



Innovating care for people with multiple chronic conditions in Europe

Caring for people with multiple chronic conditions in Italy: policy and practices

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Key points

- Italy is an ageing country with about 46% of the 50+ population suffering from multimorbidity.
- New policies and care programmes addressing multimorbidity have been introduced, with good/preliminary results in terms of integration/collaboration of care services/providers, changes in utilisation of resources, involvement of informal carers and transferability.
- Despite these developments, the current financial crisis and the related cuts in public expenditures on health and social care impact on the sustainability of the whole welfare system.
- A large part of chronic illness care for (mainly older) people suffering from multimorbidity thus continues to rely on informal help from family members.



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1. Multimorbidity: a challenge for care delivery

Until recently, multimorbidity— the occurrence of more than one chronic disease within an individual— has not received much attention from European policy-makers. However, this seems to be changing, now that it has become clear that the number of people with multimorbidity is rapidly increasing. Currently, an estimated 50 million (mostly older) people in the European Union live with multiple chronic diseases¹, which deeply impacts their quality of life in many ways (physically, but also mentally and socially). This implies an increasing demand for multidisciplinary care that is tailored to the specific health and social needs of people with multimorbidity.

Yet interdisciplinary collaboration across sectors (e.g. primary care, hospital care, social care, home care, community services) is often hindered by differences in organisational and financing arrangements between sectors. Moreover, most care delivery models are based on a single disease approach, which could bring about fragmentation, gaps or overlap in care delivery for people with multimorbidity with negative consequences for the quality of care, patient outcomes, efficiency and costs.

Integrated care models have the potential to overcome these problems by taking a holistic approach while making efficient use of resources. Such models are characterised by proactive patient-centred and well-coordinated multidisciplinary care, using new technologies to support patients' self-management and improve collaboration between caregivers. The **ICARE4EU** project (see Box 1) explores new models and care practices aimed at delivering integrated care for people with multimorbidity in 30 European countries. This factsheet describes how policy and practices are developing in Italy.

2. The challenge of multimorbidity in Italy

In 2011, among a total population of 59.3 million inhabitants, 20.5% of people were aged 65 years and older, and 6.0% were 80 years and older². Among the total EU-27, lower percentages of older inhabitants were found (65+: 17.6%; 80+: 4.8%).

Of the Italian population* an estimated 26.6% reported to have at least one long-standing illness or health problem³. Figure 1 shows the prevalence of some major chronic diseases, highlighting that prevalence rates are much higher for people aged 75+ (especially with regard to arthritis). Based on the occurrence of 14 self-reported chronic conditions, it has been estimated that approximately 46% of the population aged 50 years and older suffer from multimorbidity, i.e. have been diagnosed with at least two of these 14 conditions⁴.

* This is a rectification of the previously published country factsheet that incorrectly referred to the population aged 16 to 64.

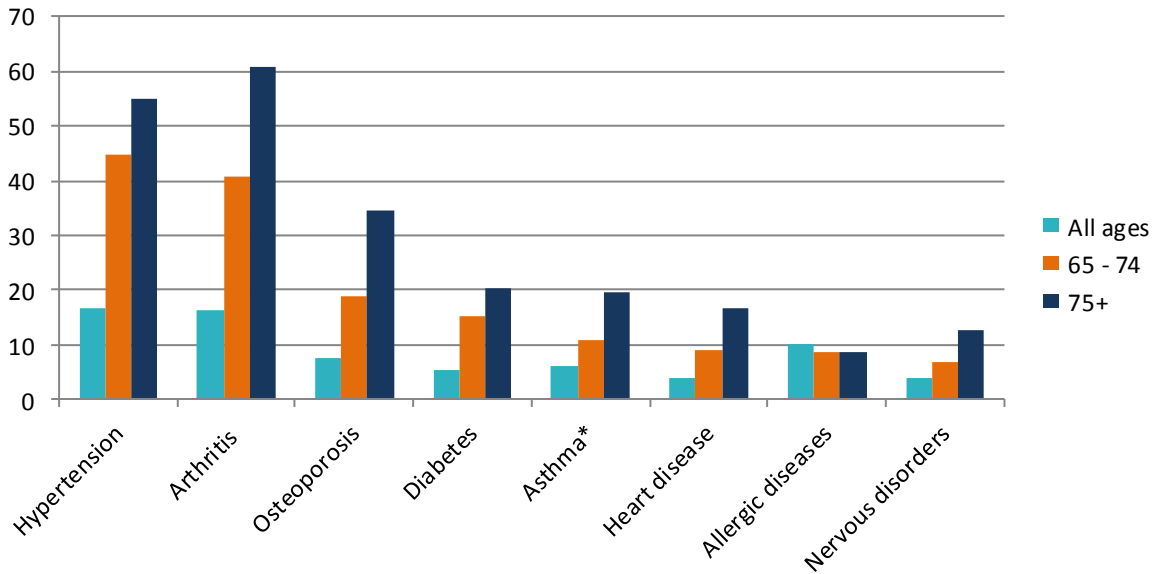
Box 1 The ICARE4EU project

The ICARE4EU project aims to identify, describe, and analyse innovative, integrated care models for people with multimorbidity in 30 European countries, and to contribute to more effective implementation of such models.

For this purpose, country experts have been contracted (one for each country) to identify programmes at a national, regional or local level in their country that focus on providing care for adult (or older) people with multimorbidity, or contain specific elements for this target group. Multimorbidity is defined for this project as *the presence of two or more medically (somatic or psychiatric) diagnosed chronic (not fully curable) or long lasting (at least six months) diseases, of which at least one is of a primarily somatic nature*. Programmes should involve a formalised cooperation between two or more services, of which at least one medical service, and they should be evaluated — or have an evaluation planned — in some way. For each eligible programme, the country expert or the programme manager completed an online questionnaire. In addition, country-level data were provided by the country experts and partly collected by the project team from European databases.

Based on all data available, good practices will be identified and studied in the second half of 2014. For this purpose, additional qualitative data from different perspectives (e.g. management, care providers, patients) will be gathered by site visits. Analysis of the good practices will result in knowledge about the characteristics and conditions for successful implementation of multimorbidity care practices in various European countries. For more information: www.icare4eu.org.

Figure 1 Prevalence of some major chronic diseases in Italy in 2013, estimations of the total population (all ages, 65-74, 75+) (% of 100 units in same age group)⁵



*Chronic bronchitis, bronchial asthma

In 2011, Italy spent 9.2% of its Gross Domestic Product (GDP) on health care, which is an increase of almost 23% in comparison with 1998 (7.5%).⁶ Across the total EU, the expenditures on health care rose from 7.9% to 9.6% over the same period (+21.5%)⁷, thus showing a similar increase. The relative amount of health care expenditures (as share of GDP) in 2011 in Italy was on the EU average and in line with other Mediterranean countries such as Greece (9.1%) and Spain (9.3%), but below Portugal (10.2%) and the greater part of northern European countries. See Appendix 1 for some general characteristics of the Italian health and social care system.

3. The Italian response to the challenge of multimorbidity

In order to respond to the increasing number of chronically ill citizens, and people with multimorbidity in particular, Italy has introduced some new policies and measures to adapt the health care system and care practices to the challenge of meeting the more comprehensive needs of these people.

Policy on multimorbidity care

Italy outlined the basics of its policy on chronic illness care in 2005⁸, when the Italian National Institute of Health and the Italian Centre for Disease Prevention and Control of the Ministry of Health developed the “IGEA” project, which aimed to improve the quality of diabetes management by implementing integrated care⁹. A next step was the promotion by the Italian Ministry of Health in 2009 of the development of the Global Alliance against chronic respiratory diseases¹⁰.

Specific policy on multimorbidity management has been formulated by the Chronic Related Group set up in 2012 by the Lombardy Region, which represents an innovative model for improving continuity of care¹¹, and by the adoption of the Expanded Chronic Care Model^o by the Tuscany Region in 2008, which keeps in consideration not only pathology but also health, social, economic and cultural conditions¹². Moreover, the Single Point of Access (carried out in 84% of the socio-sanitary districts) aims to ensure the integrated take-over of care for patients with health and social needs¹³.

The policy on chronic illness care and multimorbidity has been initiated mainly by the Italian Ministry of Health, the Italian National Institute of Health and some northern regions, in addition to representatives of patients/clients, professional providers and care centres. This

^oThe Expanded Chronic Care Model (ECCM) is the advancement of the Chronic Care Model, that combines clinical aspects of the individual with public health initiatives. This model has been adopted by the Tuscany Region in its Regional Health Plan 2008-2010. In the project included in the Box 2 only CCM had been applied.

policy has resulted in some measures addressing legislation and professionalization of care providers (e.g. a *National Guidance* and a *Training Manual* both from the IGEA Project¹⁴).

Care practices addressing multimorbidity

Based on expert information and snowballing, seven care practices or programmes^d addressing multimorbidity patients or focusing on multimorbidity management were identified in the first half of 2014 in Italy^e. From four of these programmes^f, we collected information about their objectives, characteristics and results (see Box 2). Presented below are some results of the survey, as reported by either the country expert or the programme managers.

The programmes

Among the four programmes described in Box 2, the Aria project [1] can be characterised as a local pilot project, whereas the other three are larger scaled projects. One of these is an international programme [4], one operates at a local/regional level [3], and the last one is implemented at a regional level but is fully integrated in the regular healthcare system [2]. All programmes operate at the level of daily patient care and at the policy/managerial level.

Multimorbidity orientation

Three programmes [1,3,4.] focus on specific diagnoses but also on the co-occurrence of specific chronic diseases, for instance neuromuscular diseases/severe kyphoscoliosis (with chronic respiratory failure), heart failure/COPD/diabetes, or diabetes/heart disease /hypertension/dementia. The CCM programme [2] focuses on multimorbidity in general.

Objectives

The main objective of all programmes described is related to quality of care (e.g. to improve integration and coordination of care). Other common objectives refer to utilisation and costs (e.g. to prevent misuse of services) and improving patient centeredness [1,3,4]. Other objectives relate to patient outcomes (e.g. to decrease complications or mortality) [1,4] and to improving access to health care and support services [2,4]. In the MATRICE programme information flows and administrative data related to chronic conditions are used to improve care delivery for people with multimorbidity by implementing organisational change. Other

^d This term refers to care programmes, projects and interventions that have been developed or adapted for use in (a certain region or municipality of) this country, and are actually running in 2014 (e.g. as a pilot/project or already more structurally implemented), start in 2014 or had been finished in 2013.

^e We do not assume that all available (eligible) care practices or programmes in Italy were identified.

^f A total of seven programmes were identified, but three of them did not exactly meet the selection criteria. These programmes are not described here.

objectives of this programme are improving professional knowledge on multimorbidity, identification of target patients, and monitoring adherence to standards of care [3].

Target groups

Three programmes [1,2,4] target both patients with multimorbidity and medical care providers. Two of these also target families/informal carers[1,4], and one also includes non-medical care providers[2]. In the Renewing Health programme, particularly older patients (65+) are addressed. In the CCM programme the target group are older patients with neurodegenerative diseases. ARIA addresses people with physical disability in general. In the MATRICE programme, patients are not directly targeted, but (non-)medical care providers involved in the care for people with multimorbidity are targeted.

Level of integration of care sectors and disciplines

Three programmes show a high[4] or medium[2,3] level of integration of care, management and competencies, through coordination and involvement of many organisations, e.g. hospitals and primary care practices. The main care providers in these programmes are general practitioners and several medical specialists. In the Renewing Health programme also a nursing home, outpatient/ambulatory care, patient organisations, community and home care services and other organisations participate, which implies that informal carers, home helps, social workers and district/community/hospital/specialised nurses are also involved. In the ARIA project only hospitals, patient organisations, pulmonologists and physiotherapists/exercise therapists are involved.

Experiences and results

Three programmes have been internally evaluated[1,3,4] and only one was also evaluated by an external organisation [4]. With regard to this last programme several aspects have been evaluated (e.g. process, outcomes, long-term effects, cost-effectiveness). For the other two programmes this mainly applies to the process and the software for data integration/reading the information produced [3], or to cost-effectiveness and quality of life of patients and their caregivers [1]. The CCM programme has not been extensively evaluated yet, but this is planned when the project has concluded.

Several indicators have been monitored, so that quality information will become available for evaluation purposes. For all four programmes this mainly applies to indicators on the outcome level, especially with regard to ARIA and Renewing Health (e.g. clinical outcomes, hospital admissions, patient satisfaction, cost effectiveness and quality of life). Within the Renewing Health programme additional indicators are being monitored such as

outpatient/GP visits, inpatient bed-days, mortality, HADS questionnaire, questionnaire for symptoms assessment, and patients' and clinicians' perceptions towards the service.

With regard to their results, in all programmes integration of care services and improved collaboration between care providers have been observed. Changes in utilisation of resources (e.g. reduced hospitalisations)[1,2,4], involvement of informal carers and transferability of the programme [1,3,4] were also often reported. In at least two programmes improved coordination of care [1,2], staff and client satisfaction [respectively 3,4 and 1,4], cost savings [1,4], patient involvement and use of e-health tools [1,4] were observed. Results less frequently indicated by the programme managers are improved competencies of care providers and cooperation between medical and non-medical care. The Renewing Health programme nevertheless shows better patient involvement. Results of the ARIA programme suggest that remote monitoring of fragile disabled outpatients brings about physiological tranquillity for patients and their caregivers. Moreover, this programme seems to reduce hospital admissions and decrease regional health expenditures [1] In the MATRICE programme indicators for care pathways for single diseases have been defined, and data already available within the health care units have been integrated to monitor the whole pathway of a patient longitudinally [3].

So far, country experts and programme managers have the impression that objectives of the programmes have been reached to a large extent. Preliminary results suggesting positive outcomes have been collected, but final assessments are needed for confirmation. Final results of the Renewing Health programme are expected soon.

Box 2 Characteristics of programmes addressing multimorbidity in Italy and results

ID NR	Programme	Main objectives	Target group	Care providers / organisations	Results
1	ARIA Project	<p><u>Quality of care</u> Improving care coordination/integration</p> <p><u>Utilisation & cost</u> Preventing misuse of services</p> <p><u>Improving patient centeredness</u> Improving patient/informal carers involvement</p> <p><u>Patient outcomes</u> Decreasing complications/morbidity/mortality</p>	<p>Patients, informal carers and medical care providers. The programme specifically addresses people with physical disabilities (e.g. neuromuscular diseases, severe kyphoscoliosis and bulbar muscular impairment) and chronic respiratory failure as comorbidity.</p>	<p>University and general hospital, patient organisation</p> <p><u>Care providers</u> Involved in the programme are medical specialists (pulmonologist) and physiotherapists/exercise therapists.</p>	<p>Results seem to suggest mainly improved integration/collaboration of care services/providers, coordination of care, involvement/satisfaction of patients/informal carers, changes in utilisation of resources, (e.g. reduced hospitalisations), use of e-health tools and cost saving/effectiveness.</p> <p>The programme seems also to be transferable.</p> <p>The results also suggest that the remote monitoring of fragile outpatients brings out physiological tranquility for patients and their caregiver.</p>
2	CCM Chronic Care Model Single Point of Access and Corporate Team of Specialists for taking charge of the person with dementia	<p><u>Quality of care</u> Improving care coordination/integration</p> <p><u>Improving access</u> Reducing inequalities and improving accessibility in/to care and support services</p>	<p>Patients, medical/non-medical care providers. The programme specifically addresses elderly 65+ with cognitive/neurodegenerative diseases (e.g. Alzheimer D.) The programme refers to multimorbidity in general.</p>	<p>General hospital, primary care practice, health centre, nursing home, social care and community/home care organisation.</p> <p><u>Care providers</u> Involved in the programme are general practitioners and medical specialists (neurologist, geriatrician), social workers, district/community nurses.</p>	<p>Results seem to provide mainly improved integration/collaboration of care services/providers, coordination of care, and changes in utilisation of resources (e.g. reduced hospitalisations).</p> <p>The programme has not been extensively evaluated yet, but this will be possible once the project is concluded.</p>
3	MATRICE Integration of information for managing patients in the community/territory	<p><u>Quality of care</u> Improving care coordination/integration</p> <p><u>Utilisation & cost</u> Preventing over-use/misuse of services</p> <p><u>Improving patient</u></p>	<p>Medical/non-medical care providers and management.</p> <p>No specific subgroups are specifically addressed.</p> <p>The programme</p>	<p>University hospital, primary care practices, government, health districts, local health units (ASL), regions, Ministry of Health.</p> <p><u>Care providers</u> Involved in the</p>	<p>The following have been mainly observed: integration/collaboration of care services/providers, staff satisfaction, involvement of informal carers.</p> <p>The programme seems</p>

		<p><u>centeredness</u> Identification of target group patients</p> <p>Monitoring adherence to standard of care</p> <p>This programme does not involve direct provision of health services, but collects data related to chronic conditions to improve their management.</p>	<p>refers to a combination of specific medical diagnoses (diabetes, ischemic heart disease, hypertension, heart failure, dementia).</p>	<p>programme are general practitioners and medical specialists (cardiologist, neurologist, Internist and diabetologist)</p>	<p>also to be transferable.</p> <p>Indicators for care pathways for single disease have been defined.</p>
4	<p>Renewing Health</p> <p>REgioNs of Europe WorkINgtoGet her for HEALTH *</p> <p><i>* Multicentre Project involving the following European countries: Italy, Denmark (Lead partner), Norway Finland, Sweden Spain, Greece, Austria and Germany</i></p>	<p><u>Quality of care</u> Improving care coordination/integration</p> <p><u>Utilisation & cost</u> Preventing over-use/misuse of services</p> <p><u>Improving patient centeredness</u> Improving patient/informal carers involvement</p> <p><u>Patient outcomes</u> Decreasing complications/mortality</p> <p><u>Improving access</u> Reducing inequalities and Improving accessibility in/to care and support services</p>	<p>Patients, informal carers and medical care providers. The programme addresses general people with chronic diseases (e.g. heart failure, COPD, diabetes) aged 18+ years, and more specifically frail elderly people aged 65+.</p>	<p>University and general hospital, primary care practices, nursing home, policlinic/outpatient/ambulatory care, patient organisation, community/home care organisation, ICT department, research institute, regions and external providers.</p> <p><u>Care providers</u> Involved in the programme are general practitioners, medical specialists (cardiologist, pulmonologist, geriatrician and diabetologist), Informal carers, home helps, social workers, district/community/hospital/specialised nurses.</p>	<p>Results show mainly integration/collaboration of care services/providers, patient/informal carers involvement, staff/patients/informal carers satisfaction, changes in utilisation of resources (e.g. reduced hospitalisations), use of e-health tools and cost savings/effectiveness.</p> <p>The programme is also transferable.</p>

Appendix 1 Some characteristics of the health and social care system in Italy

In Italy, health and social services still represent two different and only partially integrated sectors. The Italian National Health Service (NHS) ensures the provision of health care services. Social services are managed by municipalities, but in many cases delivered through private (profit or non-profit) accredited care providers. The integration between the two sectors, although promoted by the Law 328/2000 (which concerned the social care sector), has never been defined precisely at the national level, thus leaving the responsibility of ensuring it up to the single regions¹⁵.

Health care

The Italian parliament sets the objectives for public health and approves framework legislation. The central government (Ministry of Health) defines the targets of the NHS through the National Health Plan (NHP). Regional governments are legally responsible for planning, administration and practical delivery of services through the Local Health Units (LHUs)¹⁶. The central state and regional governments set the total budget for public health funds¹⁷, and local taxes are a major contribution mechanism in this respect¹⁸. Based on characteristics of its structure and of care service delivery, the primary care sector in Italy was labelled as of medium strength in a European comparative health systems study¹⁹.

The whole population is covered for healthcare costs, which usually include inpatient and primary care and are free at the point of use²⁰. Benefits are comprehensive, though the financial crisis and the necessity to cut down healthcare expenditures (the so-called “*Spending Review*” carried out in 2013) has had crucial consequences in terms of reduced access of patients to services²¹. Patient cost sharing is generally applied to outpatient prescription drugs, specialist visits and diagnostic procedures²², with exclusion of particular categories of people (e.g. 65+, with low income, with specific chronic diseases²³). In 2011, 77.8% of the total health expenditures was paid from public sources of funds, leaving 22.2% to be paid privately by patients or from external sources. Very recent data however show a large increase of out-of-pocket expenses, with 12.2 million Italians reporting this in the last years²⁴.

Social care, home care or care for the elderly

The Italian long-term care (LTC) system is characterised by high fragmentation in terms of sources of funding, governance, and management responsibilities. The actors involved are the central state (for national legislation) and the municipalities (delivering services) under the control of regions. LTC services are funded through general taxation, by the National Institute of Social Security (INPS) and users²⁵. The expenditures on LTC in 2010 were 1.91% of GDP: 0.49 care at home, 0.55 care in institutions, 0.86 as cash benefits²⁶. Over the last years, the growth of the expenditure dedicated to companion payments (i.e. a cash-for-care allowance available to severely disabled people) has been the most important change in LTC provision (from 6.0% to 12.5% of older users in the period 2002-2010), this however not being due to a change in the policy itself, but rather to a less and less tight

application of the requirement criteria over time. Conversely, in 2010 older users of home and residential care were respectively about 5.5% and 2%²⁷. The Italian LTC system is relying highly on a cash-for-care scheme, with direct monetary transfers prevailing over in-kind services, but it is also characterised by 1) a wide variability among regions in both funding levels and integration/supply of health and social services (more public/integrated support in North-Centre Italy)²⁸; 2) the importance of informal/family care for the elderly²⁹; and 3) the use of companion payment to privately employed migrant care workers (so called “badanti”) as private home assistants³⁰.

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