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Institutional and Organisational influence on Mental Health Management in Spanish and Italian Primary Care

ABSTRACT

Purpose:

This study aims to investigate how institutional and organisational factors affect case management of patients with mental disorders by GPs in Italy and Spain. The paper highlights the importance of improving the effectiveness of Primary Care to ensure easy access to mental health services, which is crucial in responding to the increasing incidence of mental disorders and preventing negative outcomes.

Design and Methodology:

This article details a qualitative research study that examines the management of patients with mental disorders by general practitioners (GPs) in Italy and Spain, using cross-national comparison and in-depth interviews with GPs as research methods.

Findings:

The study revealed that Italian self-employed GPs have more scheduling autonomy than Spanish Health Centre GPs. Both face high work pressure and resource scarcity, highlighting the need for targeted training. The COVID-19 pandemic led to a rise in phone consultations.

Originality:

This study provides novel insights into mental health management by examining the case management of patients with mental disorders by GPs in Italy and Spain, with a focus on the impact of institutional and organisational factors. The cross-national comparison and in-depth interviews enhance the originality of the study, offering a nuanced understanding of the constraints faced by GPs in their work context. Furthermore, the comparison of the similar Primary Care frameworks of Italy and Spain may offer insight into their evolution.

Keywords: General practitioners, Street-Level Bureaucracy, mental health, qualitative methods, cross-national comparison

INTRODUCTION

Promoting access to mental health (MH) services is essential for individual and community well-being, cost-effective healthcare, and advancing health equity. Given the high incidence of untreated mental disorders (Kessler *et al*., 2005; Wittchen *et al*., 2011), the pervasiveness of stigma, escalating healthcare costs (Doran *et al.*, 2017), and the added pressures of the COVID-19 pandemic (Asbury *et al.*, 2021; Serafini *et al.*, 2020) it is crucial to explore barriers to MH services access. Considering suicide as an indicator of mental health challenges globally, the World Health Organisation (WHO) states that for young individuals aged 15–29 years, it ranks as the fourth primary cause of death, following road injuries, tuberculosis, and interpersonal violence for both genders. Across the global population, a life is lost to suicide every 40 seconds (WHO, 2020).

Central to this discourse is the concept of patient "candidacy" (Dixon-Woods *et al.*, 2006), *i.e.*, the possibility for and ability of the individual to choose the most appropriate health service through interaction with the Welfare State and health professionals. General Practitioners (GPs) play a pivotal role in shaping this "candidacy" as they often encounter patients with psychiatric disorders and are the exclusive treaters of common ones(Grandes *et al*., 2011; Lora, 2009; WHO, 1978).

Despite being relatively understudied (Dixon *et al*., 2020), the role of GPs as front-line bureaucrats has the potential to provide unique insights into the dynamics of MH care (Dunham *et al*., 2008; Wells, 1997). Drawing from Street-level Bureaucracy (SLB) Theory (Lipsky, 2010), which emphasises the interaction between users and the State by focusing on the work of front-line public workers, this study aims to examine the hypothesis that the interplay of institutional and organisational constraints influencing GPs management of patients with mental disorders. By identifying parallels and differences in the Italian and Spanish contexts, this research will explore the macro and meso mechanisms that shape GPs' management approaches.

The paper is structured as follows. The first section assesses the theoretical framework of the study, linking it with key literature findings concerning influential factors in GPs' approach to mental disorders. The second section establishes national institutional and organisational configurations. The third gives the research methodology. The fourth section presents and debates the analysis results. The paper ends with final observations.

THEORETICAL FRAMEWORK

Lipsky theorises that street-level bureaucrats (SLBs) possess "discretion," which grants them freedom and autonomy in their roles. This allows them to decide on the type, quantity, and quality of the benefits and penalties given by their organizations. Lipsky underlines that the unique nature of their jobs often necessitates a flexible approach to address the individual aspects of scenarios (Lipsky, 2010). As the author articulates: "Certain characteristics of the jobs of street-level bureaucrats make it difficult, if not impossible, to severely reduce the programmatic formats, (...), street-level bureaucrats work in situations that often require responses to the human dimensions of situations" (2010, p.16). Hupe's (2013) differentiates between two types of discretion: one determined by laws and protocols, termed "discretion as granted", and the other being the practical autonomy exercised, called "discretion as used.

Certainly, dealing with patients requires an understanding of the "human dimensions of situations". This is because health is not merely about biological aspects; it also encompasses psychological and social dimensions (WHO, 1946). GPs are consistently engaged in addressing the individualised aspects of patient relationships. As both "state agents" and "citizen agents" (Maynard-Moody & Musheno, 2000), one of the key aspects of this role involves making autonomous decisions about patients' clinical paths, such as choosing when to refer patients to specialists. Their frontline position also means GPs are frequently the first to hear user complaints about the healthcare system (Forrest, 2003). In their capacity as street-level bureaucrats, GPs

exercise discretion, drawing from their inter-organisational informal networks to customise care (Loyens, 2019). Concurrently, they champion the needs and concerns of their patients (Dunham *et al*., 2008).

When discussing SLBs as public service workers, it's notable that they often operate under significant stress and pressure. This is primarily due to overwhelming workloads and a persistent lack of resources, including time. Lipsky points out the strategies these SLBs adopt to cope. They might establish routine management procedures and form anticipatory judgments about the characteristics and needs of users.

Factors like decentralisation significantly affect health policy implementation. Such policies, tied with discretion and autonomy (European Committee of the Regions, 2013), have implications on health organisations' autonomy and coordination issues, shaping service continuity and accessibility (Juliá-Sanchis *et al.*, 2020). Payment systems, too, play a pivotal role in influencing GP decision-making (Bjørndal *et al.*, 1994; Gosden *et al.*, 2000; Vu *et al.*, 2021).

Specific to MH, limited resources, like consultation time, impact patient satisfaction and compliance. Longer consultations generally result in better outcomes (Deveugele *et al.*, 2002; Wilson & Childs, 2002) Pandemic-era remote consultations constrained the SLB's key aspect of in-person contact, delaying effective communication by restricting non-verbal signs, being these crucial for MH management (Foley & Gentile, 2010; Hammersley *et al.*, 2019).

Barriers such as waiting lists for MH services influence GPs' referral decisions (Goldner *et al*., 2011). Waiting lists, for instance, can worsen clinical outcomes for MH patients due to the risk of deterioration (Reichert & Jacobs, 2018).

Furthermore, prescription strategies, used at times to manage time constraints, correlate with increased out-of-pocket (OOP) payments (Zuvekas & Selden, 2010) and information deficits (Thornicroft, 2008). Given the chronic nature of many MH disorders, OOP pose a financial risk, especially for economically disadvantaged patients (Zuvekas & Selden, 2010). Training and perception also come into play. GPs with misconceptions about certain disorders, like schizophrenia, might view these patients as more dangerous than their better-informed peers (Magliano *et al*., 2017).

Having explored the discretion inherent in GP roles, it is also necessary to understand the broader primary care frameworks in which they operate. Bourgueil *et al*. (2009), delve into this by identifying three models of primary care. The first is the "Non-hierarchical professional", spearheaded by health professionals without a unified primary care approach, often missing specific ambulatory care provisions. The second, the "Public Hierarchical Normative" (as observed in Spain), positions primary care under state oversight, with facilities frequently run by local entities and salaried GPs. The third, the "Professional Hierarchical Gatekeeper" (exemplified by the United Kingdom), revolves around self-employed GPs who oversee access to services and resource management. These classifications exist along a spectrum, and hybrid models are commonly adopted. For instance, both Italy and France generally tend towards a hybrid approach (Bourgueil *et al*., 2009; Kringos *et al*., 2015a).

In summary, the role of SLBs, particularly GPs, is multifaceted, shaped by both the discretion inherent in their positions and the broader policy and resource environments in which they operate. Lipsky's insights on discretion provides a foundational understanding of the decision-making processes at the frontlines of public service.

As exemplified in the context of MH management, various elements, from consultation time and decentralisation policies to training and perceptions, significantly influence GPs' decision-making. Furthermore, the three models of primary care outlined by Bourgueil *et al*. (2009) display the diverse structures in which GPs work.

NATIONAL COMPARISON

In Spain, the General Health Act (1986) established the National Health Systems (NHS) in conjunction with its European Union (EU) accession, reflecting the principles of Universal Coverage (Kringos *et al*., 2015b). Conversely, Italy had already paved the way for its NHS in 1978.

Spain's journey through the deinstitutionalisation was documented in the Report for Psychiatric Reform in 1985 and the Health law of 1986 which included psychiatry within the specialisations of the Health System (Aparicio Basauri, 1993; Guillén & Cabiedes, 1997). The NHS Strategy for MH in 2007 further consolidated this roadmap (Juliá-Sanchis *et al.*, 2020). Parallelly, Italy started deinstitutionalization in 1978, thanks to Law 180. From this moment admissions to Psychiatric Hospitals were halted, and a patient-centred approach emerged(Barbui *et al*., 2018). Both countries face issues coordinating MH, PHC and, social services, crucial for community-based mental disorder treatment (Salvador-Carulla *et al.*, 2005).

Regarding decentralisation, in Spain, the need for political stability after the dictatorship led to the transfer of the management of public services from the Central Government to Regional Governments (Guillén and Cabiedes, 1997; Vázquez-Barquero *et al.*, 2001). Italy saw its healthcare regionalization culminate in 1999, but subsequent policies ensured universal coverage and free service delivery persisted. Still, co-payment strategies introduced periodic dynamics into the system (Kringos *et al*., 2015b).

Regarding drugs, Spain tops the global ranking for benzodiazepine consumption with 110 daily doses per 1,000 inhabitants (DHD/1000 inhabitants) in 2021 (INCB, 2022). The growing trend in anxiolytics and hypnotics usage, which escalated during the pandemic, saw an increase in the defined daily dose per 1,000 inhabitants from 82.51 in 2010 to 93.05 in 2021 (Ministerio de Sanidad, 2022). During recent years, the psychotropic drugs (antidepressants, antipsychotics, and benzodiazepines) consumption in Italy, is a stable trend with a slight increase in benzodiazepine use. The average consumption of antidepressants stood at 40 DHD/1000 inhabitants from 2015 to 2017, while antipsychotic consumption held steady at 9 DHD/1000 inhabitants over the same period (AIFA, 2022).

On the professional front, GPs in Spain, salaried public servants, work full-time in multidisciplinary Health Centres. These centres operate 24/7. Each centre has a coordinator for shift organisation and minimal sanctioning responsibility (Kringos *et al*., 2015b). Contrarily, Italian GPs, categorised as public self-employed workers, in 2009 signed an agreement with Regions and the NHS to assure the community of "basic levels of care", and continuous care services 24/7 (Kroneman, 2011). To reach this goal, "aggregated functional local units" (AFTs) were created. GPs must offer five days a week of in-person consultations and two daily hours of phone availability from 8.00 a.m. to 10.00 a.m. for urgent requests. (SISAC, 2009). Recently Italy has fostered multidisciplinary Health Centres mirroring the Spanish PHC model.

Differences also exist in terms of "self-reported unmet needs for health care" (Table 1) Italy presents worse data than Spain. The perspective of Italian patients underscores the gaps in service provision, particularly regarding waiting lists.

Table 1. Reasons for self-reported unmet needs for health care*

	Financial reasons	Distance or transportation	Waiting lists
EU 27	13.0	4.0	19.4
Spain	10.3	1.1	13.0
Italy	13.6	8.3	25.2

Note: *measurement units represent % of responding people
Source: (EUROSTAT, 2021b)

Public fiscal constraints carried out during 2009-2011, intensifying Italian waiting list problems (Pavolini *et al*., 2015) prompting an increase in private occupational health coverage

(Petmesidou *et al*., 2020). Similarly, Spain saw a substantial increase in the public perception of extended waiting times, suggesting parallel availability and accessibility challenges in both countries (*ibidem*). Table 2 resumes the two national characteristics.

Table 2. Spain and Italy: A Comparative Analysis of Key Indicators

	Spain	Italy
Universal Health Coverage via Public-Private Partnerships	✓	✓
Decentralisation	✓	✓
Deinstitutionalisation	✓	✓
GPs as Gatekeepers of NHS	✓	✓
GP Remuneration	Salary	Capitation
GP Status	Public Servants	Self-employed Public Servants
Number of GPs in 2020 (per 100,000 inhabitants). EU average 78.33 (1)	91.42*	70.16
Psychiatric Hospital Beds (per 100,000 population). EU average: 73 (2)	36	9
Psychiatrists (per 100,000 population). EU average: 17 (3)	11	17
Health Expenditure (% of GDP). EU average: 8.1% (4)	7.3%	7.6%
OOP (USD per capita). EU average: 684.14 (5)	858 (21% of total health expenditure)	885 (21.89% of total health expenditure)
Mental Health Expenditure (as % of total government health expenditures). EU average: 6.21 (6)	5%	5%

Note: *data from Spain does not differentiate between General Practitioners and Generalist Medical Practitioners.
Source: (EUROSTAT, 2023b) [1]; EUROSTAT (2021) [2]; EUROSTAT (2020) [3]; EUROSTAT (2023) [4]; OECD (2023) [5]; WHO (2013) [6]

In summary, Italy and Spain, embodying the Southern European (SE) Welfare State Model, transitioned from occupation-focused to universal healthcare models from the 1980s (Ferrera, 1996). The interplay between public and private sectors is orchestrated to achieve optimal efficiency within cost containment (Petmesidou *et al*., 2014). Spanish Primary Care, marked by protocolised Health Centres, decentralisation, limited funding, cost control, and Regional Government roles (Pavolini *et al*., 2015; van der Tier *et al*., 2021), aligns with the 'Public Hierarchical Normative' model (Kringos *et al*., 2015a). Italian PHC integrates advanced strategies, capitation-based pay, cost control, and fiscal regulation. Its governance is an amalgamation of the "Public Hierarchical Normative" and "Professional Hierarchical

Gatekeeper" models. This hybrid approach underscores the importance of innovation within a traditional bureaucratic framework (Kringos *et al*., 2015a). Pertinent to this, there's a significant shift towards health centres in Italy, even while retaining a self-employed framework. Concurrently, an internal discourse is underway, deliberating the potential transition to a full public servant role.

METHODOLOGY

Research Design

A cross-national qualitative study was conducted using primary and secondary data, with the latter offering context to interpret the role and influence of GPs within the broader healthcare system. The comparison between the institutional and organisational landscapes of Spain and Italy could shed light on variations in GPs' patient management.

Data Collection and Analysis

To compare Italian and Spanish cases, ten GPs from the Health Service of Asturias (SESPA), Spain, and ten GPs from the Health Service of Central Tuscany (A*USL Toscana-Centro*), Italy, were interviewed between June and November 2022. In the comparative analysis, the primary focus is on contrasting Spain and Italy. While the two geographical areas share certain characteristics, such as a population size of around one million, the GPs selected from these regions aren't intended to represent the entire national sample.

After the Ethical Research Committee of Asturias approvement, the research proposal was presented to local Public Health Organisations, looking for GPs who were willing to participate, assuring anonymity and the possibility of withdrawing from the study. After first positive feedback, the sampling process continued by applying the “snowball” technique (Biernacki and Waldorf, 1981). The recruiting process stopped once the saturation point was reached (Francis *et al.*, 2010). To test the length and appropriateness of questions, three pilot interviews with Spanish GPs were conducted prior to the process of data collection, but these were not included in the sample.

Almost all the interviews took place at doctors’ practices. In a few cases, they were conducted by video call. All interviews were audio-recorder and conducted in GPs language. A short socio-demographic questionnaire was made before the beginning of the interview.

The open-ended interview topics were chosen starting from the macro and meso topics that could influence GPs’ management of patients with mental disorders based on the literature. The interview also explored topics based on SLB Theory, *e.g.*, discretionality, autonomy, lack of resources, their relationship with the first-line supervisor, and the presence of protocols that could limit their autonomy. In addition, open-ended questions investigated the impact of the COVID-19 pandemic.

The researcher’s “suspension of judgement” (Lindseth and Norberg, 2004) was emphasised to create a welcoming atmosphere favouring the prevention of social desirability bias (Bergen and Labonté, 2020).

To fully preserve the meaning and the experiences of the interviewee (Lindseth and Norberg, 2004), audio records were transcribed and analysed in Italian and Spanish. The categorization and analysis processes were conducted with MaxQDA. Formulating an initial set of codes through inductive and theoretical approaches, the process of identifying and categorizing the data that were relevant to the research was carried out. In addition, a deductive categorization process was used in conjunction with an abductive approach, in order to anticipate the possibility of data not fitting into pre-established categories (Dubois and Gadde, 2002). A narrative that represents the data was woven together with the assistance of broad themes and trends, discerned

through a secondary phase of coding (Miles and Huberman, 1994). Table 3 presents a summary of the participants.

Table 3. Summary of the participants

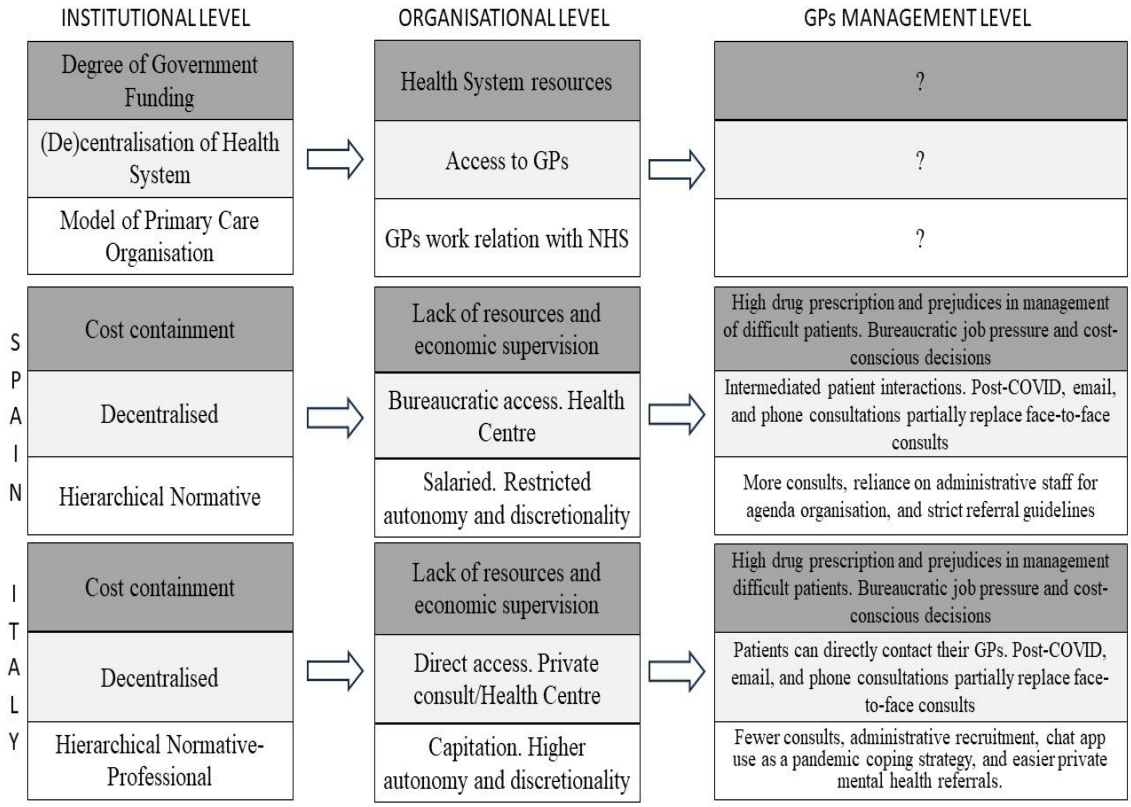
PART.	GENDER	AGE	Nº P	MC/DAY	HC
GP1S	F	55	1600	40	Yes
GP2S	M	48	1503	43	Yes
GP3S	F	59	1250	38	Yes
GP4S	F	31	1000	40	Yes
GP5S	F	59	1600	40	Yes
GP6S	M	64	1300	30	Yes
GP7S	M	60	1690	40	Yes
GP8S	M	64	1500	44	Yes
GP9S	M	28	—	—	Yes
GP10S	F	43	1400	50	Yes
GP1I	M	40	1500	27	Yes
GP2I	M	36	1500	20	No
GP3I	M	35	1550	31	Yes
GP4I	F	43	1300	28	No
GP5I	F	35	1200	15	Yes
GP6I	F	44	2020	21	Yes
GP7I	F	36	1700	38	No
GP8I	M	67	1200	28	No
GP9I	F	44	1750	40	No
GP10I	F	33	200	6	Yes

Note: The first ten GPs (above the black line) are Spanish (S), the second ten are Italian (I). GP9S is a residential doctor. Nº P=Number of patients. MC/DAY=Medical Consultations per Day (including face-to-face, telephone, and house visit consultations.) HC=working in a Health Centre.

PRINCIPAL FINDINGS

In this section, the most salient topics that appeared during interviews are presented (Miles and Huberman, 1994) according to the conceptual framework illustrated in Figure 1.

Figure 1. Impact of Institutional and Organisational Factors on GPs' Mental Health Management



Degree of Government Funding

Within the overarching objective of enhancing efficiency and reducing costs, it has been previously highlighted that GPs in both Italy and Spain are assigned financial responsibilities. GPs assume that their role as civil servants involves managing national financial resources, in terms of prescribing drugs and referring patients for specialised care. Both National Organisations constrain and allow GPs discretion by providing for supervision of spending, but with no sanctions for overspending. This GP expresses how organisational economic supervision influences his management:

> "*…it was a case in which I put a patient's life at risk for economic reasons because otherwise, it would never have occurred to me doing this evaluation*" (GP1I).

In practical terms, this implies handling significant administrative paperwork and, as a consequence, the time available for managing patients, particularly important in mental disorders (Hutton and Gunn, 2007). This Italian GP reports his difficulties with the management of time due to administrative paperwork:

> "*We are so accustomed to the bureaucracy that I can't even distinguish it from ordinary work. Regarding a working day, if it goes well, 40% is dedicated to patients. The rest is repeat prescriptions, putting together treatment plans, listing requests, correcting prescriptions made by specialists*" (GP1I).

As many GPs state, patients who present with psychological and emotional frailty need more time than a patient who is talking about a physical problem:

> "*You have eight minutes per consultation. There are consultations that are five minutes too long, especially bureaucratic ones, and there are consultations where you deal with a stressful situation, mood disorder… these eight minutes cannot be established*" (GP7S).

As previously noted, the management behaviour of GPs is influenced by the presence of waiting lists, which are in turn related to the measures of public cost containment. To avoid waiting lists, GP also can contact Public MH Services directly. This is more usual in the case of the Italian GPs, maybe due to their higher level of autonomy, and it also depends on the specialist service in the region, seeking shortcuts to help their patients (Wells, 1997). In other words, they discretionally resort to their inter-organisational informal network to personalise what they can offer (Loyens, 2019) advocating for their patients (Dunham *et al*., 2008):

> "*It can happen that you refer someone for a specialist visit, with a 30-day priority and they give the patient an appointment in four months' time… I must 'force their hand', to make it a more urgent priority*" (GP3I).

Data retrieved show how waiting lists for specialised mental care also influence the interviewed GPs' management behaviour. An Italian GP recognises that she chooses to refer to a private mental health specialist to avoid waiting lists and ensure that her patients gain quick access (dynamics in adult care differ, but what remains crucial is the doctor's approach to management):

> "*I now have a 13-year-old girl… Paediatric neuropsychiatry does not work, because it has very long waiting times…and sometimes I turn to the private specialists*" (GP6I).

Lack of time also influences drugs prescription (Thornicroft, 2008). Investigating the topic further, analysis of the GP interviews reveals that prescribing drugs is a common strategy due to the lack of time. One GP presents these considerations:

> "*Obviously the drug is more comfortable, quicker... a drug is easier to give to the patient, instead of understanding why he may have a problem and trying to solve it in another way*" (GP6I).

GPs also stated that they are trying to reduce their use of drugs. The main difficulty they reported in achieving this is the lack of time. Also, GPs commented that during the pandemic there was a trend towards medicalisation, leading to an increase in patients requesting medication, and a decreased tolerance for suffering.

Another factor influencing GPs' management of MH disorders is training (Thornicroft, 2008). The most common mental disorders in PHC, *i.e.*, affective, anxiety, and somatoform (Roca *et al.*, 2009), have complex origins. Effective management by GPs requires a blend of specific medical knowledge and emotional skills. Rather than expressing psychological distress directly, individuals often seek remedies for somatic symptoms. An experienced Spanish general practitioner discusses the general rule when prescribing drugs for "difficult" patients:

> "*What we usually do when we don't know what to do is to prescribe. 'Take this. Out.' You ask me for help, I'm supposed to give it to you. I don't know how to give it to you*" (GP6S).

The physicians interviewed report a lack of specific MH training at medical school. What they seek is not specialised training in psychiatry but specific information on how to treat common disorders and how to manage and refer patients with serious disorders, while giving them some primary help.

Both Spanish and Italian GPs acknowledge that patients with specific disorders cause rejection and fear, and as is well known, prejudices arise from a lack of knowledge. In these cases, GPs choose to refer the patient to a specialist or prescribe drugs. In cases of serious disorders, their perceived accountability decreases. These results are well summarised in these doctors' statements:

> "*Especially for me, the patient with psychosis was very scary. So much so that I was terrified because I don't know how to treat them*" (GP7I).

> "*For example, in women diagnosed with fibromyalgia, there are prejudices. Some professionals do not feel at all comfortable. They are very difficult pathologies to treat, and there is rarely success*" (GP2S).

Anticipated failure and perceived inability to deal with the problem also play a role in rejecting these patients. Coping with lack of resources, fast referral, prescribing drugs, and discomfort based on prejudices become routine (Lipsky, 2010). These are used to simplify the GPs' work and facilitate their management of users' demands. In summary, these coping mechanisms are implemented to overcome the "cognitive dissonance" (Festinger, 1957) between their clinical role and their perceived incapacity to manage patients with serious mental disorders.

Decentralisation of Health System

In Italy, private consultations potentially offer enhanced accessibility to GPs for patients. An Italian GP elaborates on this, emphasizing his personal guidelines which are crafted in accordance with the broader Health System rules:

> "*If there is an emergency, for example a fever of 38 and the patient can't go to work or even more serious things, they call me in the morning from 08 to 10 and I always see them during the day anyway. Either in the consult or I go to see them at home if they call me by 10 a.m. If they call me after 10 a.m. they can contact me leaving a message to the administrative staff"* (GP1I)

Existing literature highlights that, despite Italian GPs having higher accessibility, they hold fewer daily consultations compared to their Spanish counterparts, making more difficult the access to specialised care (Garattini *et al.*, 2023). Another consequence is that PHC in Italy is bypassed because of patients' direct access to Hospital Emergency or Private Services. It is not possible to exclude the likelihood that some of these patients might require psychological care:

> "*You can't manage all the requests you have. So, in 20 to 30% of cases, you are bypassed, and the patient goes directly to the hospital. Therefore, you no longer work as an access door. You are overwhelmed or patients go to the private system*" (GP7I).

Reflecting on the responsibilities and privileges of being a GP in a front-line role as a public servant, these Spanish GPs emphasise the crucial role of accessibility in establishing trust with patients and guiding their journey through the Health System. Given the vulnerability of patients with mental disorders, these considerations become even more significant:

> *"We have a big responsibility since we need a very big knowledge. We must generate sufficient confidence in patients so that they also consider us an adequate filter so as not to overload or saturate the health system"* (GP5S).

> *"I believe that the family doctor is the fundamental pivot where people's health should rotate. You have a complete version of the disease's social determinants. You follow people in their environment, you know their neighbourhood, how they live*

and with who. This gives you much more information than in hospital care specialties" (GP7S).

Regarding access to PHC, after the pandemic, the doctors' management of patients has moved towards a more computerised mode. Face-to-face consultation is no longer the main management tool as phone consultation became an important instrument in GPs' patient management.

Additionally, Italian GPs count on the use of social networks as a coping strategy to gather information and coordinate activities, enabling them to respond to the surge in patient demands and stay updated on the latest guidelines for pandemic management, thereby becoming part of the Organisational Communicative Infrastructure. The unplanned use of a technological instrument emerged to meet the needs of informal intra-organisational networks (Loyens, 2019) to communicate fast and comprehensive information.

The usefulness of chat applications for contacting both patients and colleagues is very clear from these Italian GPs' interviews:

"The change which has ballooned greatly is that of the digital-IT component. So, email, WhatsApp, and more. This aspect became very important. Home visits have also decreased, which were sometimes just courtesy visits in a sense. Because (during the pandemic) you couldn't go, except in special cases" (GP8I).

However, it must be considered that in chat communication, there is a lack of verbal and non-verbal components that are essential for the expression and understanding of fundamental meanings related to MH.

Model of Primary Care Organisation

Based on the data, it appears that the self-employed regime in Italy promotes a patient-centred approach, whereas the salaried regime in Spain makes corporatist influences more powerful. Closeness to the doctor could be a preventative and protective factor in the case of mental health disorders, favouring early detection and prevention of a mental disorder. This Italian GP reflects on the impact of the pandemic on her close relationship with patients:

... we felt a great distance with people at the beginning... we were in danger of losing contact, of not being able to perhaps have the neighbour who passes by and asks you how the neighbour is doing (GP10I).

Currently, there's a debate among two generations of Italian GPs. The older GPs strongly support the liberal profession, while the younger ones lean towards the Spanish model:

There is a risk of no longer being at the service of the patient. I am the caregiver of the patient. Because then, as is happening now, the let's say corporatist component is taking over, in its pros and cons. Let me be clear, this is not a criticism. But I feel that my client is my patient, not the healthcare system. Among colleagues of my generation there is this opinion (GP8I).

"*In my opinion, a GP should be a civil servant like all other public professionals This is to avoid excesses of conflicts of interest and to be able to give common objectives to the professional category, to all GPs and, together, also to the State*" (GP10I).

Regarding autonomy, Spanish GPs cannot full organise their own schedule due to their work relationship with the NHS. Their diaries are organised by administrative staff. A Spanish GP reflects on the discretion of the health administrative staff and its impact on his work:

> *"They are the ones who organise my schedule, my work. If they organise it badly, for me it is a disaster. That influences me in my relationship with a patient. ... Imagine if everyone who comes wants to see me at the moment. The administrative staff says (to the patient) - What do you want? – A prescription for a blood analysis - Well, don't worry, is not urgent. Come tomorrow at 10 -. And there is no problem. Imagine if that they say - Go upstairs (to see the doctor) -. And everyone who comes, goes upstairs ... I don't have time to see everyone, I get angry" (GP6S).*

Even so, the perceived autonomy and accountability level is still high, as evidenced in the words of this GP:

> "*In the consultations, you have absolute freedom. I am not controlled, I own my consultation, and I own the decisions I make. It is a huge autonomy, therefore, I do not have the rigidity of public servants*" (GP6S).

Regarding autonomy and the bureaucratic workload, GPs from both Spain and Italy broadly agree that administrative staff could offer a solution and extend the length of the health consultation. In Italy, administrative staff are employed by the GPs, while in Spain they are public employees too. In Italy, GPs can select administrative staff based on specific criteria, whereas in Spain staff are assigned to a Health Centre based on a public entrance exam. The important work of the administrators is both to inform and to filter:

> "*We have a girl who has agreed to work with us… She is a person with many skills and competence…. She also quantifies the health needs a little. When she is not here, the phone calls double. So, this means that she can attend to all non-medical needs*" (GP10I).

CONCLUSIONS

This comparative analysis of GPs in Italy and Spain offers crucial insights into the SLB Theory and MH literature. The investigation proposes a focus on top-down generative mechanisms affecting MH management.

Italy and Spain's healthcare systems present interesting, shared priorities alongside unique system-specific elements. These countries' professional models significantly shape healthcare approaches. While Italian GPs in a self-employed model often show a less corporate perspective, Spanish GPs in the salaried model demonstrate strong organisational commitment. Yet, regardless of these divergent models, GPs in both nations strive for efficient national resource management, evidenced by their cost-conscious decisions regarding prescriptions and specialist referrals. Concerning private referrals, Italian GPs, enjoying greater autonomy and discretion, sometimes refer patients privately. Conversely, Spanish GPs, whose salaried status may cultivate organisational alignment, typically eschew such practices.

In Italy, direct patient-GP contact strengthens doctor-patient relationship, underscoring the autonomy of the self-employed model and GPs large discretionary potential. Spain's model, meanwhile, leans bureaucratic, with appointments made via administrative staff. Italian GPs' schedule flexibility and patient interaction possibly aid MH management. In contrast, Spanish GPs' health centre ties restrict their scheduling flexibility, but they still maintain significant autonomy.

Despite these variances, there are universal issues. GPs in both Italy and Spain express concerns about the lack of specific MH training. This gap often leads to coping strategies when dealing with patients with certain disorders, such as routinised referrals or prescriptions, which may not always be the most optimal treatment approach. This could be symptomatic of the persistent societal prejudice and "soft institutionalism" (Basaglia & Basaglia Ongaro, 1966).

Biased medical practice leads to the control or alteration of individuals through medication rather than through physical institutional confines. The over-reliance on drugs appears particularly pronounced in Spain, as evidenced by prescription data.

The research also highlighted that GPs in both nations struggle with resource constraints, particularly time. The bureaucratic workload, exacerbated by the pandemic, reduces the time available for patient care, relevant for those with MH issues. However, Italian GPs can contract administrative staff to manage non-clinical patient needs and reduce bureaucracy.

In essence, this study reveals a complex interplay between shared healthcare objectives and unique systemic characteristics within the Italian and Spanish healthcare systems. It underscores how professional models and bureaucratic structures can influence the pathway to achieving these objectives, but they don't completely determine the functionality or effectiveness of the healthcare system.

This study enhances the SLB Theory by highlighting how professional structures influence discretionary practices, evidenced by the cost-saving behaviours of Italian and Spanish GPs. The identified gap in MH training illuminates an area for theoretical expansion, particularly in the influence of professional expertise on discretion. Prejudices affecting the relationship with specific patients were attributed to a lack of training in mental health. Furthermore, by studying often overlooked Southern European contexts, characterised by limited resources, low spending, and service management decentralisation, this research amplifies the comparative scope of the theory.

This article could aid policymakers by highlighting the multifaceted factors shaping the realities and practices of GPs, thereby informing strategies for the development of effective and resilient PHC systems ensuring fair access to high-quality MH services. The limitations mentioned should also be considered in the formulation of future research and policy design, to ensure a comprehensive understanding of all factors at play.

Primary limitations of this study arise from its methodology and specific variable focus. The sampling process may have yielded an unrepresentative sample, potentially skewing the depiction of the phenomenon under investigation. Given the decentralization and regional differences, these results could differ within the two NHS systems. Responses might be influenced by desirability bias. However, efforts were made to minimise this by ensuring anonymity and creating a welcoming atmosphere. Last, the scope of the research was confined to topics pertinent to the dynamics under scrutiny. Future research could involve interviews with MH patients and first-line supervisors to provide a fuller understanding of the several factors influencing GPs' MH management.

In conclusion, this analysis reveals the evolving dynamics within both the Italian and Spanish healthcare systems. Notably, Italy, capitalising on its private consulta model, is beginning to implement a Spanish-like system of health centres. Ultimately, considering the NHS's resilience during the pandemic, these findings attest to the inherent dynamism within health systems, underscoring the crucial role of ongoing adaptation in response to evolving internal and external factors.

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