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# Reforming territorial care in Italy: Evidence and lessons from European experiences

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## ABSTRACT

**Background:** European health systems are increasingly reorienting toward primary and community-based care in response to population ageing, the rising burden of chronic diseases, and vulnerabilities exposed by the COVID-19 pandemic. In Italy, Ministerial Decree 77/2022 (DM 77/2022) introduces a substantial reconfiguration of the National Health Service through the establishment of Community Health Centers, Community Hospitals, and Territorial Operations Centers. The reform aims to enhance proximity and accessibility, promote multiprofessional collaboration, and strengthen the integration of health and social services. Nonetheless, Italy's pronounced regional autonomy results in heterogeneous implementation, raising concerns about equity and uniformity of service provision.

**Methods:** This study situates DM 77/2022 within a broader European framework by comparing territorial and community-based care models in Spain, Germany, and the Netherlands. The analysis explores organizational arrangements, governance structures, financing approaches, workforce models, strategies for health–social care integration, and levels of digital development.

**Results:** Spain's *Atención Primaria* features multidisciplinary teams, strong continuity of care, and advanced digital interoperability. Germany's Bismarckian system relies on independent general practitioners, structured chronic disease management programs, and coordinated care networks. The Netherlands exhibits highly integrated chronic

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care supported by care groups (*Zorggroepen*), mature digital infrastructures, and systematic patient engagement. These models reveal both convergences and divergences in governance, financing, social care integration, and technological readiness. While Italy's reform reflects European principles of person-centered, community-oriented care, persistent challenges include workforce shortages, uneven resource allocation, and regional variability. **Discussion:** Enhancing governance coherence, reinforcing health–social integration, and investing in digital infrastructure may strengthen the implementation of DM 77/2022. Insights from European counterparts could help reduce territorial disparities, with the Department of Prevention (DP) potentially serving as a key coordinating actor. Despite limitations inherent to qualitative comparative analysis, the study offers a framework for cross-national learning and underscores the reform's potential to advance a resilient and equitable community-based health system.

**Key words:** territorial health care, primary health care, integrated health services, health system governance, public health reform

## Introduction

In recent years, European healthcare systems have undergone a profound transformation, driven by the imperative to reorient service delivery closer to home, ensure seamless care pathways, and enhance the structural integration of health and social care. These changes are in response to an ageing population, an increasing prevalence of chronic diseases, and a demand for more equitable and sustainable access to healthcare. The fragility of hospital-centered models was further exposed by the COVID-19 pandemic, highlighting the need to strengthen community-based and primary care as the foundation of resilient health systems (1-3). In Italy, Ministerial Decree No. 77 of 23 May 2022 — commonly referred to as DM 77/2022 — represents a significant milestone in the reform of community and territorial care within the National Health Service (NHS). The decree establishes models and standards for the development of territorial care, introducing new organizational structures such as community healthcare centers, community hospitals and territorial operations centers. These innovations aim to make healthcare delivery more integrated, multiprofessional, and person-centered, ensuring accessibility, continuity, and comprehensive care across the country. The role of healthcare workers (HCWs) in advancing reforms within the NHS is carefully evaluated (4-6).

DM 77/2022 constitutes the sectoral reform of the National Recovery and Resilience Plan (PNRR in Italy), implementing interventions envisaged by its specific components. It refers to proximity networks, facilities, and telemedicine for community healthcare. Indeed, primary and community care are the gateway to the NHS. New settings, specifically defined by law, such as Community Homes (hub and spoke) and Community Hospitals, address specific needs relating to medium and low levels of care complexity. Within this framework, DM 77/2022 also promotes functional links between territorial care structures and Department(s) of Prevention (DP)s. The aim is to strengthen health promotion, to ensure the infectious diseases prophylaxis in specific settings (e.g. through targeted vaccination campaigns), and to guarantee population-based interventions at a community level, according to public health principles. Ministerial Decree 77/2022 incorporates definition, responsibilities and organization of the DP, as set out in the Italian Legislative Decree 502/1992 and subsequent amendments. It establishes a functional link between the DP and the renewed territorial organization. The DP is the third operational macrostructure of the NHS (alongside the hospital and district), electively implementing the '1st macro LEA' (i.e. the first grouping of Essential Levels of Care), thereby ensuring collective prevention and public health. Despite different

regional subdivisions, many topics are common: prevention, vaccinations, cancer screening, urban hygiene and urban planning, environment-health connection, food safety and animal health, hygiene and safety in living and working environments, medical-legal certifications, health and physical activity promotion, and epidemiological surveillance. These matters are linked within an organizational structure dedicated to prevention, with HCWs specifically trained. Furthermore, the DP complements the hospital, which provides acute care, and the district, which provides care for chronic patients. Effective management requires continuity of care, strong social and health integration, and the functional coordination of local stakeholders and caregivers, including municipalities, associations, volunteers, and families. Our legal system distinguishes between 'districts' (bodies that oversee governance and determine local implementation strategies) and 'community centers' (physical locations that provide administrative, health, preventive and social integration services). General practitioners, pediatricians, outpatient specialists, health and social care professionals, and prevention experts must collaborate at a local level, providing their own specific expertise. In a functional integration, the DP maintains its organizational and technical-scientific autonomy, providing in whole or in part of the HCWs required for preventive activities. Vaccinations and screenings, for instance, play a governance role in various regional and corporate models, involving different stakeholders in specific activities. For example, in Veneto Region, 80% of influenza vaccinations are carried out by general practitioners and primary care physicians or healthcare visitors, 10% by pharmacies, 7% by social services and 3% by residential care homes, hospitals, etc. Another example is cervical cancer screening, which is performed by obstetricians as well as family counselling centers affiliated with districts and operating in community homes. The social component is placed in different ways in regional models. The Veneto Region also emphasizes the social component in its nomenclature. Local health authorities are named 'Aziende Unità Locali Socio-Sanitarie' (ULSS), a name which also reflects the social health integration. ULSS involves organizing and planning activities according to the 'Area Plans' approved by the Mayors' Conference. Moreover, the annual evaluation of the General Directors, with the mayors accounting for 20% of the score, also strengthens the health authority to guarantee the implementation of provisions under penalty of a reduction in grade and related additional compensation. Although DM 77/2022 represents a significant step forward in the process of modernizing the Italian healthcare system, concerns remain regarding its alignment with established European community-based and primary care models. The Italian system's strong regional autonomy, which results in heterogeneity in the organization and governance of services, has long been recognized as a critical factor influencing equity and access to care (7). Recent experiences in southern Italy demonstrate that local innovation can promote health equity even in a context of fragmented governance and different socio-demographic trends (8,9). Several European countries have developed well-established frameworks for community-based and integrated care, supported by national or regional strategies for chronic disease management, digital health and socio-health coordination (10-14). Examining these experiences provides a valuable opportunity to contextualize the Italian reform within a wider European perspective. The purpose of this paper is twofold: i) to compare the Italian model of territorial care, as defined by DM 77/2022, with other European models, identifying areas of convergence and divergence as well as opportunities for transferring best practices; ii) to examine the organizational, structural, and strategic components of DM 77/2022 in light of European principles of territorial care. This analysis focuses on key dimensions such as governance, socio-health integration, digitalization and community participation. It seeks to identify factors that facilitate or hinder the transferability of international experiences, and to propose policy recommendations that would strengthen and align the Italian model.

## Study design

This study is part of a broader analysis of the community-based healthcare reforms introduced in Italy by DM 77/2022. Due to the exploration and comparative nature of the research question, a qualitative approach combining document analysis and

a literature review was adopted. Policy documents and scientific literature were systematically identified within a defined timeframe (2010–2025) using selected institutional and academic sources, including PubMed, Scopus, and the official websites of national Ministries of Health, governmental agencies, and European institutions (15,16). More specifically, the analysis was based on a narrative and comparative review of institutional documents and scientific literature. A structured analytical framework was used to guide the comparison, focusing on governance, financing, workforce organization, health–social care integration and digital health. This ensured transparency and reproducibility method (17,18). Countries were selected based on the following inclusion criteria:

1. The presence of consolidated or mature community-based and primary care systems.
2. Evidence of integration between health and social care services.
3. Availability of official and scientific documentation in English.

In accordance with the eligibility criteria, three European countries were selected to represent advanced and diverse territorial care models: Spain, Germany and the Netherlands. Specifically:

- Spain has a regionally integrated *Atención Primaria* system that emphasizes continuity of care and multidisciplinary practice;
- Germany has a Bismarckian model in which primary care physicians operate as independent professionals within structured networks for chronic care management;
- The Netherlands is a benchmark for integrated chronic care and the systematic use of digital tools and telemedicine through *Zorggroepen* (Dutch for 'care groups'), which are collaborative healthcare organizations that coordinate and deliver chronic care across primary and secondary services.

These examples demonstrate the variety of governance logics and organizational traditions within Europe, facilitating a comprehensive comparison with the Italian reform and highlighting valuable insights for policy development and system enhancement.

## Results

Spain, Germany and the Netherlands have developed robust primary care systems across Europe, supported by multidisciplinary teams, community involvement and an increasing use of digital tools. However, their organizational structures, governance and degree of integration vary considerably, reflecting their different institutional and financing arrangements. To facilitate a structured comparison between the Italian territorial care model introduced by DM 77/2022 and other well-established European primary care systems, Table 1 provides a comprehensive overview of models, highlighting differences in governance, financing, the healthcare workforce, health and social care integration, digitalization, and areas of convergence and divergence.

Spain's Atención Primaria model is the cornerstone of the National Health System and is managed by the autonomous communities. Primary Care Teams (EAPs) provide comprehensive, continuous care, coordinating with social services and hospital networks. The model emphasizes accessibility, continuity and multidisciplinary work, with community health centers serving as operational hubs. Digital health is well integrated through regional e-health systems that enable shared electronic records and teleconsultations (19). Germany's health system is based on a Bismarckian insurance model. General practitioners (GPs) are independent professionals contracted by sickness funds. Chronic disease management programs (DMPs) and regional networks facilitate collaboration among physicians, specialists, and hospitals. However, integration between health and social care remains limited compared to Southern European models. Digitalization and structured chronic care pathways have improved coordination and outcomes (16). The Netherlands has a robust primary care sector that acts as a gatekeeper to the entire healthcare system. Integrated care for chronic conditions is organized through *Zorggroepen*, which bring GPs, nurses, and other healthcare professionals together under shared contracts with insurers.

**Table 1.** Comparative overview of territorial and primary care models in five selected European countries.

| Country | Governance and organization | Main primary care facilities | Workforce / Multidisciplinary teams | Health–social care integration | Digital health and coordination | Key convergence/ divergence with Italy |
|---|---|---|---|---|---|---|
| **Italy (DM 77/2022)** | National regulatory framework with strong regional autonomy; decentralized implementation within the NHS; regional variations exist (e.g., Lombardy, Sicily, Emilia-Romagna) | Community Health Centers (Case della Comunità – hub and spoke), Community Hospitals, Territorial Operations Centers | Multidisciplinary HCWs teams including GPs, nurses, specialists and social professionals; workforce availability varies across regions | Formally promoted by DM 77/2022, but implementation is heterogeneous; integration with social services and DP uneven | Digital tools and telemedicine promoted through PNRR investments; interoperability and implementation differ among Regions | Early-stage integration; heterogeneity across regions; shared focus on multidisciplinary care and digital tools |
| **Spain** | National Health System with governance devolved to autonomous communities | Community health centres (Centros de Salud) acting as hubs for Atención Primaria | Established Primary Care Teams (EAPs) including physicians, nurses and social workers | Strong integration at local level, especially for chronic/ vulnerable populations | Well-developed regional e-health systems with shared electronic health records and teleconsultations | Stronger integration and continuity than Italy; regional autonomy similar |
| **Germany** | Bismarckian insurance-based system; governance shared between federal and regional levels | GP practices and ambulatory care centres within contractual networks | GPs as independent professionals; collaboration through Disease Management Programs and regional networks | Limited integration with social care | Increasing digitalization; national efforts to improve data sharing | Integration differs from Italy; network-based approach offers lessons for chronic care |
| **Netherlands** | Insurance-based system with strong primary care gatekeeping | GP practices coordinated through Zorggroepen (care groups) | Highly structured multidisciplinary teams involving GPs, nurses and allied health professionals | High integration for chronic care; shared contracts and care pathways | Advanced use of e-health, telemedicine and digital platforms | High integration and digital maturity; Italy can learn from structured multidisciplinary approach |

The Dutch model is characterized by a high level of digital integration, standardized clinical pathways, and the systematic use of telemedicine and e-health platforms. Patient engagement and self-management are actively promoted through national and local initiatives (17). The Italian reform introduced by DM 77/2022 aims to strengthen community-based and territorial care by establishing Community Health Centers, Community Hospitals, and Territorial Operations Centers (4, 16). Community Health Centers (Case della Comunità), organized according to a hub-and-spoke model, are intended to serve as the main access point for primary and community care. They host multidisciplinary teams and facilitate coordination with social services and prevention activities. Community Hospitals address low- to medium-intensity clinical needs, supporting continuity of care and reducing inappropriate hospital admissions. Meanwhile, Territorial Operations Centers play a coordinating role in care pathways, professional integration, and digital

information flows. DM 77/2022 also envisages organizational links between territorial care structures and the DP, thereby reinforcing the public health orientation of community-based care (8, 20). However, implementation remains uneven across regions due to decentralized governance and variability in resource allocation. Compared with the analyzed European models, Italy shares a growing emphasis on multidisciplinary care, community engagement and digital transformation. Nevertheless, the Italian system is still in its early stages and is facing challenges relating to workforce availability, interprofessional collaboration and digital transformation (18,21).

## Discussion

The territorial care reform introduced in Italy through DM 77/2022 is in line with a wider European trend of strengthening primary and community-based health systems, as advocated by the WHO and the Organisation for Economic Co-operation and Development (OECD), and demonstrated by recent reforms in countries such as Spain, Germany and the Netherlands. At EU level, these reforms are increasingly being recognized as vital tools for addressing population ageing, the growing burden of chronic conditions and ongoing territorial inequalities, while ensuring the long-term sustainability of health systems. Evidence from these countries suggests that resilient post-pandemic health systems depend on sustained investment in governance capacity, HCWs multidisciplinary and digital infrastructure. In this setting, DM 77/2022 is a significant step towards redefining the governance and organization of community health services in Italy (22). The introduction of Community Health Centers, Community Hospitals and Territorial Operations Centers highlights a strategic shift away from a hospital-centred model towards integrated, person-centred care. However, the strong regional autonomy characterizing the Italian NHS poses a risk of uneven implementation, which could lead to fragmentation and unequal access to services (23). In this context, regional legislation has produced distinct organizational models across the country. For example, some regions, such as Lombardy and Sicily, have an independent Veterinary DP, whereas Emilia-Romagna formally designates the Department of Prevention as a 'Department of Public Health', reflecting a broader public health remit. Most notably, Lombardy's regional reform (Regional Law 22/2021) introduced a clear separation of strategic and planning functions, which were assigned to Health Protection Agencies (ATS), from operational service delivery, which was entrusted to Functional DPs within Territorial Health Authorities (ASST). These departments are responsible for activities such as vaccinations and screening (24). While this organizational differentiation is fully coherent with the Italian constitutional framework (25), it may strengthen strategic coordination and accountability but could also increase the risk of fragmentation if not supported by effective integration mechanisms. Comparative evidence highlights three interrelated policy dimensions that are critical for consolidating territorial care in decentralized systems. Firstly, governance coherence and accountability mechanisms are essential for translating national frameworks into equitable local delivery. Spain illustrates how a combination of strong national guidance and regional responsibility can support standardization while allowing for local adaptation. In this regard, Italy could benefit from clearer national coordination tools and performance monitoring mechanisms to support the implementation of DM 77/2022 (26). Secondly, integrating health and social services is a key challenge for ensuring continuity of care. The German and The Netherlands approaches to integration are different but structured, respectively based on contractual networks and outcome-oriented care groups (15,17). These models underscore the importance of formalized care pathways and shared accountability across sectors. For Italy, a key policy lever to reduce fragmentation, particularly for chronic, fragile, and complex patients, is strengthening interoperable care networks that span health and social domains. This can be achieved by defining specific preventive, diagnostic, therapeutic and care pathways (PPDTA), identifying the relevant actors and activities for care management and continuity of care. Thirdly, digital transformation plays an enabling role that cuts across all areas, rather than representing a stand-alone reform. In Spain and the Netherlands, shared electronic health records, telemedicine and

integrated digital platforms are well-established components of community care, supporting coordination and efficiency (17, 19). In Italy, the PNRR provides a unique opportunity to accelerate the development of digital infrastructure. However, without standardized governance arrangements and interoperability requirements, digital investments risk exacerbating existing regional disparities rather than mitigating them (4, 27). Beyond organizational structures, the success of the reform also depends on cultural and professional factors. Multidisciplinary teamwork, continuous professional development and community engagement are widely recognized as enablers of effective primary care across Europe. Although DM 77/2022 formally promotes multidisciplinary teams involving general practitioners, nurses, social workers and other professionals, these teams require stable funding, clear role definitions and interprofessional training pathways to be operationalized. This reinforces the notion that workforce policy is central, rather than ancillary, to the implementation of integrated territorial care. From a policy perspective, DM 77/2022 should therefore be interpreted as an enabling and transitional framework rather than a definitive endpoint. Aligning it with the objectives of the PNRR (27) could generate synergies between infrastructure investment and service innovation, provided governance mechanisms ensure coherence, accountability and long-term sustainability. In this sense, the Italian reform is an important example for other decentralized or regionalized health systems aimed to improve community-based care while balancing national equity goals with regional autonomy (28-31). Further research is needed to explore the substantial regional heterogeneity shaping the implementation of DM 77/2022, particularly in the field of prevention. Within this heterogeneous institutional landscape, the role of the DP varies considerably across regions in terms of organizational positioning and operational capacity, reflecting differences in financing, workforce availability and local socio-economic conditions. Comparative analyses with other federal or strongly regionalized systems, such as those in Spain and Germany, could provide valuable insights to assess territorial inequalities. The strategic role of the DP is worthy of particular attention, as it is a distinctive feature of the Italian system within the European landscape. It has strong innovative elements compared to the new healthcare challenges linked to demographic and lifestyle changes, as well as the 'one health' approach. Although prevention has been formally integrated into territorial care under DM 77/2022, its implementation is unevenly distributed across the territory. Strengthening the DP through flexible, multidisciplinary and intersectoral approaches, particularly with regard to the climate–environment–health nexus, could enhance equity, emergency preparedness and the sustainability of the Italian NHS. Even with relatively modest investment, a more integrated prevention system based on strong analytical principles of population health management could significantly reduce disparities between regions and improve population health outcomes. Future research should assess the impact of different regional organizational structures — particularly the separation of strategic and operational prevention functions — on the integration, efficiency and equity of community care. This will help to identify and standardize the most effective and efficient models. This study is subject to limitations relating to its qualitative and descriptive comparative approach, as well as cross-country differences in data availability. Nevertheless, it offers an interpretative framework for policymakers and researchers interested in cross-national learning on territorial care reform. Further research should assess the regional implementation of DM 77/2022, the impact of digital health on continuity of care, and the effectiveness of multidisciplinary models in improving population health and reducing inequalities (32).

## Conclusion

DM 77/2022 represents a reference model for the reform of territorial healthcare in Italy, laying the foundations for a more integrated, people-centered, and prevention-oriented system. The decree provides a clear and coherent vision aligned with European objectives and stands as a meaningful example for other healthcare systems. Its implementation is currently in a phase of progressive consolidation, aimed at reducing differences across regional contexts. While allowing adaptation to territorial needs, local specificities

highlight the need for stronger coordination and a more consistent application of the planned measures. To fully realize the potential of DM 77/2022, investment is needed in three key areas: structured integration between prevention and territorial services, coordinated adoption of interoperable digital solutions, and the consolidation of multidisciplinary teams supported by continuous training. From this perspective, the decree should not be viewed as an endpoint, but as a solid foundation for the progressive and sustainable improvement of community-based care. This analysis can serve as a basis for a policy brief, highlighting priority areas for action and the steps needed to consolidate and improve community-based care.

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