.12%
Veneto	99	349	792	44.07%

Region	CdC planned	Total mandatory services active	Total mandatory services planned	Index of active mandatory services
Molise	13	37	104	35.58%
Liguria	33	81	264	30.68%
Umbria	22	44	176	25.00%
Tuscany	156	297	1248	23.80%
Lazio	147	258	1176	21.94%
Piedmont	95	166	760	21.84%
Sardinia	80	39	640	6.09%
Sicily	164	58	1312	4.42%
Calabria	63	8	504	1.59%
Puglia	123	10	984	1.02%
Abruzzo	43	1	344	0.29%
Basilicata	19	0	152	0.00%
Campania	191	0	1528	0.00%
Friuli-Venezia Giulia	32	0	256	0.00%
Autonomous Province of Bolzano	10	0	80	0.00%
Autonomous Province of Trento	10	0	80	0.00%
Aosta Valley	4	0	32	0.00%

The scientific literature available on such a specific and sectoral topic is largely focused on local experiences of the health authorities that are further advanced in implementing services, whereas no significant studies have been carried out to support local systems facing structural disadvantages⁵.

⁵ In this regard, it is worth noting the experiences developed in Emilia-Romagna, including: Bobini M., Fattore G., Longo F., Meda F., *La Casa della Comunità come piattaforma erogativa decentrata dell'ospedale hub. Il caso dei servizi oncologici della Casa della Salute di Bettola (AUSL PC)*, MECOSAN 2022, No. 121, DOI, Franco Angeli; as well as Andena A.M., Vendramini E.A., Malvermi L., Bardasi P., Caprioli S., Tagliaferri I., *La gestione strategica della sanità territoriale alla luce del DM 77: il caso della AASUL di Piacenza*, MECOSAN 2023, No. 128, DOI, Franco Angeli; and Bergamaschi M., Castellini G.C., Lega F., Maggioni E., Violi F., *Il DM 77 nell'Azienda USL-IRCCS di Reggio Emilia: tra passato, contingenze e progettualità future*, MECOSAN 2024, No. 129, DOI, Franco Angeli.

Relevant experiences from the Lazio region include: Barbara A., Mussetto I., Cipolla C., Monchi R., Mulas M.F., Zazzera A., Donetti D., Quintavalle G., *Lo sviluppo di un modello integrato di cure in transizione: il caso delle AOU Sant'Andrea, ASL Roma 1, ASL Roma 4 e ASL Roma 5*, MECOSAN 2023, No. 128, DOI, Franco Angeli; and Lombardi M., Ventura M., Cristofaro C.L., Reina R.,

Yet the objectives of the National Recovery and Resilience Plan (PNRR)—which require the activation of at least 1,034 CdC by mid-2026—can be achieved only if those parts of the National Health Service that lag behind manage to close the gap within a very short time frame. This will be possible only by addressing in depth the principal cause of delay, identified as a clear problem of professional workforce availability (Del Vecchio M., 2022).

For this reason, the present study aims to examine in detail the barriers hindering the integration of general practitioners (MMG) and paediatricians of free choice (PLS) into the CCHs, drawing on the perspectives of professionals and employing an approach that conceptualises CCHs as ecosystems (D'Andeamatteo A., Antonucci G., Arquilla P., 2023). The analysis focuses on a regional system that has historically lacked both Case della Salute and significant forms of aggregation within contracted primary care.

4.1 Why the Abruzzo region represents a relevant case study

Regional Resolution No. 15 of 17 January 2023 approved the programming act aimed at establishing monoprofessional organisational forms and defining the modalities for the participation of contracted

Cenciarelli S., Parrocchia S., Ciarlo G., Lombardi A., *Organizzare l'azienda sanitaria di Latina alla luce del DM 77: analisi ed esperienze*, MECOSAN 2024, No. 129, DOI, Franco Angeli.

For Tuscany, reference should be made to: Tadderini F., D'Amato M.G., Tozzi V., Limaj S., Capitani E., Pagliantini G., Turillazzi R., De Luca A., D'Urso A., *DM 77/2022: la riorganizzazione dei servizi per rispondere ai bisogni dei pazienti fragili e cronici. L'esperienza dell'Azienda USL Toscana Sud Est*, MECOSAN 2023, No. 128, DOI, Franco Angeli.

For Liguria: Romiti A., Giacobbe S., Clemente F., Brioschi A., Petralia P., *Digitalizzazione e sanità di prossimità: il progetto "Tigullio, luogo di salute" della ASL4 Liguria*, MECOSAN 2022, No. 123, DOI, Franco Angeli.

For Piedmont: Rosa A., Capolupo N., Pacileo G., *Implicazioni e sfide dell'implementazione del DM 77/2022 nell'assistenza sanitaria territoriale: il caso dell'ASL di Alessandria*, MECOSAN 2023, No. 128, DOI, Franco Angeli.

primary care professionals (GPs, paediatricians of free choice, and outpatient specialists) in multiprofessional organisational models.

The programming act provides a detailed assessment of the implementation status of the Balduzzi Reform in the Abruzzo Region, offering a precise description of the situation of contracted primary care at the time of the approval of Ministerial Decree 77/2022.

In numerical terms, the territorial organisational forms for the provision of primary care active in Abruzzo in 2022 consisted of **24 AFTs of General Medicine, 6 AFTs of Paediatricians of Free Choice, 7 AFTs of Outpatient Specialists**, and **8 UCCPs** at regional level (Regional Resolution No. 15 of 17/01/2023, Table 4). In absolute terms—given a population of 1,275,950 inhabitants—these figures are not particularly significant, although they do indicate the presence of a minimum degree of aggregation.

What the data highlight, however, is the overall **very limited participation** of professionals in the existing organisational forms: only **150 of the 962 GPs**, only **1 of the 134 paediatricians** and only **11 of the 282 outpatient specialists** operated within a UCCP.

Regarding the characteristics that UCCPs must possess to be classified as Community Health Centres, the data presented in the programming act show a considerable gap between the current situation and the expected configuration at full implementation. Although all **8 UCCPs** active (out of the **25 planned**) have a nursing clinic, only **6** guarantee 24/7 continuity of care; only **3** are equipped with a Single Access Point (PUA); and only **one** is equipped with a Community Hospital, an emergency medical services post (118), and residential services for chronically ill non-self-sufficient patients (Regional Resolution No. 15 of 17/01/2023, Table 10).

This starting point makes the implementation of the territorial care model envisaged by Ministerial Decree 77/2022 more challenging, as the emerging Community Health Centres cannot result from an

incremental evolution of Case della Salute—which were not present in the region—nor can they, in most cases, represent a development of existing UCCPs, for the reasons explained above.

Abruzzo may therefore be considered a particularly relevant region for studying the dynamics of implementing DM 77/2022, especially in those contexts where Community Health Centres constitute a **radical innovation** within the territorial healthcare system.

5.0 Research method

To investigate how General Practitioners (GPs) perceive the organizational transition required by Community Care Homes (CdC) and to explore the conditions necessary for their effective integration, a mixed-method research design was adopted. The study was conducted within the Local Health Authority (ASL) of Pescara—an emblematic case of a territorial system with limited prior associative experiences among GPs.

The research unfolded in three sequential phases:

5.1 Exploratory interviews

The first phase consisted of semi-structured interviews with key informants involved in the organization and delivery of territorial care. These included district managers, representatives of GP networks, coordinators of experimental UCCPs, and administrative officers responsible for primary care planning. The purpose of this phase was to identify emerging themes, operational challenges, and contrasting perceptions of the territorial-care reform.

5.2 Focus groups and questionnaire development

Based on insights from the interviews, a structured questionnaire was drafted and subsequently refined through two focus groups held with contracted GPs of the ASL of Pescara. The focus groups allowed for:

- validating the relevance and clarity of the questionnaire items,
- capturing nuanced views on aggregation, digital infrastructure, and CdC expectations,
- integrating practical concerns expressed by practitioners during the discussion.

This iterative process helped ensure both content validity and contextual alignment with local professional dynamics.

5.3 Survey administration

The final questionnaire was administered to all contracted GPs of the ASL of Pescara during a mandatory continuing education course titled “*The reform of territorial healthcare*”, held in June 2025. Out of 242 eligible GPs, **210 completed the questionnaire**, yielding an **86.77% response rate**—a remarkably high level of participation, which strengthens the representativeness and reliability of the findings.

5.4 Local context of aggregation models

The survey results must be interpreted in light of the specific organizational context of the ASL of Pescara. As of mid-2025:

- only **23 GPs** (9.5% of the total) belonged to an aggregation formally aligned with the Balduzzi Decree;
- these 23 professionals represented **15.33%** of all GPs involved in Balduzzi-type aggregations across the Abruzzo Region;
- **no Functional Aggregations (AFT)** were active in the province;
- and the only two UCCPs (in Penne and Scafa) remained **experimental**, lacking several key infrastructural and organizational requirements.

This situates the ASL of Pescara among those territorial systems where the CdC implementation challenge is particularly acute, not only in terms of infrastructure but also in terms of professional culture, associative capacities, and readiness for interdisciplinary collaboration.

6. Results

The findings of the survey highlight that, although the forms of aggregation implemented by General Practitioners (GPs) in the ASL of Pescara differ substantially from those envisioned by the Balduzzi Decree, a significant share of professionals have nonetheless experimented with aggregated practice throughout their careers.

6.1 Existing experiences of aggregation

The findings of the survey nevertheless show that, although developed in forms different from those envisaged by the Balduzzi Decree, GPs have autonomously experimented with various forms of professional aggregation. Overall, 55.23% of respondents reported having carried out their activity within some form of aggregated practice. Among those who answered in these terms, the majority (71.55%) had experience of group-based arrangements in different forms from those envisaged by the Balduzzi Decree: professional experiences mainly concern **Network-based Primary Care** (68 cases), followed by **Group Practice** (45), **Associative Practice** (18), and, to a much lesser extent, **cooperative-based arrangements** (2).

These data confirm that, albeit in heterogeneous and often informal ways, a considerable proportion of GPs have experienced collaborative modes of practice, even in a region where structured aggregations have been limited.

6.2 Perceived benefits and drawbacks of aggregation

Among respondents with previous experience in aggregated settings, the most frequently reported **benefits** were:

- **improved management of absences** due to greater ease in arranging substitutions (93 responses),
- **enhancement of clinical and organizational activities** through collaboration with other health professionals (94 responses),
- **economic advantages**, particularly in terms of financial incentives (71 responses).

Conversely, the most commonly identified **drawbacks** included:

- **increased fixed operating costs** (78 responses),
- **greater overall workload** associated with coordination and shared responsibilities (71 responses),
- **organizational complexity** arising from the need to coordinate multiple professional roles within the same structure (50 responses).

These perceptions reveal that aggregation generates recognizable benefits but is also associated with significant burdens, particularly in contexts where organizational support is limited, and where aggregations have historically emerged in an unstructured and voluntary manner.

6.3 Opportunities and risks associated with Community Care Homes (CCHs)

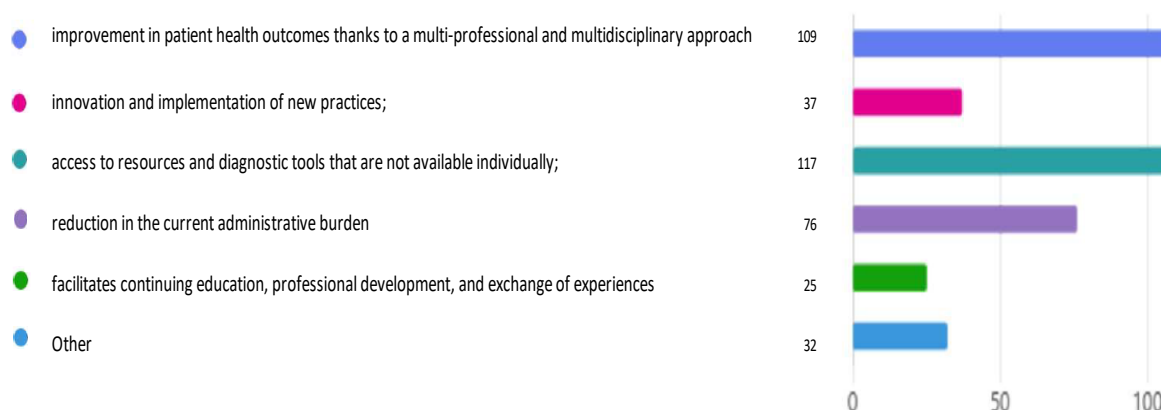
When asked about the opportunities offered by the CCHs model, respondents most frequently identified:

- **access to diagnostic resources and instruments** not available in individual practices (117 responses),

- **improved health outcomes** for patients through a multi-professional approach (109 responses).

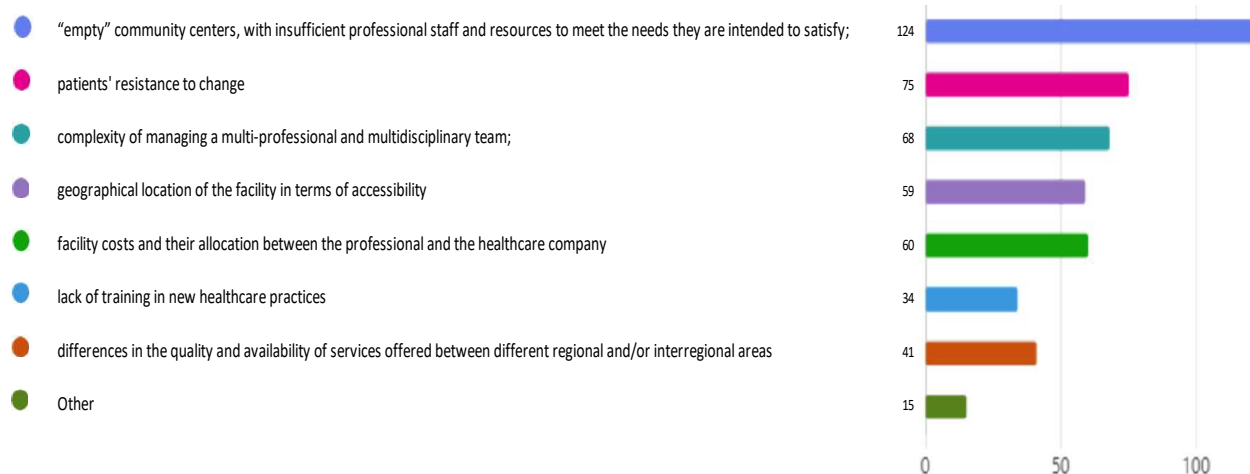
These elements reflect the potential of CCHs to overcome long-standing limitations of solo practice and isolated professional work.

Figure 1 - Opportunities of CCHs for MMG (from 1 to a maximum of 3 responses to the survey questionnaire)



However, respondents also expressed concerns. The most common **risk** identified was the possibility of creating “**empty buildings**” — CCHs with insufficient staff, inadequate equipment, or limited service availability (124 responses).

Figure 2 - Risks of CCHs for MMG (from 1 to a maximum of 3 responses to the survey questionnaire)



This concern reflects the fear that infrastructure alone will not guarantee meaningful organizational change unless accompanied by adequate professional integration and resource allocation.

6.4 Indicators for monitoring the functioning of CCHs

Respondents were also asked to identify the key indicators that should be used to monitor the performance and effectiveness of CCHs. The majority (119 responses) identified:

- **Emergency Department visits** as the primary metric to evaluate the impact of territorial care on acute service utilization.

Other indicators considered useful included:

- **waiting times** for appointments and specialist consultations (85 responses),
- **degree of utilization of CCHs services** (79 responses),
- **number of avoidable hospital admissions** for patients who could benefit from home-care programs (76 responses).

Together, these indicators reflect a strong awareness among GPs of the systemic role of CdC in reducing inappropriate hospital use and improving care coordination.

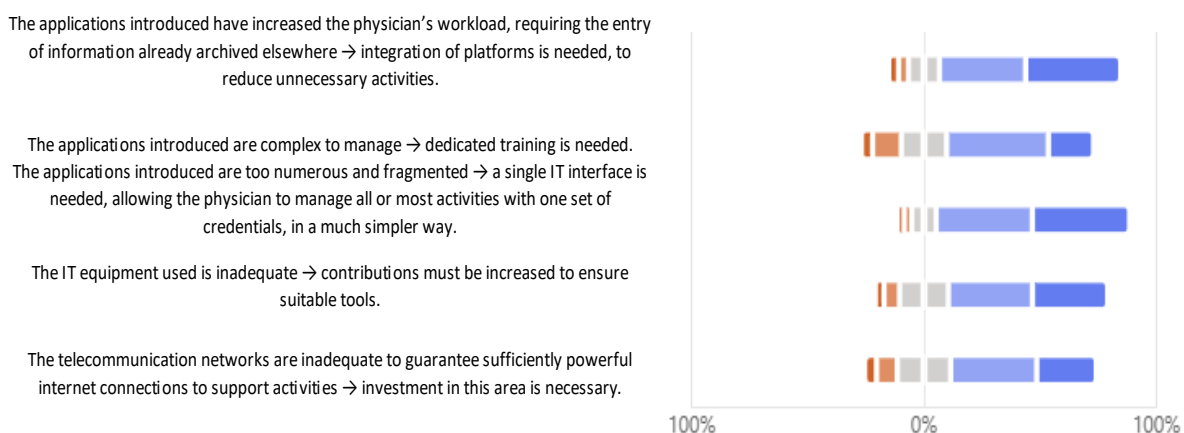
6.5 Perceived digital complexity

The study also explored the degree of adoption and usability of digital tools—an essential component for implementing the territorial-care model envisioned in DM 77.

The results show widespread use of the telephone and email: the vast majority of respondents use the telephone to monitor specific clinical situations (173) and email to send drug prescriptions to chronically ill patients (155). By contrast, the use of email for transmitting therapeutic indications is more limited (103), while all other forms of digital support identified during the focus groups—such as applications or tools for video consultations and remote monitoring, which are already in use in other territorial settings—are currently negligible.

This difficulty, which had already emerged during the preliminary qualitative phase, was explored in greater depth through a specific measurement using a Likert scale. This instrument was used to assess the degree of agreement with five potential explanations for the phenomenon, previously identified during the focus groups. As shown in the following figure, all the proposed hypotheses received strong agreement from respondents, with particularly high consensus regarding statements referring to excessive complexity resulting from the fragmentation of digital applications and the lack of interoperability among available solutions. These issues often force professionals to spend additional time entering information that is already available and stored in other digital support systems.

Figure 3 - Limits of digitalization in the experience of General Practitioners



These findings reveal that digital infrastructure, as currently deployed, is perceived as a significant barrier to the efficiency and integration of professional activities—rather than as an enabling tool. This is particularly relevant given that the NRRP allocates substantial resources to telemedicine platforms and the Electronic Health Record (FSE), both of which are essential for the operational functioning of CCHs.

7. Discussion and conclusions

The historical trajectory of aggregation experiences within the ASL of Pescara—largely developed through informal arrangements that differ substantially from those envisioned by the Balduzzi Decree—has significantly shaped GPs’ perceptions of the reform introduced by DM 77. Although aggregated practice facilitated **simpler management of absences**, participating professionals reported that it also entailed **higher fixed costs, greater workload, and increased organizational complexity**. These perceptions stemmed from the **limited institutional structuring** of past aggregations, where the Local Health Authority played a minimal role and much of the organizational responsibility rested on the professionals themselves.

Over the years, aggregation processes lacked strategic planning and consistent regional and corporate guidelines. They were often driven primarily by contractual incentives rather than by broader organizational objectives. Only the two experimental UCCPs in Penne and Scafa benefited from dedicated corporate facilities; elsewhere, the absence of adequate logistics hindered aggregation—whereas, in other regions, well-planned infrastructures often served as catalysts for collaboration.

The design embedded in DM 77, however, offers a path to overcome these limitations. First, the **construction of CCHs facilities**, financed through substantial NRRP investments, promises to resolve long-standing issues related to inadequate infrastructure—an obstacle that has traditionally

hindered the development of territorial care. Second, the NRRP also allocates important resources to the **digital infrastructures** required to support new modes of professional activity within CCHs, including telemedicine platforms and the Electronic Health Record (FSE). These tools are crucial for reducing information fragmentation, enhancing interoperability, and simplifying administrative burdens—issues repeatedly highlighted by GPs in the survey.

The challenge for the ASL of Pescara—and for regions facing similar conditions—is therefore twofold:

1. **to close the implementation gap** with regions that have already advanced in activating CdC services;
2. **to define sustainable, effective modalities for integrating contracted primary-care physicians** into the new structures.

Despite existing obstacles, the findings of this study suggest that **no insurmountable barriers** stand in the way of achieving these goals. The local system may not have benefited from the same historical trajectory as regions with established CdS networks, but:

- the availability of infrastructural investments,
- the standardization introduced by DM 77,
- the strong interest expressed by GPs in accessing diagnostic resources and improving patient outcomes,
- and the recognition of clear indicators for monitoring CCHs performance

constitute favorable conditions for successfully implementing the reform.

The key challenge lies in engaging professionals, first and foremost by restoring an adequate level of knowledge of the new organisational models and operational arrangements. The training course entitled “The reform of territorial healthcare”, delivered as part of the mandatory continuing

education programme for GPs in 2024, clearly moves in this direction and has demonstrably achieved its objectives, with 100% of participants successfully passing the learning assessment.

Once a shared understanding of the foundational principles underpinning the new model has been ensured, further initiatives can be undertaken to valorise the specific experiences of the professionals to be involved in the newly established Functional Territorial Aggregations (AFTs).

In this way, the activation of AFTs can be designed to simultaneously address both macro-level organizational challenges and micro-level issues affecting individual professionals or small professional groups—issues that have already been experienced under different organizational arrangements, albeit still centered on aggregation.

Such an approach presupposes a deeper and more structured involvement of professionals, this time in a bidirectional manner, potentially extending to co-design processes for the services to be activated. This need is clearly illustrated by the experiences of those local health authorities that are more advanced in the implementation pathway.

The choices made by professionals are decisive for the establishment of AFTs and, consequently, for determining the staffing needs of the Community Health Centres hosting the various AFTs. Moreover, even once AFTs have been defined, the decisions of individual professionals remain crucial in shaping the clinical and care pathways of their patients.

This includes the possibility of delivering certain services within GP practices and, more broadly, the exercise of the so-called gatekeeping role—that is, the “filtering” function regulating access to specialist and diagnostic services or to hospital admission (Agenas, 2022).

For these reasons, the concluding consideration concerns the centrality of the role of GPs within the new organisational model of territorial healthcare. The integration of contracted primary care into

Community Health Centres is a process that cannot be achieved without the active and sustained involvement of professionals.

If these enabling conditions are met, the CdC model can evolve into the primary-care equivalent of the hospital—a structural and organizational reference point for managing health needs of lower clinical complexity but high organizational interdependence.

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Conclusions

This doctoral research set out to examine the transformation of territorial healthcare in Italy through the implementation of Community Care Homes (CCHs) within the broader reform introduced by the National Recovery and Resilience Plan (PNRR) and Ministerial Decree 77/2022 (DM77). Conducted within the framework of an industrial PhD developed through the collaboration between ASL Pescara and the University “G. d’Annunzio”, the thesis combined scientific inquiry with direct organizational engagement, offering a unique opportunity to investigate the reform both analytically and operationally. Across four empirical studies, the dissertation explored the institutional, organizational, digital, and professional dimensions shaping the emergence of CCHs as innovation ecosystems in a late-adopter regional context.

One of the original contributions of this research lies precisely in its embedded perspective. By operating within the organizational environment in which the reform was being implemented, the study gained direct access to institutional actors, governance processes, managerial dynamics, and professional perceptions that are often difficult to observe in real time during large-scale public sector transformations. This positioning made it possible not only to analyse the formal architecture of the reform, but also to capture the tensions, adaptations, informal practices, and organizational negotiations accompanying the transition toward new territorial care models.

Overall, the research demonstrates that while the reform provides a clear institutional and infrastructural framework for reorienting the Italian healthcare system toward community-based care, its effective implementation depends on a broader set of enabling conditions that extend beyond structural investments alone. These include professional engagement, organizational culture, interprofessional collaboration, digital maturity, institutional coordination, and participatory governance. The findings show that the success of Community Care Homes depends not only on the

availability of physical infrastructures and technologies, but even more on the ability of healthcare systems to mobilize the people operating within them, fostering trust, collaboration, and shared responsibility.

1. Integrated Findings Across the Four Studies

The cumulative evidence emerging from the four empirical chapters reveals several interconnected insights into the dynamics governing the implementation of territorial healthcare reform in Italy.

1.1 Community Care Homes as ecosystems of innovation

The first study conceptualized Community Care Homes as multi-actor ecosystems integrating organizational, technological, institutional, and professional dimensions. This perspective proved foundational for the entire thesis. The findings showed that CCHs should not be interpreted merely as new physical facilities, but rather as organizational platforms designed to support collaborative, digitally enabled, and community-oriented care. Their effectiveness depends on the construction of shared identities, collective learning processes, integrated governance mechanisms, and interdisciplinary professional practices.

1.2 Digitalization as an enabling but insufficient condition

The second study highlighted the crucial role of digital infrastructures—including telemedicine, electronic health records, and interoperability systems—as enabling conditions for proximity care and service integration. At the same time, the findings demonstrated that digitalization alone cannot guarantee organizational innovation. Technologies and financial investments remain insufficient

unless accompanied by training initiatives, organizational readiness, and coordinated governance arrangements. Fragmented information systems, heterogeneous regional implementation strategies, and uneven digital competencies continue to generate misalignments between national policy ambitions and operational realities at the local level.

1.3 Misalignments between policy design and implementation

The third study examined the practical tensions emerging during implementation, revealing persistent gaps between the conceptual design of the reform and the concrete organizational conditions within which it is enacted. These tensions include unclear professional boundaries, insufficient communication across services, variable digital infrastructures, uncertainty regarding operational responsibilities, and limited involvement of frontline professionals in planning processes. Such misalignments reflect broader systemic challenges affecting the Italian healthcare system, including legacy organizational cultures, unequal resource distribution, fragmented governance structures, and limited participatory approaches to organizational change.

1.4 The central role of General Practitioners in enabling reform

The fourth study—based on the largest empirical data collection conducted within the thesis—highlighted the central role of General Practitioners (GPs) in enabling the effective implementation of DM77 and Community Care Homes. The findings demonstrated that professionals' perceptions of the reform are strongly shaped by previous experiences of aggregation, organizational culture, levels of institutional support, and concerns regarding professional autonomy within integrated care models.

In particular, the evidence emerging from ASL Pescara revealed how prior experiences of professional aggregation—often characterized by weak institutional coordination, limited strategic

guidance, and highly autonomous organizational arrangements—continue to influence current attitudes toward the reform. For many professionals, previous aggregation models were associated with increased organizational complexity, higher management burdens, and insufficient operational support. These experiences contribute to shaping skepticism and uncertainty regarding the practical implementation of CCHs and the redistribution of responsibilities within new territorial governance arrangements.

At the same time, the study demonstrated that professional engagement represents the decisive enabling factor for reform implementation. Even in the presence of infrastructures and regulatory frameworks, territorial healthcare transformation cannot succeed without the active participation of GPs and other community professionals. Knowledge, training, organizational recognition, and involvement in decision-making processes emerged as fundamental determinants of this engagement.

Importantly, the organizational and managerial dynamics observed within the Abruzzo context appear consistent with broader patterns characterizing the ongoing transformation of territorial healthcare across Italy. Although Abruzzo represents a relatively late-adopter regional context when compared with more consolidated experiences in regions such as Emilia-Romagna or Tuscany, the evidence collected within ASL Pescara reveals structural and governance-related challenges that are widely embedded within the decentralized architecture of the Italian National Health Service. These include fragmented governance arrangements, heterogeneous regional implementation capacities, uneven levels of digital maturity and interoperability, as well as persistent tensions between traditional forms of professional autonomy and the collaborative logic underpinning integrated models of community-based care.

These considerations are further supported by the regional disparities emerging from the implementation levels of mandatory services within Community Health Centres across Italy. The evidence presented in Table 1 highlights a highly heterogeneous national landscape, characterized by significant asymmetries in the operational activation of services envisaged by DM77. While regions

such as Lombardy (60.69%) and Emilia-Romagna (59.32%) display comparatively advanced levels of implementation, several southern and late-adopter regions show extremely limited activation rates. Abruzzo, in particular, records only 0.29% of active mandatory services despite the planned establishment of 43 Community Health Centres, positioning the region among the lowest-performing territorial healthcare systems nationally. Similar delays emerge in regions such as Calabria (1.59%), Puglia (1.02%), Sicily (4.42%), and Sardinia (6.09%), while several territories—including Campania, Basilicata, Friuli-Venezia Giulia, and the Autonomous Provinces of Bolzano and Trento—had not yet activated mandatory services at the time of data collection. These discrepancies suggest that the implementation of territorial healthcare reform remains deeply conditioned by variable organizational capacities, governance models, institutional coordination mechanisms, and regional administrative trajectories. Consequently, the reform process appears far from homogeneous, reflecting the persistent territorial fragmentation historically characterizing the Italian National Health Service.

From this perspective, the criticalities emerging in the Abruzzo case should not be interpreted merely as localized implementation weaknesses, but rather as manifestations of broader institutional, organizational, and cultural dynamics shaping the national trajectory of territorial healthcare reform. The ASL Pescara experience therefore acquires analytical relevance beyond its regional boundaries, offering empirically grounded insights into the systemic conditions that may facilitate—or hinder—the implementation of Community Care Homes within other Italian healthcare organizations undergoing similar processes of transformation.

Across all four studies, one overarching conclusion clearly emerges: territorial healthcare reforms are fundamentally human-driven transformations. Structural investments and digital infrastructures create the conditions for change, but implementation ultimately depends on professionals' trust, motivation, adaptive capacity, and willingness to collaborate within new organizational frameworks.

2. Contributions of the Thesis

2.1 Theoretical Contributions

The thesis offers several contributions to the literature on health policy, public management, and healthcare innovation.

First, it advances the conceptualization of Community Care Homes as health innovation ecosystems, integrating organizational, professional, technological, and governance dimensions within a unified analytical framework. In doing so, the research contributes to overcoming purely infrastructural or administrative interpretations of territorial healthcare reform.

Second, the thesis contributes to scholarship on public value co-creation by demonstrating how territorial healthcare reforms require collaborative governance, distributed leadership, and the active involvement of professionals operating at different institutional levels.

Third, the research enriches debates on primary care transformation by examining the evolving role of General Practitioners within healthcare systems undergoing structural redesign. In particular, the findings highlight how professional engagement, organizational trust, and prior institutional experiences significantly influence reform trajectories.

Finally, one of the original contributions of the thesis lies in connecting national reform objectives with the organizational realities experienced within a late-adopter regional context. The Abruzzo case demonstrates how local implementation processes reflect broader systemic tensions embedded within the decentralized governance structure of the Italian National Health Service. Through the ASL Pescara experience, the thesis provides empirically grounded insights into the organizational conditions that may either facilitate or hinder territorial healthcare transformation.

2.2 Methodological Contributions

Methodologically, the thesis demonstrates the value of adopting mixed-methods approaches to investigate complex healthcare reforms, combining document analysis, interviews, focus groups, and survey methodologies to generate multi-level evidence.

The industrial PhD framework represented a further methodological strength, enabling direct access to institutional actors, managerial processes, organizational decision-making, and professional dynamics in real time. This embedded research position allowed the study to capture dimensions of implementation that are often inaccessible through external observational approaches alone.

The integration of qualitative and quantitative evidence also strengthened the robustness of the findings, allowing the research to combine interpretive depth with empirical generalizability.

2.3 Managerial and Policy Contributions

For healthcare managers and policymakers, the thesis provides several operationally relevant insights.

The findings highlight the need for early and meaningful involvement of healthcare professionals—particularly General Practitioners—in organizational planning and governance processes. The research also emphasizes the importance of investing in training initiatives, digital competencies, and communication strategies capable of fostering shared understanding and reducing uncertainty during periods of organizational transition.

Furthermore, the evidence underlines the necessity of strengthening interoperability, institutional coordination, and integrated governance mechanisms across territorial services. The thesis also

demonstrates the strategic importance of participatory design and co-production approaches in supporting organizational legitimacy and professional engagement.

The experience of ASL Pescara suggests that successful implementation of Community Care Homes requires not only infrastructural investments, but also sustained organizational support, adaptive governance capacity, and long-term investment in professional relationships and organizational learning processes.

3. Implications for Future Research

This research opens several avenues for future investigation.

First, longitudinal studies are needed to monitor the long-term maturation of Community Care Homes, including their organizational performance, clinical outcomes, sustainability, and impact on patient experience.

Second, comparative analyses across Italian regions may help clarify how institutional capacity, organizational culture, governance arrangements, and historical trajectories influence reform implementation in different territorial contexts.

Third, further research should evaluate the impact of digital innovation—including telemedicine, interoperability systems, and digital literacy interventions—on care integration, accessibility, and equity.

Fourth, additional studies are needed on professional identity transformation and organizational adaptation, particularly regarding how General Practitioners and other territorial healthcare professionals negotiate new collaborative and governance roles.

Finally, future research should further explore participatory and co-design approaches involving managers, healthcare professionals, patients, and local communities in shaping the future evolution of Community Care Homes.

4. Final Reflections

This thesis demonstrates that the reform of territorial healthcare in Italy represents a historic opportunity to realign the Italian National Health Service with the needs of an ageing population characterized by increasing levels of chronicity and care complexity. Community Care Homes have the potential to become the organizational backbone of a more accessible, integrated, digitally enabled, and community-oriented healthcare system. Yet their success cannot be considered automatic or guaranteed.

What emerges from this research is that territorial healthcare reform is not merely a matter of infrastructures, technologies, or regulatory compliance. Rather, it represents a profound process of organizational, cultural, and professional transformation requiring time, interaction, negotiation, and trust-building among the actors involved.

The evidence generated within the Abruzzo region—and particularly through the ASL Pescara experience—demonstrates both the opportunities and the criticalities associated with implementing Community Care Homes in late-adopter contexts. At the same time, the organizational and managerial dynamics identified throughout the research reveal structural analogies with broader national implementation challenges, suggesting that many of the tensions observed locally reflect systemic characteristics of the Italian healthcare system as a whole.

The findings ultimately confirm that territorial healthcare reform can succeed only if it embraces an ecosystemic vision of innovation, where change is co-produced through the interaction of policymakers, healthcare professionals, managers, institutions, patients, and communities. In this

perspective, investing in infrastructures and technologies remains essential, but insufficient in itself. Equally necessary are investments in professional engagement, organizational learning, institutional trust, collaborative governance, and shared responsibility.

In this sense, the thesis contributes not only to academic debate, but also to a broader institutional and societal commitment: supporting the evolution of a public healthcare system capable of remaining equitable, resilient, sustainable, and responsive to the needs of citizens in an increasingly complex healthcare environment.