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Health protection and territorial health organization: The figure of the family and community nurse (IFeC)

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Abstract.
BACKGROUND: The improvement of health represents a goal for all countries in the world in a global way and, compared to earlier stages of development, there is a significant focus by the public health system on community and home-based services in particular.
OBJECTIVE: This objective was reaffirmed during the last World Health Summit (May 2021), at which the leaders of the G20 countries, together with other member states, signed the "Declaration of Rome".
METHODS: The paper contains the study of the impact that the COVID-19 pandemic has determined on the organization of the health system, through the study of the data provided by the main national and international organizations in the health field.
RESULTS: It emerged that the field of personal, family and community care are certainly an area of growth for nursing, which also in the European context, is showing an increase importance given to services and care activities outside the hospital and home in particular. In all of this, the roles that nurses can assume are differentiated and articulated.
CONCLUSIONS: In the complexity of this perspective, families and community seem to emerge as a point of reference for a nursing care that is certainly going through a decisive moment in the slow, but inexorable path towards the emancipation of its disciplinary status and the development of its ability to provide new, original and autonomous responses to the needs of the assisted population.

Keywords: State, health, nurse, territory, EU, WHO, COVID-19

1. A new perspective of territorial health organization

During the last World Health Summit (May 2021), the leaders of the G20 countries, together with other adhering states, signed the "Declaration of Rome", which, while originating from the pandemic and related needs, identified 16 coordinated government actions, in order to promote a more efficient international strategy for improvement and with a view to a universal health organization [1].

The commitment made by the States has also focused on the need to rethink the current healthcare organization, both in the direction of a new institutional model that removes centrality of care from the hospital and attributes it to less complex healthcare facilities, but with a greater territorial presence [2], and with a view to improving the professional quality of healthcare personnel, also by introducing new specializations and a new concept of alliance between medical and nursing staff.

After all, the organizational architecture deriving from the constitutional system of health protection has inevitably undergone a significant trauma as a result of the recent and still current health emergency, highlighting the need to provide citizens with a modern health care, capable of intercepting needs that are progressively new and different than the past, as well as responding to sudden needs before that a State cannot find itself unprepared for, within the perimeter, including economic, of a welfare state [3].

At the same time that the United Nations General Assembly adopted the Universal Declaration of Human Rights and the Republican Constitution came into force in Italy, the World Health Organization was established, proposing to define health as "a state of complete physical, mental and social well-being of the individual dynamically integrated into his natural environment and not merely the absence of disease, mental and social well- being of man dynamically integrated into his natural environment and not only the absence of disease", thus introducing the subjectivity of health assessment, focusing not only on medical aspects, but also on the evaluation of the quality of life and organization of services, as it would later be called in modern language.

Therefore, the definition of health includes elements that are not limited to the mere removal of the state of disease: it is not enough to treat, but it is also necessary to prevent, raise awareness, inform, promote healthy behaviors and oriented to the welfare, referring to a relational dimension of participation in civil and social life and the full self-realization, which refers to the constitutional principle of substantive equality. This is a condition of multidimensional nature, difficult to verify in practice, but particularly useful for the configuration of the idea of health as one of the fundamental values of the legal system.

In fact, this formulation marked the passage from the centrality of illness to the centrality of health, which began to be placed in a context that also included social and psychological aspects, as well as the relationship between the individual and society.

With this in mind, through the Rome Declaration, States parties agreed to invest in the worldwide health and care workforce, to achieve the triple benefit of better health, acceleration of development, and progress in social inclusion and gender equality, by developing mutually recognised competencies through education and training, also through relevant WHO initiatives including the WHO Academy; invest in community health and in health systems to achieve strengthened, resilient, inclusive, high quality health services, continuity of care, local and home care, and public health capacities in all countries; invest in multilateral WHO-led mechanisms to facilitate assistance and response capacities for use in developing and crisis affected countries; and invest also in water sanitation and hygiene in health care facilities to reduce infection risks and safeguard healthcare workers.

Primary care is the most recent evolution of the concept and praxis of general practice born in England in the 1800s. The general practitioner was a figure in itself, which differed from the physician (internist), as well as from the surgeon, because he did not deal with specialized problems of organs and apparatuses, but all the health problems of people, of which he knew the history and psychology.

The primary health care provider was the first point of contact for health problems, who liaised with the health care system (gatekeeper), was the manager of health care (clinical manager) and the purchaser of services on behalf of their patients (commissioner). WHO defined primary health care in the 1978 Alma Ata Declaration (USSR) as essential and universal because it meets basic health needs and must be accessible to all individuals and families.

Therefore, in order to continue to guarantee the necessarily universal nature of access to care and the effective exercise of the right to health, it is now necessary to take vigorous action to strengthen (and in some cases create) territorial health care, considered as an institutional presence within small communities of citizens, in order to avoid resorting to hospitals, as well as the provision of health services at home, with clear savings in terms of economic and social costs for the community [4].

In order to respond to the present and future demand for health, general practice must be recognized as a fully-fledged specialist discipline, which must be reorganized in order to meet the growing need for health. The general practitioner should become a clinical manager, liaising with the other professional figures, integrating with the diagnostic and hospital structures, each with his or her own specific skills and autonomy, providing that the specialised nurse (IFeC) should take on the role of case manager, within the framework of a synergic and not of subordination, now belonging to a definitively outdated conception of medicine, to which we shall return later.

Guaranteeing free assistance and care to those who need it, as provided for by the Constitution, means creating a system and care pathways that cannot be fragmented, as the system currently is (from the "Case della Salute", to the Functional Territorial Aggregations, to the Cooperatives and to the Complex Primary Care Units), without any operational uniformity, with management and logistic difficulties, not always favoured by the local health agencies, which are almost always oriented towards results and operating methods, rather than towards outcomes and care pathways.

At present, there is no real link between the hospital and the territory, with the resulting ineffectiveness of the continuity of care, which is fragmented, since there is an ever-increasing logic of performance marketing, often detached from a clinical context, and an ever-increasing load of bureaucratic activities required by the institutions, which burdens the doctors and above all on the GPs, in addition to the not always adequate working conditions in which the health workers are required to operate.

Care is a single process, hospital and territorial, which should be carried out under a single functional organisation, in which institutionalised intermediate structures should be established and recognised as an integral part of the organisation, within which the patient should find the solution to his problem or be referred to the hospital for second-level diagnostics or hospedalisation.

Therefore, in the new reform perspective of the aforementioned criticalities, it will be necessary to plan and programme the territorial services in terms of capacity and intensitỳ of care, as well as to apply operations management logics which, applied to the territorial settings, will make it possible to understand how many patients are actually within the perimeter of the catchment area of each service and how many visits they really and on average need.

Combining these demand data with supply data, i.e. the number of professionals (general practitioners, specialists and nurses) and the average intensity of care provided, it will be possible to understand the available capacity with respect to the existing demand for care. In light of the gaps between demand and capacity, the services will have to identify certain allocative choices suitable for maintaining and guaranteeing the universalistic coverage of the National Health Service.

The entire "new health strategy", as the PNRR defines it, cannot do without two fundamental components: the digitalisation of healthcare and integration between the various structures and professional figures involved. It is all too clear that the risk of fragmentation of services can have a negative impact on the quality and cost-effectiveness of the entire health system.

Technology and information technology are essential for developing telemedicine services and giving the right role to tools such as the Electronic Health Record ("Fascicolo Sanitario Elettronico – FSE"), while the figure of specialists must become a fully-fledged part of local medicine, contributing to the creation of those complex or multi-professional teams that can really make a difference to the health of citizens.

The renewal of diagnostic equipment and of the various electromedical devices must be the substratum, throughout the country, on which to graft new paths, supported not only by new structures, but, above all, by a conscious management of the tools and professional skills available, keeping up with technological and scientific development and with current digital technologies.

The electronic health record, e-prescription, telemedicine, as well as diagnostics and treatment based on Big Data and Artificial Intelligence, adequately exploiting the cloud and infrastructure, through to innovative digital therapies (DTx), must not remain formulas without content, but must be appropriately updated, enhanced and, above all, used.

The boost that the investments envisaged by the PNRR will have to give to Italian healthcare over the next few years mainly concerns the public sector, but it is impossible not to consider the importance of the private component, whether or not under contract, in the healthcare sector in our country.

It is clear that, in the face of such major innovations in the Italian National Health System, private actors must always be able to interact as best they can with the public component. Many patients, or their families and caregivers, for instance, are now playing an active role in the use of health services, and the more digitalisation takes place, the greater their role will be. Sometimes, however, perhaps in local contexts, this type of user comes up against situations in which, despite the good use of tools such as the "Fascicolo Sanitario Elettronico FSE" by the public health service, the contracted structure does not have the appropriate management tools, representing a functional limitation and thwarting the entire process of digitalisation.

In a healthcare model that cannot do without the fundamental contribution of private for-profit (or non-profit) structures, this sector must be prepared for the challenges of the coming years, in a process of integration of the entire healthcare sector to maintain and increase the attention paid to its patients and, consequently, the quality and competitiveness of the services provided.

2. The figure and role of the family and community nurse

As a result of the agreement reached at the State-Regions Conference, on 18 December 2019 the Health Pact for the three-year period 2019–2021 was issued, which, even before the health emergency flared up, also highlighted the role that the nursing profession can play in territorial care in increasing the coverage of care continuity needs, therapeutic adherence and integration with social welfare services.

These characteristics call for a care model that is considerably different from the hospital-centered one, oriented towards a territorial offer that emphasises an approach more focused on the person's daily life context.

The need to strengthen the network of territorial assistance and to promote, through proactive nursing care, the take-charge of the patients are also highlighted in art. 1, paragraph 5, of Law Decree no. 34 of 19 May 2020, coordinated with Conversion Act no. 77 of 17 July 2020 containing "urgent measures regarding health, support for work and the economy, as well as social policies connected to the epidemiological emergency from COVID-19" and in the Document containing Guidelines for Family/Community Nurses ex. L. 17 July 2020, no. 77, approved by the Conference of Regions and PP.AA. on 10 September 2020.

Therefore, national and international policies in support of the universal right to health are based on the awareness of the need to strengthen health care in the territory, giving a central role to the "new" figure of the family and community nurse.

Already in 1998 the WHO, in the document Health 21 [5] (a document drawn up to provide the reference framework for health policies and strategies for the member states of the WHO Europe Regional Committee), identified 21 objectives to be pursued for the global improvement of health, mainly based on three values: health as a fundamental human right, equity in health and solidarity in action among countries, among groups of people, as well as the participation and responsibility of individuals, groups and communities and institutions in the development of health.

Most notably, Objective 15 emphasises the importance of integrated health care with a focus on primary health care, introducing the concept of the family nurse. This new figure should offer lifestyle advice, family support and home care services for a limited number of families.

The family doctor and the family nurse will have to interact with local community structures on health problems, and it will be the prerogative of each citizen to freely choose these two figures. The main objective is to develop disease and injury prevention, and to ensure early and effective treatment of all patients who do not require hospital care. Care provided in (second- and third-level) hospitals should be a support to first-level healthcare and thus focus exclusively on diagnostic and therapeutic functions that cannot be provided in first-level facilities.

Subsequently, the WHO in 2000, through the document: "The family health nurse - Context, conceptual framework and curriculum", defines the role of the family nurse as a figure included in a multidisciplinary team of health workers for the achievement of objectives established in the Health 21 document. Nurses (together with doctors) are defined as "the mainstay of the service network" and their competences will mainly have two aims: to promote and protect the health of the whole population throughout the whole life span and to reduce the incidence of the most common diseases and accidents by alleviating the suffering they cause.

The family nurse will help individuals and families to cope with chronic illness and disability and stressful times, spending a large part of their time in patients' homes and with their families, providing advice on lifestyle and risk factors, and assisting the whole family on health issues so that, through early diagnosis, it can be ensured that family health problems are treated from their onset.

In Italy, a first significant regulatory intervention was in 2012 with the Balduzzi decree no. 158/2012, which proposed a nationwide reorganization of primary care in home and community-based settings, through the establishment of outpatient clinics providing continuous care (night and day), health homes and community hospitals.

However, it is only with the subsequent 2019-2020 Health Pact that the family and community nurse officially becomes part of territorial care throughout the country, as it is provided that in primary care there must be "family/community nursing care, to guarantee the complete integrated health care of people" and it also states the need to "enhance the value of health professions, especially nurses, in order to cover the increased need for continuity of care and therapeutic adherence, in particular for the most fragile individuals with multiple disabilities".

The 2019–2021 Health Pact also establishes that, in order to promote greater consistency and accessibility of health and sociomedical care, thus ensuring integration with social-welfare services, guidelines will be defined for the adoption of benchmarks, also considering the different regional experiences underway, encouraging integration with all professional figures, including family and community nursing, to ensure the complete integrated care of people.

Recently, the decree-law (the so-called "Rilancio" decree) of 19 May 2020, no. 34, in article 1, paragraph 5, converted into law no. 77 of 17 July 2020, introduced the figure of the family or community nurse into the state system in order to strengthen nursing services and to enhance the care on the territory of subjects identified as suffering from COVID-19, also assisting the special units of continuity of care and the services offered by primary care".

However, this provision is not only an emergency measure, but also a much broader one, providing that: "The regions and autonomous provinces, in order to guarantee the highest level of assistance compatible with public health requirements and the safety of treatment in favour of infected persons identified through health risk monitoring activities, as well as of all vulnerable people whose condition is aggravated by the current emergency, if they have not already done so, shall increase and direct therapeutic and assistance

actions at home level, both with the aim of ensuring the increased monitoring and assistance activities connected with the epidemiological emergency, and to strengthen the integrated home care services for patients in home isolation or subject to quarantine, as well as for people suffering from chronic illnesses, with a disability, with mental disorders, with pathological dependencies, the non-self-sufficient, with palliative care needs, pain therapy, and in general for situations of fragility".

In July 2020, as a result of a review of the document "Position Statement- The Family and Community Nurse" the National Federation of Associations of Nursing Professions defines its vision on the role of the Family and Community Nurse, describing the competences in line with the European guidelines considered strategic for health promotion and chronicity/fragility management on the territory.

It defines the Family Nurse as: "The professional responsible for nursing processes in the family and community setting, possessing specialist knowledge and skills in the field of primary care nursing and public health. He acts competently in the provision of complex nursing care, health promotion, prevention and participatory management of individual, family and community health processes, operating within the primary health care system.

The Family and Community Nurse has health as an objective and operates by responding to the health needs of the adult and pediatric population of a specific territorial and community context and by promoting health and social integration of services. He acts in professional autonomy, belonging to the nursing services of the reference District, in close connection with health and social services and with other professionals of the National Health Service.

In conclusion, in the renewed organisational vision of territorial healthcare, the new nursing figure is recognised as having the task of intervening both at an individual and family level (with direct and indirect interventions aimed at the person, his or her family and reference persons) and at a community level (with actions aimed at the community, in which the problem finds solutions because the relationships that generated it are changed).

3. Administrative support action

Starting from the Position Statement and the Health Pact, the Regions drew up a document approved on 10 September 2020 by the Conference, which makes the figure of the family and community nurse uniform throughout the territory.

He is qualified as a specially trained professional, who has a strong orientation towards proactive health management and operates by responding to the health needs of the population of a specific territorial and community reference area, promoting health and social integration of services.

It operates on the territory, according to the regional organizational models, it spreads and supports a culture of prevention and promotion of correct lifestyles, it is active for the early interception of needs and their solution. It guarantees a continuous and proactive presence in the area/community of reference, provides direct services on the assisted persons when necessary and is active in facilitating and monitoring care and continuity of care paths in strong integration with other professional figures in the territory, to meet different needs expressed in urban and sub-urban contexts. It carries out its activity by integrating it into a wider health and social protection network, capable of activating and supporting the resources of patients and caregivers, volunteers, the private social sector and the community in general.

This professional is placed within the district services/structures and guarantees his presence in line with the regional and territorial organization ("Case della salute", homes, outpatient clinics, offices

and branches of the municipalities, places of life and local sociality where it is possible to carry out educational, prevention, care and assistance interventions).

It acts within the framework of the Health Authority's strategies and of the company structure it belongs to, it works in close synergy with General Medicine, the Social Service and all the professionals involved in the reference settings in a logic of recognition of the specific autonomies and professional areas and of multi-professional interrelation and integration.

Mission 6 of the PNRR, the National Recovery and Resilience Plan sent to the European Commission on 30 April 2021 and approved on 22 June 2021 by the European Commission and on 13 July 2021 by the Economic and Financial Affairs Council (Ecofin), is heading in the same direction; a Plan that envisages EUR 192 billion financed through the Recovery and Resilience Facility and EUR 13 billion from ReactEU; in addition to these there are EUR 30.64 billion from the "complementary fund" (state appropriations), bringing the total to EUR 235.15 billion.

This investment aims at strengthening the supply of intermediate care at a territorial level through the activation of the Community Hospital, i.e. a health facility within the territorial network for short-stay hospitalization and intended for patients who need medium/low clinical intensity health interventions and short stays. The investment will take the form of the creation of 381 Community Hospitals, whose relative operativeness in terms of human resources will be guaranteed by the involvement of various professionals and certainly by the family nurse, for his/her role of connection and coordination with the general practitioner that is attributed to him.

Lastly, in September 2021, the Health Commission of the Regions, dealing with the reorganization of the role and workload of the family doctor, recalled the need for the latter to equip himself with a structure present operating throughout the territory, which also includes the figure of the nurse, in a perspective of synergy and professional alliance, capable of ensuring the best response to the actual care needs of citizens, with a view to overcoming the old rationale of subordination.

Conflict of interest

None to report.

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