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THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN ITALY

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AND

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1. The long-term care system in Italy

1.1 Overview of the system (summary) (including the philosophy of the system)

In Italy, social care and integrated social–health care services are assuming an increasingly prominent role, owing to i) the rapid growth in demand for long-term care (LTC) services, and more generally, for health care and social services for the elderly, caused by the rapid ageing of the Italian population; ii) changes in the family structure; and iii) other socio-economic changes, notably the increase in women's labour participation.

The LTC system in Italy is characterized by a high level of institutional fragmentation, as sources of funding, governance and management responsibilities are spread over local (municipalities) and regional authorities, with different modalities in relation to the institutional models of each region. The actors directly involved in the organization of LTC services are municipalities, local health authorities (*aziende sanitarie locali*, ASLs), nursing homes (*residenze sanitarie assistenziali*, RSAs) and the National Institute of Social Security (Istituto Nazionale Previdenza Sociale,INPS), but other players are involved in planning and funding these services – i.e. the central state, regions and provinces. Additionally, in Italy a significant share of LTC expenditure is funded directly by households. Moreover, a large part of caregiving is still provided by informal carers, especially in regions where public services are less advanced and in families that cannot afford the cost of private services. Privately purchased home care is often provided by immigrants.

In Italy, public long-term care for older persons includes three main kinds of formal assistance: community care, residential care and cash benefits. The Italian National Health Service (Servizio Sanitario Nazionale,SSN) plans and manages, through local health units (*aziende sanitarie locali*), home health-care services – the so-called 'integrated domiciliary care' (by the *assistenza domiciliare integrata*,ADI)– and other health services provided in residential settings. Personal social services, both domestic and personal care tasks provided at home (by the *servizi di assistenza domiciliare*, SAD)and institutional social care are managed at a local level by municipalities, although this should be planned in coordination with the ADI. Long-term care is delivered by both public and accredited private providers of health and personal social care. The health care services provided by the SSN are free of charge, whereas social care

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is means-tested and users can pay up to the full cost of it. National and local taxation are the main funding sources of public long-term care.

The National Institute of Social Security provides a cash benefit (*indennità di accompagnamento*) to disabled persons, independent of their financial situation. This cash benefit is not directly linked to an obligation to purchase goods or services, and it is aimed at improving one's personal condition and can thus be used to compensate the household for informal care. Nevertheless, the *indennità di accompagnamento* is usually considered part of LTC expenditures in Italy, unlike invalidity pensions. Other cash benefits are provided by some municipalities, but these are usually means-tested.

LTC in Italy is also characterized by a wide variation among regions and areas in both funding levels and the structure of the services provided. In Italy, rather than one national LTC system there are many regional LTC systems. For instance, the levels of expenditure by municipalities are very diverse, although the information available is poor. Data from the survey by the National Institute of Statistics (Istituto Nazionale di Statistica, ISTAT) reveal that in Italy in 2005 municipalities' expenditure on social services was on average around €117 per capita, ranging from €34 in the Calabria region to €253 in Friuli Venezia Giulia region.[1] These data entail many limitations and therefore can only provide an indication of the interregional differences. Total expenditure per person institutionalized in residential institutions for the elderly varies widely by region, as does the proportion funded by public institutions, namely the SSN and municipalities. The structure of the LTC servicesprovideddiffersgreatly by region too. For example, the number of elderly persons institutionalized ranges from 500 per 10,000 inhabitants aged 65 and older in Trentino Alto Adige down to 48 in the Campania region (see Table 9 in section 3.4). The number of elderly persons receiving home health-care services ranges from 2.7 to 89 per 1,000 inhabitants aged 65 and older (see Table 10 in section 3.4).

Generally speaking, in northern Italy the culture of public service in LTC is rather widespread, partly owing to the high level of participation by women in the labour market. These regions – and municipalities – have been making an effort to improve their LTC system, thanks also to their more developed management capabilities and their larger economic resources. In the south, by contrast, the care burden rests mostly on families, with poor public support. In any case the demand for a general, national, integrated LTC system – although with decentralised management responsibility – seems to be strong all over the country and the debate on possible reforms has been going on since the early 1990s.

Law No. 328/2000 determined the main objectives for LTC policies, requiring the set-up of a minimum level of social care services to be provided throughout the country. The National Health Plan 2006–08 identified efforts to strengthen home-based care – instead of institutional care – as a first priority and claimed to reinforce cooperation between institutions and formal and informal groups in order to improve care. Nevertheless, regional objectives differ as does their commitment, and national reform is still lacking. Even the 'essential levels of service' – i.e. the national standards – have not been set, and therefore the entitlementsrelated to them have not been settled. The main obstacle to a comprehensive national reform of LTC is funding, given Italy's high level of public debt, together with the political preference for alternative policies to support households, such as fiscal benefits or cash benefits (or both), with a more direct and immediate impact on people's perceptions.

[1] See *Spesa per interventi e servizi sociali dei comuni singloli e associati per area di utenza e per regione – Anno 2004*, ISTAT, Rome.

1.2 Assessment of needs

In Italy there is not a single, national legal definition of persons in need of care to which one can refer.To obtain the cash benefits provided by the INPS, a claimant must apply to the ASL in charge of deciding whether the health requirements (in terms of disability and dependence, see the next section) are present, through its medical commission. If this is the case, the claimant is referred to anINPS commission, which makes the final decision.

ASLs of the Italian National Health Service are responsible for assessing the degree of disability of citizens living in their catchment area, but their criteria are not homogeneous. For most health and social services, the needs assessments are carried out by a multidisciplinary team of the ASL – in most of them by the geriatric evaluation units (Unità di Valutazione Geriatrica), which include doctors, nurses, social workers and sometimes administrative employees. This team in some cases classifies the claimants into categories of need, setsout the care plan and chooses the type of provider. In contrast, in Lombardia the citizen freely chooses the provider(s), which can classify clients according to their needs.

The severity of need is assessed by regions in different ways. Each region has a specific classification system and sometimes the regions present some variations within them. Usually these multidimensional evaluation processes are built on validated international standards, for example SVAMA[2] (Veneto) and VAMA (Trento province), which include the BARTHEL ADL standard; VAOR (Abruzzo, Basilicata and Calabria); BINA (Emilia Romagna and Friuli Venezia Giulia); SOSIA (Lombardia); AGED PLUS (Liguria); 'Scheda VITA' (Bolzano Province); and MDS (minimun dataset) ADL LONG FOMR (Toscana). In all of these processes the instrumental abilities play a secondary role, in that they are either not taken into consideration or they are evaluated but not used to determine the level of need.

Starting from activities of daily living (ADL), the classification is supported by other evaluation systems, for example the 'health condition'on a cumulative illness rating scale (CIRS), or ICD IX (International Classification of Diseases) or ICPC (International Classification of Primary Care). From a regulatory point of view, there has been a renewal of all the evaluation procedures, with a greater emphasis on a multidimensional approach, following the creation of the LTC national fund. Yet there has been no indication that a standardization of classification and evaluation systemswill be carried out (Gori, 2008).

1.3 Available LTC services

In Italy the LTC system, including health and social care services and cash benefits, consists of three main components:

- health services for elderly and disabled persons, including outpatient and home-based care services, semi-residential and residential services, psychiatric services and those for drug and alcohol addicts;
- cash benefits (*indennità di accompagnamento*) provided (and funded) directly to all disabled persons by the INPS,independent of their age and financialsituation. This monetary aid is not directly linked to purchasing LTC services, but is generally considered part of the LTC system. Indeed, the Ragioneria Generale dello Stato [State General Accounting Department] of the Italian Ministry of Economy and Finance includes this item in public expenditures on LTC for long-term projections of public

[2] SVAMA (Scheda per la Valutazione Multidimensionale dell'Anziano) includes the following dimensions: health, self-sufficiency, social relationships and financial situation.

expenditures, as agreed at the EU level by the Economic Policy Committee Working Group on Ageing (WGA), following the OECD's guidelines (Ragioneria Generale dello Stato, 2008);

- social care services provided at the local level. This field of intervention, mainly in-kind, is managed by municipalities. Social care services areprovided in institutions, such as nursing homes for the elderly or semi-residential institutions, or as home-based care services. Along with in-kind interventions there are some limited cash benefits provided by municipalities; and
- in addition to these three components,the invalidity pensions provided by the INPS could be included as part of the LTC system as they are, de facto, a long-term income support mechanism for dependent persons. But invalidity pensions are not included in theRagioneria Generale dello Statoorthe WGA's assessment of public LTC expenditures, since they are not social benefits, but rather belong to the pension system.

The national cash-benefit scheme, funded by the central government out of general taxation, is a universalistic intervention, neither linked to the payment of social security contributions nor means-tested. Persons eligible for this cash benefit must be i) assessed as 100% disabled and dependent, i.e. unable to walk without the permanent help of a companion or unable to carry out the activities of daily living and being in need of continuous assistance; ii) not in a residential institution whereby the costs are charged to the public administration. This cash benefit is provided every month; beneficiaries are free to use it to purchase LTC services or not, and in 2009 the monthly benefit was set at €472.

Regions, provinces and most frequently municipalities fund other forms of cash benefitsfor the households of dependentindividuals but there is a high degree of variation in both the level and nature of these cash benefits across Italian geographical areas. These cash benefits may or may not be linked to purchasing services. These types of cash benefits are increasingly relevant in some northern Italian regions, and started to be provided at the end of the 1980s.During the 1990s they became more widespread, mainly supporting home-based care.

Italy does not have any national legislation concerning cash benefits to households in order to support the care of relatives. These cash benefits were originally thought of as a measure to support relatives – typically the spouses or daughters/sons of the elderly person – while now they are mainly targetedat co-funding private home-helpers and carers (Beltrametti, 2008). These cash benefits are provided as monetary support or as an integrated part of other personal and social care services provided by the local authorities (NNA, 2009).

The eligibility criteria for regional and local LTC services as well as cash benefits are not harmonized. In general, the evaluation units, besides undertaking the multidimensional assessments of need, decide on the accessibility to some home-based or residential services. Members of the municipality (or municipal associations) in charge of the social services are included in the evaluation unit or work in agreement with the ASL. The evaluation concerns both health and social factors. The financial situation is often valued through ISEE (Equivalent Economic Situation Indicator, a tool to assess the economic household situation, combining income and assets). For cash benefits the access criteria in some cases are set at the local level (municipality or ASL), while in other cases they are fixed by the regions or in combination (the regions set an ISEE threshold and some broad evaluation criteria) (Bertoni et al., 2008; Cicoletti, 2008).

1.4 Management and organization (role of the different actors/stakeholders)

The organizational structure of the Italian LTC system is split between the two sectors involved in LTC – theSSN (National Health Service)authorities and the municipalities.

Services provided by the SSN

Under the Italian constitution, health is a guaranteed right and the SSN, founded in 1978 (replacing a system of health insurance funds), aims at providing uniform and comprehensive care, financed by general taxation.

The SSNhas undergone major reforms in the last 15 years, including the decentralization of health policy responsibilities to the intermediate level of government (21 regions, with on average a population of 3 million). The central government has exclusive power to set system-wide rules and health services that must be guaranteed throughout the country – i.e. the SSNentitlements. Regions have responsibility for the organization and administration of publicly financed health-care through the ASLs (local health authorities) (Tediosi et al., 2009) and for capacity planning, even if the central government often imposes obligations and parameters (like a maximum ratio of beds/residents and a ceiling on pharmaceutical expenditures). Nevertheless, regions with high levels of debt and which are unable to contain SSN deficits must undergo budgetary balance plans to be agreed with and to be implemented under strict control by the central government. The central government is responsible for monitoring the provision of services, but there is actually a lack of concrete action in this field. Regions are also responsible for quality control in relation to private accredited providers.

ASLsare in charge of delivering or purchasing health-related home-care services (nursing, physiotherapy, specialist and GP visits, etc.), residential health care and other long-term care services for the elderly (e.g. long-term stays in hospital and rehabilitation stays in hospital or other residential settings). Health community services are in most regions managed by health districts, a local articulation of ASLs.

ASLsfund health services provided to patients by public providers and by private accredited providers (e.g. residential services). Regions set the payment systems for residential services, which in most cases are based on a fee per day of stay. Patients are in principle free to choose among public and private, accredited, health service providers.

Personal social services

Personal social services are still underfunded by the public sector and there are huge differences among areas of Italy in the quality and quantity of the services provided.

According to Law No. 328/00, regions exercise the functions of planning and coordinating social services, as well as monitoring implementation. In 2000, many regions approved or modified their framework laws on social services and other planning documents, sharing the planning and management responsibilities with the municipalities (or their associations) in various ways and measures (Giorgi and Ranci Ortigosa, 2008).

The delivery of services is mostly regulated by regional legislation, but even within the same region the services provided differ widely among municipalities. The latter are responsible for planning and managing personal social services, either delivering them directly or contracting them out to private providers. The LTC services provided by municipalities are home help (care) services and residential social care.

1.5 Integration of LTC

Health services and social services are still divided into two sectors in Italy. Responsibility for social services rests with the municipalities under the control of the regions. Regions are responsible for health services, run by the ASLs. The integration of the two sectors, envisaged by the regulation, has never been defined nationally, and in fact it remains a regional responsibility. Only in some regions are health and social services managed in an integrated way, usually by ASLs and mainly in northern and central regions, such as Emilia Romagna, Toscana and Liguria.

2. Funding

LTC services are funded by the SSN, regions/municipalities, INPS (National Institute of Social Security)and by users. Funds provided by the SSN, municipalities and INPS all come from general taxation.

Data on LTC expenditures in Italy are limited and incomplete. The Ragioneria Generale dello Stato, as part of the mid- and long-term forecasts of the pension and health systems, estimates current and future public LTC expenditures. According to the latest available data, in 2007 public LTC was around €25.6 billion, that is about 1.66% of GDP (Table 1) (Ragioneria Generale dello Stato, 2008). The main components of public LTC expenditures are those related to health services (€12.5 billion or 0.81% of GDP) and the cash benefits provided by the INPS (€10.8 billion or 0.70% of GDP), while personal social-care services are only €2.5 billion or 0.16% of GDP. Around 68% of public LTC expendituresis for services provided to persons aged 65 or older (57% of the health component, 77% of the cash benefits provided by the INPS and 75% of the other personal social-care services). Around 30% of public LTC expenditures is for home-based and semi-residential care and 27% for institutional care, while cash benefits account for 43%. The health services component included in the LTC public expendituresmake up 65% of it. This component entails home-based and outpatient services (23%), institutional services (42%), psychiatric services (24%, which also covers services at home as well as outpatient and residential settings), with the rest pertaining to services for drug and alcohol addictions and long-term hospital admissions.

The Ragioneria Generale dello Stato (2008) has estimated that in 2050 public LTC expenditures will reach 2.8% of GDP, mainly owing to population ageing. This increase will mainly stem from the cash benefits provided by the INPS.

These figures do not include expenditureson invalidity pensions provided by the INPS. The expenditureson cash benefits – also in the form of invalidity pensions – by the INPS that could be considered part of the LTC system in 2005 are estimated at around €23.1 billion (Ministero dell'Economia e delle Finanze, 2009). This figure is more than twice that for the cash benefits considered part of LTC (*indennità di accompagnamento*).

As for private expenditures, all of the LTC health services funded by the SSN are free of charge and patients do not pay co-payments. Home help (care) provided by social services (SAD) and institutional long-term care is funded by municipalities and service users are charged co-payments based on means testing. Co-payments are required not only from users but also from their relatives.

Co-payments should, in principle, be based on criteria defined by each region (Art. 8, Law 328/2000) consistently with those of the National Social Plan – according to the D.Lgs. 109/1998, which introduced a means-test system based on ISEE (see section 1.3). In practice, however, few regions have defined these criteria and therefore they leave ample room for municipalities to define co-payment modalities.

In fact, co-payments can be up to the full service cost depending on the type of service. In institutional settings, if any health care is provided the SSNwill cover the costs, usually on the basis of a daily tariff set at the regional level. The other costs of institutional care are covered by the municipalities and users. The co-payment can vary mainly according to the level of disability and the family financial situation.

There is no official data on private expenditure, which should include user payments for institutional care, the costs of private insurance and those paid by users for privately purchased home care and co-payments. A recent attempt to estimate both the total and private expenditures for residential care (on the basis of ISTAT data) highlighted that almost half the cost is borne by users (NNA, 2009; ISTAT, 2007). On average, the monthly expenditure per person admitted in residential institutions was estimated at €2,260, ranging from €1,528 for residential care institutions to €2,454 and €2,702 for the two types of nursing homes present in Italy (Table 2). Users pay €1,065 per month on average (with a range of €929-1,194, depending on the type of institution), which is around 47.1% of the total costs (with a range of 60.8% to 39.6% by type of institution). The total expenditure for institutional care was estimated at around €6.27billion in 2004, of which 43.6% was covered by the SSN, 9.4% by municipalities and 47.1% by users. Thus the private, out-of-pocket expenditures for institutional care was estimated at €2.95 billion (Table 3). In addition, 56.7% of elderly persons in residential care pay the entire costs of it, 35.5% pay only part of the costs and 8% do not pay because of their poor financial situation.

The estimates available for insurance premiums for LTC are around €50 million for 2008 (Rebba, 2009). There are no official data on private expenditures for home-based social care. A recent study tried to estimate private, home-based social care provided to elderly persons on the basis of various sources, and came to the conclusion that it should be around €9.8 billion, with €9.3 billion attributed to services purchased on the market (both grey and regular) and €0.5 billion for co-payments of publicly funded services (Rebba, 2009). The same study estimated that the value of informal home-based care would be around €4.8 billion. Putting together all of these estimates, private expenditureson LTC would be around €12.8 billion. Still, these data are very uncertain, and in practice it is nearly impossible to estimate private contributions to LTC expenditures.

Table 1. Public expenditure on LTC in 2007

LTC expenditure	**Total in million €**	**In % of GDP**	**Total in million € for citizens 65+**	**In % of GDP**
Health services (component)	12,513.8	0.81	7,106.6	0.46
Cash benefits (from INPS)	10,814.4	0.70	8,342.5	0.54
'Other LTC services' (social care services)	2,471.9	0.16	1,853.9	0.12
Total	**25,800.1**	**1.66**	**17,303.0**	**1.13**

Source: Ragioneria Generale dello Stato (2008).

Table 2. Average expenditure per person admitted in residential institutions, in 2004 (monthly values, €)

Type of institution	€ Covered by						
	SSN		Users		Municipalities		Total
	(€)	(%)	(€)	(%)	(€)	(%)	(€)
Residenza assistenziale	398	26	929	60.8	201	13.2	1,528
Residenza socio-sanitaria	1,036	42.2	1,194	48.7	224	9.1	2,454
Nursing homes (RSAs)	1,418	52.5	1,071	39.6	213	7.9	2,702
Average	**983**	**43.5**	**1,065**	**47.1**	**212**	**9.4**	**2,260**

Source: NNA (2009).

Table 3. Estimated total expenditure for residential care in 2004 (million €)

Type of institution	Million € covered by						
	SSN		Users		Municipalities		Total
	(€)	(%)	(€)	(%)	(€)	(%)	(€)
Residenza assistenziale	307.31	26.0	717.31	60.8	155.20	13.2	1,179.81
Residenza socio-sanitaria	1,010.93	42.2	1,165.11	48.7	218.58	9.1	2,394.62
Nursing homes (RSAs)	1,413.67	52.5	1,067.73	39.6	212.35	7.9	2,693.75
Total	**2,731.91**	**43.6**	**2,950.15**	**47.1**	**586.13**	**9.4**	**6,268.19**

Source: NNA (2009).

3. Demand and supply of LTC

3.1 The need for LTC (including demographic characteristics)

The Italian population has been ageing rapidly because of both the slow down of fertility rates and the increase in life expectancy. In 2007, almost 20% of the Italian population (59,131,287) was aged 65 or older (11,792,752), while 5.3% was aged over 85. In the same year, the age dependency ratio was 32.2% (considering those aged over 65), while that considering individuals aged 80 and older was 6.75%. The parent support ratio for those aged 80 and older (the ratio between the population aged over 80 and the population aged 50-64) was close to 28% (Table 4). ISTAT forecasts that in 2050 the share of persons aged 65 and older will rise to 33% of the population and the share of those aged 80 and older will be 13.5%.

For the estimation of the population in need of LTC, it has to be underlined that no national legal definition of 'LTC care needs' is available in Italy. In fact, the National Institute of Statistics does not define persons in need of LTC – it only defines disabled persons.[3] A person is considered disabled if s/he has limitations in at least one of three dimensions (physically, in activities of daily living and in communications), taking into account the eventual use of devices. ISTAT derives from this classification four typologies of disability, one of them including persons forced to remain in bed or in a chair. The number of personsin need of LTC

[3] Although the ISTAT definition has statistical interest, it is not a legal definition or linked to any entitlements.

living at home can be estimated from the *Indagine multiscopo sulle famiglie* [Household Multipurpose Survey] conducted by ISTAT. According to ISTAT data referring to 2005, the number of persons with one or more serious limitations in ADL is 2.61 million, 2.08 million of whom are aged 65+ (Solipaca, 2009). Moreover, 6.3 million persons present one light limitation – not a very serious one (Tozzi, 2009). With reference to the population in 2007 and applying ISTAT's serious disability rates, the number of persons in need of care aged 65+ would be about 2.3 million, whereas applying SHARE rates, as used in the *2009 Ageing Report* (European Commission & WGA, 2008), the estimate would be almost 2.5 million persons aged 65+.

A recent study on the health costs of LTC(Age.na.s., 2009), also using data from the ISTAT survey, estimated the number of persons in need of LTC services.Taking into account only those with three or more limitations in activities of daily living, the number of persons in need in Italy would be around 882,179, with 712,775 being aged 65 and older – around 6.5% of all those aged at least 65 (Table 4).

These figures do not include individuals admitted in residential institutions. The number of elderly persons in institutional care is available from ISTAT for the year 2005. The total number of the elderly in institutional care was 229,628, among whom 70.3% (161,328) were considered dependent (Table 5).

Combining the two estimates, the total number of persons in need of care would be around 874,000, but this figure is not reliable give the variations in the definitions used by ISTAT's surveys.

Table 4. Share of older persons in the population and number of persons in need of LTC in 2006

	Total (in % of total pop.)	**Men (in % of total pop.)**	**Women (in % of total pop.)**
Share of persons 65+	19.73	8.21	11.52
Share of persons 80+	5.12	1.7	3.42
	Total (in % of pop. 65+)	**Men (in % of pop. 65+)**	**Women (in % of pop. 65+)**
Share of persons 80+	25.95	8.62	17.33
	Total (in % of pop. 20-64)	**Men (in % of pop. 20-64)**	**Women (in % of pop. 20-64)**
Age dependency ratio 65+	32.3	26.7	37.6
Age dependency ratio 80+	6.75	4.59	8.82
Parent Support Ratio 80+	27.91	9.27	18.64
Number of persons in need of LTC (only including those living at home)	882,179	–	–
Number of persons in need of LTC aged 65+ (only including those living at home)	712,775	–	–

Sources: ISTAT (http://demo.istat.it/pop2006) and (2006); Age.na.s. (2009).

Table 5. Elderly persons (aged 65+) in institutional care by health condition, 31 December 2005(values per 1,000 inhabitants aged 65+)

Persons in institutional care		Men		Women		Total
(Health status)	(No.)	(%)	(No.)	(%)	(No.)	(%)
Self-sufficient	18,309	33.7	49,991	28.5	68,300	29.7
Dependent	359,706	66.3	125,358	71.5	161,328	70.3
Total	**54,279**	**100**	**175.349**	**100**	**229,628**	**100**

Source: ISTAT (2005).

3.2 The role of informal and formal care in the LTC system (including the role of cash benefits)

Informal care is extremely important in the Italian social protection system, but the data available are limited and uncertain.

A study on the ISTAT Household Multipurpose Survey (Fraboni, 2009) shows that in 2003 34.2% (30.6% in 1998) of households including at least one person with serious self-sufficiency limitations had received informal help by non-cohabiting individuals in the previous four weeks (28.4% non-financial aid).In addition, 20.3% had received assistancefrom the private sector (15.9% in 1998) and 21.7% from the public sector (14.2% in 1998). At the same time, 48% of suchhouseholdshad not received any kind of help and 18% had received only informal assistance.

3.3 Demand and supply of informal care

While the households including at least one person withserious self-sufficiency limitations that had received informal help by non-cohabiting individuals in the previous four weeks representeda little over 30%, the number of personswho gave at least one form of care assistance to a non-cohabiting adult in the previous four weeks was 2.2 million, according to ISTAT. Unfortunately, ISTAT databases do not include any information on the demand for and supply of informal care received by cohabiting carers. The EUROFAMCARE national report on Italy (Quattrini et al., 2006) estimates that 3-3.5 million individuals provide care to a dependent relative, based on the ESAW survey results, which show that 11% of persons aged 50+ (about 2.35 million) provide care to a dependent older relative.

3.4 Demand and supply of formal care

Institutional care

In Italy there are three different kinds of residential services: *residenze assistenziali*(accommodating 28% of the elderly), with mainly hotel services for self-sufficient persons; *residenze protette*, accommodation that offers more health care, aimed at helping clients recover as much psycho-motor capability as possible; and *residenze sanitarie assistenziali* [nursing homes], which also provide health care for dependent clients. Between 2000 and 2005, the latter increased their role on the supply side, with 24,400 more beds. The total ratio of beds on the supply side of the system to the total number of elderly persons is 2.3%.

The total number of beds available is 265,326, 28% in *residenze assistenziali*, around 36% in *residenze socio sanitarie* and around 36% in *residenze sanitarie assistenziali*(Table 6). There is

wide diversity in the total number of beds in residential care institutions across Italian regions and also among the types of institutions. Only 35% of the residential care beds available are public, whereas 43% belong to private not-for-profit institutions and 22% to private for-profit ones (Table 7).

The number of elderly personsin institutional care is still relatively low by international standards, being 19.8 per 1,000 inhabitants aged 65 or older. This average hides the huge interregional variation, from around 4 per 1,000 elderly persons up to 49 (Tables 8 and 9).

Table 6. Number of beds in institutional settings by type of institution and region, 31 December 2005

Regions	***Residenza assistenziale* for the self-sufficient elderly**	***Residenza socio-sanitaria* for the elderly**	***Residenza sanitaria assistenziale* (nursing homes)**	**Total**	**% of total**
Piemonte	24,085	13,311	6,092	43,488	16.4
Valle d'Aosta/Vallée d'Aoste	53	728	148	929	0.4
Lombardia	1,653	2,790	50,668	55,111	20.8
Trentino-Alto Adige	19	2,958	5,269	8,246	3.1
Veneto	6,471	23,026	4,921	34,418	13.0
Friuli-Venezia Giulia	2,263	7,437	1,709	11,409	4.3
Liguria	718	8,962	2,732	12,412	4.7
Emilia-Romagna	8,469	17,773	2,149	28,391	10.7
Toscana	3,180	1,689	10,783	15,652	5.9
Umbria	631	1,281	286	2,198	0.8
Marche	3,430	3,120	1,479	8,029	3.0
Lazio	7,541	1,070	4,109	12,720	4.8
Abruzzo	1,219	2,036	799	4,054	1.5
Molise	281	1,022	20	1,323	0.5
Campania	3,889	643	1,020	5,552	2.1
Puglia	3,777	2,587	301	6,665	2.5
Basilicata	387	248	0	635	0.2
Calabria	628	340	1,157	2,125	0.8
Sicilia	3,713	4,235	910	8,858	3.3
Sardegna	1,565	365	1,184	3,114	1.2
Total	**73,972**	**95,620**	**95,734**	**265,326**	**100**

Source: ISTAT (2005).

Table 7. Institutional care – Number of beds by provider type

	Places/beds (No.)	Beds (%)
Institutional care, total	265,326	100
Institutional care by provider type		
Public institutional care	92,864	35.0
Private not-for-profit institutional care	114,090	43.0
Private for-profit institutional care	58,372	22.0

Source: ISTAT (2005).

Table 8. Persons receiving institutional care

	Total		Men		Women	
	(No.)	(%)	(No.)	(%)	(No.)	(%)
Persons receiving institutionalcare	298,250	–	92,491	–	205,759	–
Persons receiving institutional care by age group						
0-14	11,983	4.02	6,351	6.87	5,632	2.74
15-19	5,815	1.95	3,082	3.33	2,733	1.33
20-24	4,772	1.60	2,529	2.73	2,243	1.09
25-29	–	–	–	–	–	–
30-34	–	–	–	–	–	–
35-39	–	–	–	–	–	–
40-44	20,222	6.78	11,527	12.46	8,695	4.23
45-49	–	–	–	–	–	–
50-54	–	–	–	–	–	–
55-59	–	–	–	–	–	–
60-64	25,830	8.66	14,723	15.92	11,107	5.40
65-69	–	–	–	–	–	–
70-74	31,404	10.53	13,391	14.48	18,013	8.75
75-79	40,169	13.47	12,540	13.56	27,629	13.43
80-84	158,055	52.99	28,348	30.65	129,707	63.04
85+	–	–	–	–	–	–
Total	**298,250**	**100**	**92,491**	**100**	**205,759**	**100**

Source: ISTAT (2005).

Table 9. Elderly persons(aged 65+) in institutional care by type of institution and setting, 31 December 2005 (values per 1,000 inhabitants aged 65+)

	Per 1,000 inhabitants aged 65+		
Region	**Men**	**Women**	**Total**
Piemonte	21.20	47.84	36.78
Valle d'Aosta/Vallée d'Aoste	19.69	48.60	36.71
Lombardia	13.58	35.76	26.77
Trentino-Alto Adige	29.16	56.69	45.45
Bolzano/Bozen	26.22	52.04	41.28
Trento	31.77	60.54	49.00
Veneto	16.96	42.57	32.15
Friuli-Venezia Giulia	19.62	49.23	37.41
Liguria	15.71	33.89	26.53
Emilia-Romagna	14.65	30.63	23.95
Toscana	8.35	21.25	15.87
Umbria	6.57	15.42	11.69
Marche	10.95	24.49	18.74
Lazio	7.20	15.46	12.02
Abruzzo	8.56	16.28	12.99
Molise	11.72	23.95	18.80
Campania	3.41	5.34	4.53
Puglia	5.20	10.11	8.02
Basilicata	3.80	5.21	4.60
Calabria	4.11	6.84	5.66
Sicilia	5.03	8.62	7.09
Sardegna	10.09	17.49	14.33
Total	**11.26**	**25.90**	**19.81**

Source: ISTAT (2005).

Home care

The home care services funded by the public sector are home health care (by the ADI), funded by the SSN, and home personal care (by the SAD), funded by local authorities (mainly municipalities).

The ADI,formally introduced in Italy in the early 1990s at the national level, in principle includes both home help (social care) and home health care (home nursing, physiotherapy, specialist and GP visits), but most of ADI clientsonly receive assistance for health care. Needs assessmentsare generally done by the Unità Valutativa Geriatrica[geriatric evaluation units], an assessment and planning unit composed of social and health-care professionals (in which the responsibility lies with the latter) who define a care plan.

According to the latest national data available, referring to 2003, in Italy the number of elderly persons who used home health care (by the ADI) was 27.3 per 1,000 residents aged 65 or older (Table 10) with huge variations across regions (ranging from 5.8 to 89.4 clients per 1,000).

Table 10. Users of home health care (ADI) aged 65+ in 2003 by region (number of users/1,000 persons aged 65+)

Region	**ADI users 65+ per 1,000 residents 65+**	**ADI users as % of 65+**	**SAD users as % of 65+**
Valle d'Aosta	2.7	0.3	3
Piemonte	16.8	1.8	1.5
Liguria	19.5	3.2	1.2
Lombardia	26.8	3.6	1.7
Trentino - Alto Adige	n.d.	–	–
Bolzano	–	0.5	4
Trento	–	1	3.2
Friuli Venezia Giulia	79.1	7.2	2.6
Veneto	37.7	6.4	1.8
Emilia – Romagna	46.6	5.7	1.9
Toscana	30.7	2.1	1.2
Umbria	24.6	4.3	0.6
Marche	27.8	3.9	0.9
Abruzzo	17.9	3.6	2.6
Lazio	18.9	3.8	1.2
Molise	89.4	3.7	4
Puglia	11.8	1.6	0.8
Campania	9.1	1.6	1.5
Basilicata	41.8	4.3	1
Calabria	5.8	2.7	1.5
Sicilia	7.1	1	2.8
Sardegna	5.7	1.2	2.5
Italy	**27.3**	**3.2**	**1.7**

Sources: CENSIS Fondazione(2005), Ministero dello svilupp o economico (2009) and ISTAT (2008).

Municipalities provide home help through their social services (SAD) without any integration with health care services. In some regions, the enforcement of regional provisions has enabled the social services offered by municipalities to become integrated with those provided by the local health authorities (ASLs). The supply of social services is inadequate to meet the population's needs and is extremely diverse across Italian regions. On the whole, 4.9% of persons aged 65 or older receive home care, 3.2% receive home health care (0.6% of whom also receive social services) and 1.7% social services (alone).

Data on the number of hours of care per recipient are limited too. The number of hours of home health care received per year is on average 24, showing the limitations of the public services (Ministero della salute, 2008). A recent study estimated the cost of home health care in Italian regions, showing that if the average expenditure is €88.6 per person aged 65 or older, the differences are profound, with values ranging from €16 to €235 (Table 11).

Table 11. LTC costs for health care in 2007,by type of care and region

	Per person aged 65+ in €				
Region	**Home care (ADI)**	**Health and personal care**	**Semi-residential care**	**Residential care**	**Total**
Piemonte	76.01	10.94	13.25	253.45	353.65
Valle d'Aosta/Vallée d'Aoste	99.44	43.22	0	51.76	194.42
Lombardia	75.04	7.65	16.21	426.9	525.8
Bolzano/Bozen	187.28	207.66	102.35	931.44	1428.73
Trento	16.49	0	0	1167.26	1183.75
Veneto	98.58	83.03	7.36	501.08	690.05
Friuli-Venezia Giulia	234.98	24.87	11.28	338.94	610.07
Liguria	83.59	38.92	5.06	176.16	303.73
Emilia-Romagna	157.12	3.47	13.11	315.69	489.39
Toscana	110.06	15.92	8.06	219.36	353.4
Umbria	152.89	14.15	4.47	203.47	374.98
Marche	130.45	13.38	1.23	157.1	302.16
Lazio	n.a.	n.a.	n.a.	n.a.	n.a.
Abruzzo	89	11.09	16.76	145.92	262.77
Molise	71.45	6.56	1.74	77.93	157.68
Campania	40.04	40.9	18	14.45	113.39
Puglia	53.75	1.7	11.98	50.28	117.71
Basilicata	139.27	12.45	3.42	16.66	171.8
Calabria	n.a.	n.a.	n.a.	n.a.	n.a.
Sicilia	35.66	17.72	30.2	54.2	137.78
Sardegna	53.46	8.24	6.14	31.16	99
Total	**88.66**	**22.21**	**13.92**	**252.85**	**342.44**

Source: Age.na.s. (2009).

Data indicating the concentration of home social services are not available. The only information that can be used as a proxy is the average expenditure per client, which is estimated at €1,728 (NNA, 2009).

Private home care is increasingly important in the Italian LTC system, although there are no official data on this aspect. According to the little data available, 6.6% of those aged over 65 (NNA, 2009) received home care privately. Private home care is provided mainly by migrant workers on individual basis: in 2008 it was estimated that around 700,000 migrant workers were employed to provide home care to elderly persons (NNA, 2009).

Cash benefits

The cash benefits provided by the INPS are an important part of the LTC system in Italy. According to the latest available data, 9.5% of persons aged 65 and older received cash benefits in 2008. This percentage rose from 2.1% of persons aged 65-69 to 5.3% of those aged 70-79, and up to 23.8% of those aged 80 and older (Table 12).

Table 12. National cash benefits

Year	Number of INPS cash benefit beneficiaries (000)	% of persons aged 65+	Age group (%)		
			65-69	70-79	80+
2001	577.4	5.5	1.4	3.1	16.1
2002	639.3	6.0	1.5	3.5	16.8
2003	708.6	6.5	1.6	3.8	17.7
2004	796.0	7.2	1.7	4.1	19.1
2005	880.6	7.7	1.8	4.4	20.4
2006	971.3	8.4	1.9	4.8	21.8
2007	1,051.9	8.9	2.0	5.1	22.8
2008	1,131.7	9.5	2.1	5.3	23.8

Sources: NNA (2009); on population, ISTAT (http://demo.istat.it/); on cash benefits up to year 2004, INPS database (http://servizi.inps.it/banchedatistatistiche/vig9/index.jsp).

Cash benefits funded by the local authorities – mainly municipalities, but also provinces and regions – differ greatly among Italian regions. Table 13 shows the percentages of the population aged 65 and older receiving cash benefits from local authorities (along with the average monthly amount) – which range from 3.5% of the population in the Bolzano Province to zero in some southern regions.

Table 13. Cash benefits funded and provided at the regional and local levels

Region	Year of establishment	% population 65+ receiving cash benefits	Avg. gross monthly amount €
Provincia di Bolzano	2007	3.5	515
Veneto	2007	2.2	200
Emilia-Romagna	2006	1.9	246
Liguria	2008	1.6	330
Friuli-Venezia Giulia	2007	1	375
Lombardia	2006	0.9	–
Provincia di Trento	2006	0.6	345
Umbria	2005	0.4	418
Toscana	2006	0.3	–
Piemonte	2006	0.2	–
Abruzzo, Calabria, Sicilia	2003 (Sicilia & Calabria) and 2006 (Abruzzo)	<0.3	–
Puglia, Sardegna	2007 (Puglia) 2008 (Sardegna), data n.a.	–	–

Source: NNA (2009).

4. LTC policy

4.1 Policy goals

Various governmental dispositions regulate the LTC system in Italy. The first parliament act related to elderly persons in this respect wasthe Finance Law No. 67/1988, which scheduled the creation of 140,000 beds for dependent persons.The DPCM of 22 December 1989 set out the rules for nursing and residential care facilities (*residenze sanitarie assistenziali*). The Objective Project “Healthcare for older people”, approved in the National Health Plan 1992–94, was the first reference tointervention for those aged 65 and older byregional and local governments, designing the local network of services and giving a key role to evaluation units (within ASLs) for needs assessment.

A framework national law was enacted in November 2000 (Law No. 328/2000), which had a number of objectives. It declared that its overall aim was to establish a minimum level of social care services to be provided throughout the country. The actual tools (financial and normative) provided to pursue this goal were nonetheless weak.

The most recent provisions are included in the National Health Plan 2006–08, which identified strengthening home care as a first priority as opposed to institutional care. This plan also points to reinforcing cooperation between institutions and formal and informal groups in order to improve care. The previous National Health Plan (2003–05) mentioned “cash and care” approaches, implying the transfer of money to families for purchasing health and social services by qualified providers, with a view to supporting home care. The same document addressed two other important targets: i) reorganizing the service net to foster integration between health and social services; and ii) creating a specific financing mechanism for LTC.The latter was subsequently established by the Finance Law for 2007 (Law No. 296/2006), which assigneda

symbolic amount of resources to be shared among regions and autonomous provinces, according to the number of elderly dependent persons and some socio–economic indicators.

4.2 Integration policy

The entire sector is characterized by strong regionalization and a municipal orientation (mainly in the service planning and management stages), which results in significant differences among areas, in terms of the resources invested in the system, access to services, selective criteria for the service beneficiaries, types of services available, etc. In particular, there are substantial differences among the regions (19 regions and 2 autonomous provinces) in the following aspects of the system:

- the choice of whether to merge the health and social care components of LTC, in terms of establishing a unique department and planning path at the regional level;
- the strategic decisions on the features of the service net (cash transfers vs.strengthening home or residential services, vouchers,a greater presence of public vs. accredited private providers, etc.);
- the implementation of an ad hoc regional fund for LTC and the rules adopted to finance and manage it;
- the tools adopted to plan, coordinate and manage care, i.e.the presence (or not) of a unique access point; the evaluation unit set-up and location; the presence (or not) of the needs-assessment tools and their different criteria; the presence (or not) of means testing;
- the different residential, semi-residential or home service arrangements. For example, an analysis of residential services reveals considerable differences in
  - coverage targets (e.g. beds per person for those aged over 65);
  - the categories of beneficiaries included, i.e. the elderly (also those with dementia), disabled persons, those in vegetative states and AIDS patients;
  - how the accrediting system is managed in terms of the structural and organizational standards required to obtain authorization or accreditation; and
  - the financing systems adopted, i.e.the sourceof resources, covered and not covered expenditures, paymentprocedures, and percentage of health and social coverage.

4.3 Recent reforms and the current policy debate

Since the mid-1990s there has been a debate about national reform of the LTC system in Italy – with various proposals being advanced onthe contents, interventions and funding modalities. Yet so far, national reform ofthe LTC system has not been implemented.

A potentially important, recent change is the establishment of a new ring-fenced fund for LTC services that was approved by the Finance Law for 2007 – which set aside a symbolic amount of €100 million for 2007 and €200 million for each of the following two years. The Finance Law for 2008 increased these funds with an additional €100 million for 2008 and €200 million for 2009. These LTC funds aimed, in the long run, at guaranteeing the implementation of essential levels of care to dependent persons across the entire country. The move was seen as a way to provide Italian regions with an incentive to augment the resources made available for LTC, establishing regional LTC funds. Additionally, the former central government had agreed on a framework law with the goal of reforming LTC and social policies for families, but this was not passed by the parliament due to the change of national government. Although the amount of resources allocated tothe LTC fund was small, this was the first attempt to explicitly allocate

resources to LTC from the national level, which might serve as leverage to reduce the fragmentation of responsibilities and funding. Indeed, following the establishment of the national LTC fund, some regional LTC funds have been established. The current government confirmed the national LTC fund, following an agreement with the regions (Agreement for the New Health Pact 2010–12, signed on 10 October 2009), but it has only made available resources for 2010 (€400 million).

The very recent, important reform introducing fiscal federalism (the Delegation Law No. 42/2009 approved in May 2009) suppresses all financial transfers from the centre to the decentralized governments, but requires the integral funding of essential functions (health care, social care and education) in every region. This should be guaranteed through financial equalization, with a view to ensuring essential levels of service – i.e. the national standard – set by national law. Because the essential levels of service for LTC have not yet been set – probably because of a lack of resources to fund them – it is not clear what will happen. Indeed, the implementation of fiscal federalism might further increase the institutional fragmentation of LTC, exacerbating the already wide differences across regions and municipalities.

4.4 Critical appraisal of the LTC system

In Italy the LTC system is still underdeveloped with significant variation among regions.It is characterized by a high degree of fragmentation among institutions as well as sources of funding and governance, with management responsibilities spread over local (municipalities) and regional authorities, according to different modalities in relation to the institutional models of each region.

The Italian LTC system presents a number of unresolved issues.

The first concerns the residual role played by social care services compared with the rest of social security and health interventions. The Italian welfare system has always preferred cash benefits. For example, in 2008, the €386 million spent by the general government went into three macro areas of the system (Ministero dell'Economia e delle Finanze, 2009):

- 66% on social security (pensions and other cash contributions),
- 26% on health expenditure (services), and
- 8% on care expenses (services and financial contributions).

The secondissue pertains to social rights (juridical) weaknesses. As opposed to health policies, social policies cannot appeal to rights guaranteed by constitutional or other kinds of laws. Policies for the elderly have always been vague and solely focused on someimportant but not essential aspects (for example the structural requirements for nursing and residential care facilities). Law No. 238/2000 focused on the institutional aspects of local policies, instead of defining the essential levels of care (a basic benefit package). The 2007 proposal for a delegation law also failed. The outcome of Delegation Law No. 42/2009 on fiscal federalism is uncertain and the essential levels of service that should be funded have not yet been set. Finally, a third issue is that the supply side of care remains fragmented at the local level.

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About ISAE – Istituto di Studi e Analisi Economica

The Institute for Studies and Economic Analysis (Istituto di Studi e Analisi Economica, ISAE) is a public research institute that conducts analyses, research projects and forecasts suited to economic and social policy decisions. ISAE carries out business and consumer surveys, provides quarterly and annual macroeconomic forecasts, supplies studies on economic structure, public finance and welfare, examines the economic policies attained through the public budget and through regulation, and analyses the complex dynamics of sustainable development in its environmental, economic and social aspects.

Under the 6thResearch Framework Programme financed by the European Commission, ISAE has participated in three projects: AHEAD (Ageing, Health Status and Determinants of Health Expenditure), in which ISAE specifically studied in-depth the question of health costs prior to death; AIM (Adequacy and Sustainability of Old-Age Income Maintenance); and EU KLEMS (Productivity in the European Union: A Comparative Industry Approach).

The latest publications of ISAE (relevant to the project) are the following:

"Sistemi sanitari e invecchiamento nell'Unione Europea" [Health systems and ageing in the EU] in F. Kostoris Padoa-Schioppa (ed.), *Rapporto sullo stato dell'UE*, ISAE, Rome, 2002.

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ANCIEN

Assessing Needs of Care in European Nations

FP7 HEALTH-2007-3.2-2

Launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

1) How will need, demand, supply and use of LTC develop?

2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (http://www.ancien-longtermcare.eu).