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Assessing Needs of Care in European Nations

QUALITY ASSURANCE POLICIES AND INDICATORS FOR LONG-TERM CARE IN THE EUROPEAN UNION

COUNTRY REPORT: ITALY

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Abstract

In Italy, regions are at the centre of the system providing long-term care services, which typically include residential services, formal home care and monetary benefits. The regions define their own policies for the provision of care, ranging from needs assessment and monitoring tools to the accreditation of service providers. Quality assurance policies are primarily directed at residential services and formal home care, but as this research report highlights, there are many differences across regions.



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Quality Assurance Policies and Indicators for Long-Term Care in the European Union

Country Report: Italy

ENEPRI Research Report No. 102/February 2012

Georgia Casanova*

1. Introduction

In Italy the governance of services for long-term care (LTC) is a complex issue. There are too many institutional actors with a high degree of territorial fragmentation and no centralised, powerful policy-maker. Since Italy is a regional system, the central government has been deprived of most strategic decisions. The regions are the centre of the system and define their own policies and instruments. Residential services, home care and monetary benefits are the typical Italian services for long-term care. The quality assurance policies are primarily directed at residential services and formal home care, but there are many differences across regions.

2. Organisation of LTC quality assurance

The reform of Title V of the Italian Constitution has increased the legislative power of the regions concerning health and social care policies. Social care and health care in Italy are regional responsibilities. The stakeholders involved are the central government, regional governments, local health authorities, municipalities and provinces.

Central government. In 2010 the central government structure was reorganised by establishing the ministry of health as the central organ of the health service. The reform of the Italian Constitution reserves exclusively to the state the determination of those benefits related to civil and social rights that must be guaranteed throughout the country. As regards the social and health care system, the state, for several years, was responsible for the organisation and management of services. Since the reform, it has assumed the role of overseeing implementation of the right to health care and other services associated with addressing the needs of individuals and families, and preventing and alleviating conditions of distress. This role results in producing recommendations on standards that aim at promoting and developing interventions, policies and monitoring instruments for managing quality assurance in the regions.

Regions. Regional administrations are the real core of the system. In general, the regions transpose national recommendations into regional laws. In the context of social and health care, the regions define the following aspects for their quality assurance systems:

- their own standards of health care (Livelli Essenziali di Assistenza, LEA) and social care (LIVEAS);
- the kinds of multidimensional assessment tools used to evaluate the health status and needs of elderly persons;
- monitoring tools (regional information systems, observatories, etc.);
- rules for the authorisation and accreditation of services and professionals; and
- recommendations for or the imposition of external quality-accreditation systems.

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National Agency for Regional Health Services (AGENAS). This public entity acts as a liaison and decision-support organisation for the ministry of health and the regions on the development strategies of the national health system.

The main objective of the Agency is to monitor the provision of services and compliance with the standard levels of care (LEA). In addition, the Agency promotes and conducts studies on methods to assess and monitor quality in its various dimensions. In this sense it can be considered an interregional organisation primarily concerned with the quality of health and social care. The Agency carries out the following activities:

- evaluations of the provision of standard levels of care (LEA);
- cost analyses of services;
- proposals for the organisation of health services;
- studies on service innovation, quality and cost containment;
- the promotion of patient safety; and
- the monitoring of service waiting times.

National Commission for the definition and updating of services guaranteed to all citizens. The Commission has the task of defining the criteria to update the list of standards for services.

Committee for the verification of the provision of services guaranteed to all citizens. This Committee has the task of monitoring the provision of services according to standard levels of care (LEA). The criteria used are appropriateness and efficiency in the use of resources, as well as the adequacy between the services to be delivered and the resources made available by the national health system.

The Committee involves the following main institutional stakeholders: the ministry of health, the ministry of economy and finance, and representatives of the regions designated by the Conference of Presidents of Regions and Autonomous Provinces. The Committee relies on the support of the National Agency and uses information from a specific monitoring system and the New Health Information System (NSIS).

Local health authorities (LHAs). The LHAs are territorial entities that directly or indirectly provide health and social care services to citizens. The LHAs are the main actors implementing regional strategies in health and social care. The LHAs are organised into territorial districts. Each district has an organisational unit devoted to the multidimensional assessment of the health status and needs of elderly persons. This multidimensional assessment unit (MAU) has the role of assessing the health of citizens seeking health and social services and identifying the appropriate services (home care, residential care, etc.) and providers. The MAUs are multi-professional units that involve different specialties and roles, such as general practitioners, geriatricians, psychologists and social workers. In some districts, MAUs periodically assess the health status of the elderly to verify the quality of providers' services. The LHAs may also become a source of data for regional information systems or develop their own information systems.

National Institute of Social Security (Istituto Nazionale per la Previdenza Sociale, INPS). This institution provides cash benefits for disabled persons (*indennità di accompagnamento*) at the national level. Even if the rationale for this benefit is for families to use it to buy health and social services on the market, there is no control over the actual use of it. INPS also provides information flows on these benefits to the ministry of health and other institutions.

Nursing homes (Residenze Sanitarie Assistenziali, RSAs). These facilities are involved in the quality assurance system in order to obtain institutional accreditation and thus reimbursement by the national health system. Yet they can become promoters of quality assurance by requesting and obtaining international quality certifications (e.g. ISO and Joint Commission International).

Municipalities. As the main institutions responsible for social care, municipalities can participate in monitoring the application of specific quality mechanisms promoted by the regional administration. They provide personal and social care services to the elderly, either directly or by appointing private providers.

Provinces. These territorial authorities are organisationally above municipalities. In some cases, because of their highly targeted training skills and employment policies, they provide training and develop accreditation programmes tailored to social care professionals.

3. Quality assurance policies

3.1 Standard levels of care

After the reform of the Italian Constitution, the identification of national levels of care is one of the main goals left to the national government. Since Italy is governed by a regional system, a centralised process for identifying uniform health and social care services is needed. Regions need to provide these services to their citizens but they can choose to add further services. National standards of care may refer to health care (LEA) or social care (LIVEAS).

- **LEA, standard levels of health care and mixed social and health care.** The central government is responsible for setting the ‘essential levels of care’, that is a set of services that must be guaranteed uniformly across regions. An agreement between the state and regions in 2001 precisely defined LEA standards through a positive list (services to be guaranteed), a negative list (services not guaranteed) and services partially covered by the national health system (according to precise clinical conditions). Regions may add further services funded by local taxation. LEA standards include preventative, community and hospital services. Among the community services are LTC services for the elderly, such as home care, home nursing care and residential care. A monitoring committee is responsible for monitoring the regions’ compliance with LEA standards, along with the appropriateness of services and efficiency in resource utilisation. In the last decade, most regions have included additional services (such as rehabilitation and dental health) that were not included in the LEA. LEA standards represent a way to guarantee equity of access to the same levels of service even in a regional system like Italy’s. Also, LEA standards are intended to be a fundamental instrument for controlling expenditures of the national health system, even if this second goal is not fully achieved.
- **LIVEAS.** As a concept, these standard levels of social care were introduced in 2000 by the Social Care Act (Law 328/2000). Among the standards that regions and municipalities need to implement are “interventions in favor of the elderly and the disabled in support of their permanence at home, their socialization, and their access to residential and semi-residential structures”. But a national law expressly defining the LIVEAS to be adopted by regions is still lacking. After more than a decade since their conception, LIVEAS standards, unlike LEA standards, have not been defined or implemented.

3.2 Information systems

One of the key elements for quality management in LTC is the availability of detailed and updated information on various aspects of the problem. The need to standardise the data is a very sensitive issue: between 2003 and 2005, the Commission on Statistical Information¹ sponsored an ad hoc survey entitled “The statistical information for the elderly”. The survey highlights that in Italy data on elderly care are often collected and aggregated using different methods. The possibility to use the data effectively in cross-sectional and longitudinal studies is reduced. Today there is a tentative effort to integrate these data into a single Information System for LTC (SINA), the first real experience of a systematised and coordinated collection of data for long-term care at the regional and national levels.

Still, SINA is not the only experience relevant to the development of statistical information concerning LTC. The New Health Information System is a national system with a module for the standardisation of data collection on residential and home care.

Following the law on the reform of social services (Law 328/2000), there has been a clear trend in Italy towards the production of statistical data at the local level (especially regional). Nationally, there have been no particularly significant initiatives for the systematisation of information on social services; the only exception is the census by the National Institute of Statistics (ISTAT) on municipal social services, published in the years 2003, 2005 and 2007–08. This survey has collected some data on the elderly and home care.

SINA started on an experimental basis in 2009 and was coordinated by a committee composed of representatives of major institutional stakeholders. It has sought to define a minimum set of data to collect at the regional level. This set was defined from evaluation forms used in each region. SINA is relevant to the national system for quality management for several reasons:

- it is a quantitative monitoring tool specifically addressing long-term care;
- its implementation requires the involvement of various levels of administration; and
- the contents of the survey were defined by a bottom-up process.

The project has developed a patient record that the regions participating in the project have started to complete since 2010. The patient record takes into account a minimum dataset related to three dimensions of LTC:

- health status (the need for health care),
- functional structure (autonomy), and
- social structure (formal and informal support through the classification of services already adopted in the regions).

The system is expected to feed national and regional strategic plans to improve the quality of LTC in the near future.

¹ The Commission for the Guarantee of Statistical Information is an independent collegiate body called upon to ensure the fairness, completeness and quality of statistical methodology, with particular reference to the National Institute of Statistics.

3.3 Authorisation and accreditation

Authorisation and accreditation are the main systems through which the quality of the service is guaranteed in formal care. Authorisation refers to the formal verification by a public body that a provider meets the standards to operate in the market. Accreditation refers to the possibility for that provider to operate as a node of the national health system. If a provider is accredited it can obtain reimbursement from the national health system for its services. In some cases, the accreditation is extended to include care pathways, such as home care assistance, in response to complex social and health needs.

The accreditation reflects the necessity of evaluating the response to a need for care and its standardisation, with the aim of overseeing and improving the quality of the response. In this sense it can be considered the main instrument for quality assurance in Italy. The accreditation procedures in Italy are particularly popular for residential care and are implemented in accordance with rules established at the regional level as well as with general criteria established by the state.

Accreditation and authorisation may refer to both health and social care. As for health care there are four stages:

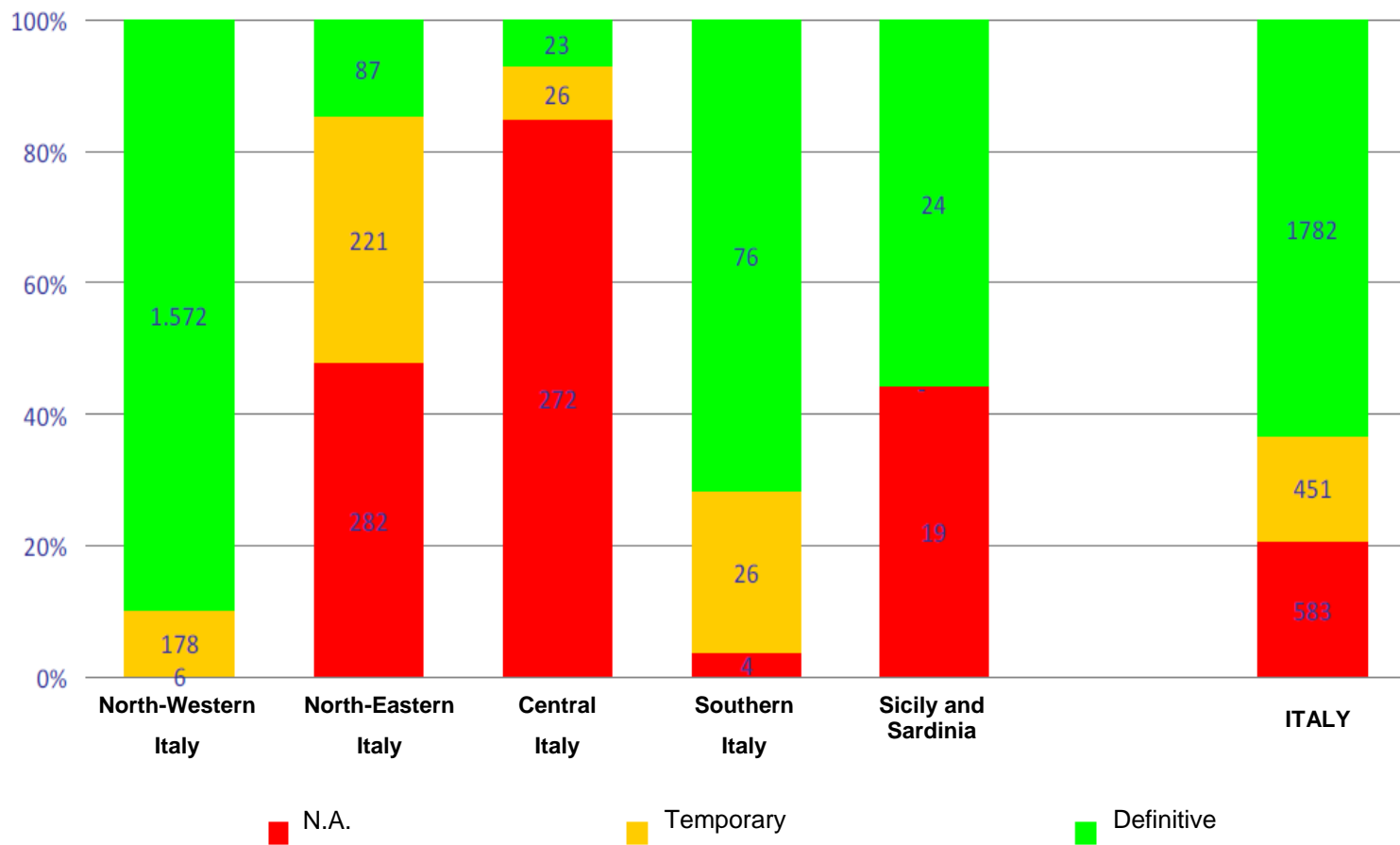
- 1) authorisation for the facility,
- 2) authorisation for the provision of services,
- 3) institutional accreditation, and
- 4) contractual agreement.

Accreditation in social care is a recent procedure (since Law n. 328, 2000) if compared with accreditation in health care, which started in 1992 (D.lgs. 501 n. 502). Regions have the power to authorise and accredit providers in social and health care. Some regions have uniformly governed the procedures for the accreditation of health and social care, while others have chosen to separate the two areas, specifying different procedures for the health sector and the social one.

As regards social facilities, the main reference is Law 328/2000, which identifies a system of licensing and accreditation for all residential and semi-residential services, whether these are managed by public, private or non-profit organisations (such as cooperatives, voluntary organisations, associations and institutions of social welfare, foundations and charities) or other private entities.

In 2010, AGENAS counted 2,816 private residential institutions for the elderly in Italy (AGENAS, 2010). Approximately 63% of them have attained definitive accreditation (having provided evidence of meeting the minimum standards and passed an inspection). The rest of the residential institutions have either received temporary accreditation (without the inspection) or there is no evidence of what step in the accreditation process they have reached. Figure 1 shows the stages of accreditation by geographical area in Italy in 2010: definitive, temporary or 'not available'.

Figure 1. Status of accreditation of private, formal facilities for institutional care in Italy



Source: AGENAS (2010).

3.4 Accreditation of social care pathways

To meet a growing need for the care and assistance of frail or disabled persons, at the regional level policies are being developed for the establishment of ‘care networks’ and the training of caregivers. Social workers and families in some regions are being trained professionally in social care. These interventions are particularly interesting because they represent a shift from a system of accreditation typically focused on organisational structures to an accreditation system focused on care pathways.

These training courses, which are run by local authorities, training agencies, trade unions, associations, private social-welfare organisations (albeit with a different content) are designed to improve the quality of care. The topics may include

- Italian language and Italian law courses for immigrant social workers; and
- courses on personal care, nursing care and psychological care.

Since 2007, formal home-care service providers in the Emilia-Romagna region have been expected to provide assistance through tutoring, consulting, assisting, integrating and substituting informal caregivers. The tutoring activity, performed by properly trained staff of the network, is both a mechanism of support to the family and a check on compliance with the care plan. Likewise in the Lombardia region, the provision of training and information to immigrant social workers (*badanti*), informal caregivers and patients is highly recommended (*circolare del 27.12.2007, “Indicazioni per i piani di formazione del personale dei servizi sociali e sociosanitari, anno 2008”*). In Sicily, a recent regional decree (DGR 885/2010) recommends the development of training courses for social workers and assistance to informal caregivers. Box 1 presents an example of the accreditation of home care services in Sassari.

Box 1. Accreditation of home care – Example of the city of Sassari

The city of Sassari has an accreditation process that entails three phases.

1) Verification of minimum requirements

The minimum requirements consider the structure in relation to the standards, along with industry expertise and financial viability.

2) Provisional accreditation

The provisional accreditation requirements concern

- organisational skills, i.e. professional qualifications, case-management capacity, human resource management (staff turnover) and the ability to stimulate a response (time standard);
- structural requirements, i.e. access, availability, time and resources available for the service; and
- quality assurance requirements, i.e. the training of workers and managing the relationship with clients (statements about service levels, a claims-management system and client satisfaction).

3) Final accreditation

By special invitation, the requirements of the previous stage are re-evaluated.

3.5 Evaluation tools: Multidimensional evaluation forms

A fundamental component of the Italian quality assurance system is the assessment of needs through standardised tools. A disabled person to be assisted through the formal care system is subject to an assessment of his/her condition of self-sufficiency, conducted by a Multidimensional Assessment Unit with a standardised, multidimensional assessment form.

The composition, organisation and procedures of the MAU are established by regional standards. The region also defines the contents of the multidisciplinary evaluation. Table 1 presents the main standards used in Italy for the multidimensional assessment.

Table 1. Multidimensional assessment standards in Italian regions

Region	Multidimensional assessment method
Abruzzo	RUG
Basilicata	RUG
Calabria	RUG
Campania	SVAMA
Emilia-Romagna	BINA
Friuli Venezia Giulia	RUG-VALGRAF
Lazio	RUG
Liguria	AGED
Lombardia	SOSIA
Marche	RUG
Molise	SVAMA
Piemonte	Form still experimental
Puglia	SVAMA
Sardegna	na
Sicilia	na
Toscana	MDS-BADL (mix of RUG and SVAMA)
Umbria	RUG
Valle D'Aosta	SVAMA
Veneto	SVAMA
Province Bolzano	na
Province Trento	SVAMA

Source: Masera et al. (2011).

In general, the multidimensional assessment is a process and not just a dynamic and interdisciplinary instrument. As such, it is more than a tool developed to identify and describe (or predict) the nature and extent of health problems, including the physical, psychological and functional characterisation of a disabled person and his/her resources and potential. The global diagnostic approach, through the use of validated instruments and scales, can identify an action plan for social and health care interventions tailored to the individual.

Over the last decade in Italy, the multidimensional assessment has been subject to active debate, which has seen the testing of assorted evaluation forms associated with various approaches and

models to analyse the abilities of elderly and disabled persons. Different evaluation forms have been tested across the country.

Nowadays, among the diverse methods for assessing the health status of the elderly, the Multidimensional Assessment Form of the Elderly Person (SVAMA) has gained momentum, having been adopted by six regions. Indeed, integrated with other forms, it has become a multidimensional assessment of reference for SINA.

As shown in Table 1, the most diffused standards are the SVAMA and RUG (Resource Utilisation Group). RUG is a method that crosses the assessment of an individual's ability to perform activities of daily living (ADLs) with an estimate of the efforts required by the care provider. If a common standard across regions had been available, it would have been possible to integrate health status data, which could have been used for LTC quality assurance at the national level.

4. LTC quality indicators

4.1 Types of quality indicators at the national and local levels

A quality assurance system that is as scattered and diverse as that just described for Italy is consistently lacking in many national-level quality indicators. The available indicators are based on the monitoring tools existing today. As already argued in previous sections, the information systems on long-term care in Italy are characterised by heterogeneity across regions and sometimes within regions.

The different distribution of local expertise has contributed greatly to determining territorial specificities that some projects and monitoring tools at the national level have nonetheless made more homogeneous. We are referring particularly to the New Health Information System and to SINA. We use these sources for our study.

The starting point of the examination is the example of multidimensional assessment. Thanks to the efforts that have homogenised the different national projects mentioned above, data collection has now reached a good level of internal consistency and comparability.

Quality indicators are mainly based on two dimensions:

- the organisation of services (type of service, performance, number of services provided and professionals involved); and
- the use of services (coverage by type of service requested, number of hours of service delivery per case and waiting times).

Needs are also assessed in order to understand the degree of appropriateness of services, notably the lack of self-sufficiency/degree of autonomy, existence of a social network and financial resources.

It should be noted that recently, especially with regard to ADLs, indicators of the need for care that can function as indicators of quality have been set. Specifically, we refer to the repetition of the multidimensional assessment of an individual patient (the annual appraisal) and the need of the family caregiver for training/accompaniment.

4.2 Selected quality indicators

Using the information discussed in the previous section, we look at a selection of some of the most widely used indicators of quality in home care in Italy and residential services. Box 2 presents the national minimum requirements for nursing homes (the RSAs).

Box 2. Minimum requirements for the authorisation of nursing homes

Nursing homes in Italy, the RSAs, are residential structures providing social and health care services to disabled and elderly persons who could not be easily assisted through home care. Nursing homes must comply with some minimum requirements to obtain authorisation to operate.

Beds. The nursing home needs to have between 20 and 120 beds, organised in modules of 10 to 20 beds (according to the intensity of care required). Among every 4 modules, 1 module should be dedicated to individuals suffering from dementia.

Rooms. There must be 1-, 2-, 3- and 4-bed rooms where privacy and access to a fully equipped bathroom is guaranteed.

Services in each module (every 10-20 beds). Services in each module are to include a living room/social space, kitchen, dining room, service room with a bathroom, a bathroom equipped for disabled persons, closets, and areas for rubbish, tools and consumables, respectively.

Space for therapies. This includes an ambulatory care room, a rehabilitation room (fully equipped) and a gym.

Space for socialisation. Space in this regard refers to that for religious services, a bar (or vending machines), living rooms, a barbershop, rooms for occupational health, a green area and bathrooms.

Support service areas include an entrance, spaces for reception, mail, telephone and administrative offices, kitchen and accessory rooms, laundry, repository, rooms for the staff and a mortuary chapel.

Size. Concerning size, the requirements specify the following:

- a) the total surface of the nursing home should be 40/45 m² per guest;
- b) the living space should be 28 m² per person, 38 m² per two persons and 52 m² per three persons; and
- c) rooms should be 12 m² per person, 18 m² per two persons and 26 m² per three persons.

Temperature. In rooms the temperature should be no less than 20° C in winter and no more than 28° in summer.

Technology. The ambulatory room should be equipped with devices and drugs for emergencies. Devices and materials for occupational health, mental and physical rehabilitation, socialisation and the ambulation of disabled persons must be present.

Organisation. The organisation of services must guarantee the dignity, freedom, privacy, religious practices, social relations, personalisation and social inclusion of the client, along with qualified staff and access and inclusion of the client's family and friends.

Services. Depending on the intensity of care, service requirements cover general medical care and specialties, pharmaceuticals, nursing care, rehabilitation, consulting services, dietary services, personal care, preventative services, occupational health care, transportation, religious services, etc.

Medical direction. Requirements here relate to the involvement of a doctor or a professional nurse.

Staff. These requirements concern staff cover nurses, rehabilitation therapists, occupational therapists, educators, social care workers, psychologists and dieticians. Depending on the type of nursing home (intensive care or not) different quantities of staff per category are required.

Regions add other types of indicators to the minimum requirements. Table 2, while not exhaustive, includes the most important indicators used across regions.

Table 2. Set of quality indicators in Italian regions

	Indicator	Definition
Home care (ADLs)	Coverage	Number of services/population 65+; percentage
	No. hours/patients	Number of hours dedicated to each patient; absolute value
	No. hours/patients/ professional roles	Number of hours dedicated to each patient for each professional role (physician, nurse, rehabilitation, etc.); absolute value
Residential care	Beds	Number of available beds; absolute value
	Waiting list	Number of waiting days elapsed between the request and admission; absolute value
	Daily professional coverage	Number of hours of health personnel

Source: Author's compilation.

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- Decreto del Presidente del Consiglio dei Ministri 30 marzo 2001 recante: *Atto di indirizzo e coordinamento sui sistemi di affidamento dei servizi alla persona*.
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- Decreto del Presidente della Repubblica 3 maggio 2001, *Piano nazionale degli interventi e dei servizi sociali 2001-2003.*
- Decreto del Presidente della Repubblica 14 gennaio 1997, *Approvazione dell'atto di indirizzo e coordinamento alle regioni e alle province autonome di Trento e di Bolzano, in materia di requisiti strutturali, tecnologici ed organizzativi minimi per l'esercizio delle attività sanitarie da parte delle strutture pubbliche e private.*
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- Decreto Legislativo 12 aprile 2006, n. 163, *Codice dei contratti pubblici relativi a lavori, servizi e forniture in attuazione delle direttive 2004/17/CE e 2004/18/CE.*
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- Direttiva 2004/18/CE del Parlamento europeo e del Consiglio, del 31 marzo 2004, *relativa al coordinamento delle procedure di aggiudicazione degli appalti pubblici di lavori, di forniture e di servizi.*
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- Legge 8 novembre 2000, n. 328, *Legge quadro per la realizzazione del sistema integrato di interventi e servizi sociali.*
- Legge 8 novembre 1991, n. 381, *Disciplina delle cooperative sociali.*
- Legge 7 agosto 1990, n. 241, *Nuove norme in materia di procedimento amministrativo e di diritto di accesso ai documenti amministrativi.*
- Legge 23 dicembre 1978, n. 833, *Istituzione del servizio sanitario nazionale.*

About LUISS Guido Carli

LUISS Guido Carli is a university based in Rome and focusing on three social sciences: Economics, Political Science and Law. It has a well known academic faculty, with prestigious professors and highly qualified experts, able to give an added value to different kind of training activities (including post-graduate courses, masters and PhDs) and research activities. The school is characterised by the presence of several research centres: Research Centre for Business Law, Research Centre on International and European Institutions, Public Administration Research Centre “Vittorio Bachelet”, Experimental Economics Centre and Planning Observatory for the World Economy, Industrial and Financial Research Group, Monetary Economics Observatory and Research Centre, Centre of Applied Research for Corporate Management, Centre of Social Science Methodology, Centre for Research and Studies on Human Rights and the Strategic Studies Centre. LUISS Guido Carli is based on a multi-area structure and cooperates with more than 100 European and non-European universities, elaborating international research projects and organising meetings, debates, workshops on a range of topics.

In particular **LUISS Business School**, a division of LUISS Guido Carli University, operates in research and in graduate training for Young Adults, General Managers, Public Administrators and Health Administrators in various fields such as management, finance, marketing, accounting, HRD, macroeconomics, quality systems, international law, civil law, fiscal law, competition law, facility management, clinical governance, environment, insurance, tourism, labour market, industrial relationships. The Healthcare and Public Management Area of LUISS Business School performs both research and training activities in the field on health administration, with particular focus on clinical governance, risk management, health information systems.

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, epidemiological 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.

Work Packages. 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 back 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.

Principal and Partner Institutes

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. Other partners include: German Institute for Economic Research (DIW); Netherlands Interdisciplinary Demographic Institute (NIDI); Fundación de Estudios de Economía Aplicada (FEDEA); Consiglio Nazionale delle Ricerche (CNR); Università Luiss Guido Carli-Luiss Business School (LUISS-LBS); Institute for Advanced Studies (IHS); London School of Economics and Political Science- Personal Social Services Research Unit (PSSRU); Istituto di Studi e Analisi Economica (ISAE); Center for Social and Economic Research (CASE); Institute for Economic Research (IER); Social Research Institute (TARKI); The Research Institute of the Finnish Economy (ETLA); Université de Paris-Dauphine-Laboratoire d'Economie et de Gestion des organisations de Santé (DAUPHINE- LEGOS); University of Stockholm, Department of Economics; Karolinska Institute-Department of Medicine, Clinical Epidemiology Unit ; Institute of Economic Research, Slovak Academy of Sciences (SAS-BIER); Center for Policy studies (PRAXIS). Most of the ANCIEN partners are members of the European Network of Economic Policy Research Institutes (ENEPRI).