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COUNTRY REPORT

Italy: emerging policy developments in the long-term care sector

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1 Introduction

This report provides an overview of recent evidence emerging in terms of interventions and policy measures in the four main areas of interest investigated by the Network in the Italian context.

The first of these areas is the subject of the section, authored by Carlos Chiatti, focused on cost-effective measures aimed at reducing dependency. This discusses a series of policy documents and initiatives based on a preventative approach, targeting those factors which are more likely to have a positive impact on dependency levels in the Italian population, and providing an institutional framework for developing appropriate interventions at local level. After an analysis of the barriers preventing the implementation of such policy measures in the Italian context, this section briefly outlines some examples of innovative efforts in this area.

The second section, by Giovanni Lamura, describes interventions and policy measures to support unpaid carers, starting with an overall illustration of the Italian context, in which means family care still provides the bulk of long-term care (LTC). Following a depiction of the main support available for family carers in the country, the crucial role of privately employed – mainly migrant – care workers in household-based care is also analysed, as it represents another strategic pillar of the Italian “way” to provide LTC. The overview of recent policy developments in this area includes a description of initiatives at national and regional levels, with a focus on two specific measures: the vouchers used as a payment tool for private care work; and the recent trend to promote corporate welfare programmes to support family carers.

The third contribution, Francesco Barbabella’s section on innovative care models and technologies to improve outcomes for people with LTC needs, starts by discussing the technological components of innovation. This includes a description of the characteristics of Italy’s main policies adopted at national level in this field, with a focus, on the one hand, on the framework developed to improve the healthcare information system and, on other hand, on the guidelines proposed to develop the main forms of telecare services. This chapter ends with an overview of policies concerning organisational innovation, and a brief evaluation of the impact of such policies.

The final section, authored by Georgia Casanova, describes the main strategies and examples of practices adopted in Italy to maximise coordination and integration in care provision. It begins with some introductory remarks concerning the concepts of integration and coordination, moving on to analyse how they are implemented in the Italian context in terms of governance and institutional approaches. This investigation examines the potential room for innovation in this regard, addressing how coordination issues are tackled within the formal provision of care services, but also in terms of relationship between formal (public/private) and informal care. Finally, some examples of innovative practices and policies in this field are provided, against the background of the evidence emerging from two major initiatives.

2 Interventions and policy measures to reduce dependency cost-effectively

Carlos Chiatti

2.1 Recent policy documents at national level

The literature suggests that the most cost-effective measures for addressing dependency are those based on a preventative approach. Several studies show that measures targeting factors such as lower extremity functional training, sedentary lifestyle and environmental hazards, frequency and quality of social contacts, and diet, have the potential to reduce dependency in a cost-effective manner (see Box 1 at the end of this chapter, and related references). The importance of such measures is recognized by the most relevant policy documents in Italy's Health and Social care sectors, which provide an institutional framework for the development of this type of intervention both at municipal and regional level.

2.1.1 The National Health Plans and the Pacts for Health

In the past, the 'National Health Plans' (*Piani Sanitari Nazionali*) used to represent the reference documents for national level strategic planning for health care. The plans usually covered a time-period of three years and outlined the main approach to be considered by the National and Regional Authorities in charge of ensuring health care delivery and health promotion. The themes of disability prevention and reduction of dependency burden have always been directly and indirectly addressed by these documents, but while they provide guidance they do not represent a binding provision for the Regional Care Services.

More recently, the limitations of the National Health Plans have led to their partial replacement by the so-called 'Pacts for Health' (*Patti per la Salute*)

(Ministry of Health, 2014). These are briefer and simpler in their structure, and focus on financial provisions rather than strategy, directly affecting the amount of available funding for health care services at regional level. The most recent Pact for Health, 2014–2016, set the total amount of the National Health Care Fund, but also gave binding indications to the Regions in relation of how the supply of hospital care should be decreased and primary care reformed, through a progressive integration of existing services and the strengthening of the role of General Practitioners (GPs). Disability prevention is among the main strategic objectives of the Pacts, which propose initiatives such as Single Access Points (see paragraph 2.3 below), Comprehensive Assessment of Patients' Needs and Individualized Care Plans for reducing disability burden.

2.1.2 The National Prevention Plans and related Regional Plans

Chronic conditions and disability are extensively addressed by the 'National Prevention Plan' (*Piano Nazionale della Prevenzione*). The latest available Prevention Plan covers the period 2014–2018 (Ministry of Health, 2014b) and stresses several so-called 'macro-objectives', including that of reducing the burden of non-communicable diseases. The strategies (often called 'the programmes') for achieving this objective are then defined autonomously by each Region, which has the duty to create its own 'Regional Prevention Plan'. The regional plans detail the programmes, related interventions, and indicators. The Ministry of Health uses these indicators for monitoring the progress made during duration of the plan. Examples of programmes included in the regional plans are described in Table 1.

Table 1: Examples of programmes for reducing dependency included in Italy's Regional Prevention Plans

	Name and characteristics of the programmes	Indicators used
Sardegna	P-1.2: Healthy Community (Comunità in salute): includes activities aimed at increasing physical activity levels among citizens, including people older than 64. This will be mainly promoted through communication campaigns	• Number of people over 64 who are physically active • Hospitalization rate for hip fracture among people under 75
Friuli Venezia Giulia	Macro-objective 1: Includes a number of activities aimed at increasing self-management skills among citizens, including the development of an app for the monitoring of cardiovascular risks, course for professionals and awareness campaigns	• Number of people over 64 who are physically active • Number of people who have reduced daily salt intake

Source: author, from data retrieved from Ministry of Health (2017)

2.1.3 The National Plan for Chronic Diseases

Recently, the Ministry of Health promoted the realization of a 'National Plan for Chronic Diseases' (*Piano Nazionale Cronicità*) (Ministry of Health 2016), with the aim of harmonizing the interventions at regional and local level in the area of chronic disease management. The document has been approved by all Regions and represents now the main strategic reference for all interventions and policies aimed at improving the quality of life of individuals affected by chronic diseases and their families.

The document is structured in two parts. The first contains general principles for policymaking in the field, while the second contains disease-specific recommendations for the implementation of Care Pathways (the so-called *Percorsi Diagnostici Terapeutici Assistenziali*, or PDTA) for the following diseases/conditions: renal, rheumatic,

gastrointestinal, cardiovascular, neurodegenerative, respiratory and endocrine (see some examples in Table 2 below). For each condition, the plan provides a brief epidemiological overview, a list of major critical issues in the current organization and the definition of the recommended interventions in that particular area, including general and specific objectives, expected results and indicators for monitoring effectiveness and efficiency of the care provided.

The National Plan for Chronic Diseases is the most significant current reference in Italy for the implementation of cost-effective interventions to reduce disease-related dependency, although its primary focus on people with an existing disease limits its application to the context of tertiary prevention.

Table 2: Example of recommendations contained in the National Plan for Chronic Disease

Condition	Intervention(s) recommended	Indicators of quality of care
Heart failure	1. implement integrated care pathways for patients affected by HF 2. promote integration of care between hospital and community care facilities 3. promote collaboration between professionals working in hospital and community-care settings, especially when caring for the most severe cases 4. promote technological innovation, especially at home, using telemedicine and telecare to monitor the clinical condition of the patients and avoid hospitalization	• % patients receiving home care • % patients using telemedicine
Parkinson's disease	1. provide training opportunities for all professionals in primary care settings to promote early diagnosis interventions 2. improve professionals' skills, especially those required to work in a multidisciplinary environment 3. improve the adherence of available care pathways to existing clinical guidelines 4. increase the availability of rehabilitation interventions 5. increase the epidemiological knowledge about the incidence/prevalence of the disease 6. define the characteristics and adequacy of the hospital and out-patient facilities providing care for people with Parkinson's disease 7. improve appropriateness and quality of care, throughout the progression of the disease 8. promote integration of care through new management tools shared by all professionals 9. create facilities for the delivery of complex therapies and interventions (e.g. electrical deep brain stimulation)	• % diagnosed patients within the time period recommended by the clinical guidelines • % patients enrolled in care pathways which provide evidence-based care
COPD	1. create respiratory score risk chart 2. implement training programmes and other communication strategies to raise awareness of the disease 3. increase multidisciplinary integration using care pathways 4. further develop programmes for the empowerment of patients, increasing awareness of professionals and non-professionals on the importance of drug adherence and compliance 5. improve effectiveness and efficiency of home care services (oxygen therapy and mechanical ventilation), with a specific focus on end-of-life care 6. test new model for 'intermediate' care facilities able to meet accreditation standard at national level 7. further development of respiratory rehabilitation 8. invest in telemedicine-based models 9. training and awareness raising among GPs and strengthening their integration with hospital-based professionals 10. caregiver training and further development of the home care services 11. use of multidimensional assessment strategies of the patients (e.g. using the ICF framework) 12. ensuring mobility of the patients across different Regions, offering oxygen therapy while away from their usual residence	• number of days of hospitalization/number of hospitalizations per patient • number of re-hospitalizations per patient/year • % patients cared in home care setting

Source: own elaboration on data from Ministry of Health 2016

2.1.4 The National Plan for Dementia

Another policy that deserves attention is that underlying the ‘National Plan for Dementia’ (*Piano Nazionale Demenze*), which was developed by the Ministry of Health in close cooperation with the Regions and the national patient/carer associations and approved in October 2014 (Ministry of Health 2015). Addressing the challenges of dementia requires that comprehensive and cross-sectoral strategies are well defined at a national level, and National Strategic Plans for Dementia are relatively new not only in Italy, but also in many other countries (Alzheimer Europe, 2016).

These national strategies are particularly important in countries such as Italy, where policy responsibilities are split among different administrative levels, so that country-wide strategic recommendations and interventions have to be interpreted at regional level and tailored according to the specific characteristics of the local contexts. This is the reason why many regions, responding to their specific needs, have approved regional dementia plans for the implementation of the national strategy. For instance, the dementia plan of the Marche Region focuses on the most relevant local issues: reducing fragmentation of care, developing integrated care pathways and increasing community care services.

2.2 Barriers to the implementation of interventions, and policy measures to reduce dependency cost-effectively

Contrary to what most policy documents might suggest, interventions and policy measures targeting dependency using a cost-effective approach are not common in Italy, being in most cases loosely integrated with routinely provided care services. The Italian welfare state is indeed still focused on measures addressing dependency ‘ex-post’, i.e. after the onset of the problem, rather than trying to prevent it. Concrete examples of policies that explicitly address the need to reduce dependency cost-effectively are therefore hard to

find, outside the context of the regional health plans described above. Several factors contribute to this scarcity of policy measures and interventions.

First, the structure of the Italian LTC system and its governance mechanisms are often fragmented, being the result of the intersection of three different public policy domains: health care, social care, and pensions (see also Section 5 below for a more detailed analysis of this issue).

Health care services in Italy are administered by the Regions, which are responsible for funding and coordinating the local health care authorities (*‘Aziende Sanitarie Locali’*, ASL). The Ministry of Health has only residual competencies, as a consequence of federalism, including primarily the definition of the so-called Essential Levels of Assistance (*Livelli Essenziali di Assistenza*, LEA), the list of core services that the Regions are obliged to provide to citizens in community, institutional and/or acute care settings. At a local level, the municipalities are responsible for social care provision, while pensions and care allowances are administered by the Italian National Pensions Institute (INPS).

In such a fragmented context, cooperation among the different policy sectors can often be difficult, leading to the so-called ‘silo mentality’, a mind-set present in some institutions where single sectors concentrate only on their own performances and results, overlooking the broader societal and long-term outcomes. This type of mentality contrasts with the multi-causality of the disablement process, where extra costs in one policy area (e.g. costs for home help services) are often negative for one administration budget, but have the potential to generate positive outcomes in other policy domains (decreased use of hospital emergency departments, for example). On top of this, the characteristics of the financing system and payment schemes for LTC services do not provide an incentive for prevention, as in the best case care delivery is based on fees-for-service systems, for example those based on the Diagnosis Related Group (DRG) system.

Second, given the lack of coordinated and effective support from health and social care, the bulk of family caregiving responsibility falls on families (see section 3 for more details on this topic). In most cases, these have to turn to migrant care work or to institutional care for their older dependent relatives. In practice the capability of families to contribute to the health and wellbeing of their older relatives, thus preventing the progression of disability, is strictly dependent on their situation in terms of socioeconomic status (e.g. education, occupation and income), resilience to stress, and context of living (e.g. rural vs. urban).

Last, but not least, the Italian welfare model has traditionally relied on monetary transfers, rather than on provision of services, as reflected by the fact that the availability of public services in Italy, both home and residential care, has always been among the lowest in western Europe (Jacobzone, 1999; Huber *et al*, 2009). The main form of monetary transfer, the national attendance allowance, is granted by the Italian National Pensions Institute only to people with a severe dependency status. This fact, combined with the scarce availability of in-kind services, leads to the paradoxical situation in which families often wait for the dependency status of their family relatives to worsen in order to be able to receive some formal support, rather than trying to keep them as independent as possible.

people, in integration with other care providers in the area, hospital specialists and e-health technologies. The aim of this innovative model is to improve continuity of care for people with complex needs, which cannot be satisfied by a single professional. Although the results emerging from this experience – now in its sixth year – seems to be promising, the Lombardy Region is considering moving towards a new model, in which patients with the most critical conditions would be no longer followed by GPs, but by care managers (Bussola Sanità 2017).

A similar experience is that of the Expanded Chronic Care Model in Tuscany, which takes into consideration not only pathology but also health, social, economic and cultural conditions.

Other initiatives of interest are those for the implementation of the ‘Single Point of Access’ (*Punti Unici di Accesso*) which aims to ensure that frail citizens (including dependent older people) can receive information and take up all the required (and available) care services by accessing a single office. The underlying hypothesis of these initiatives is that facilitating the access of users to services can be an effective measure to increase the effectiveness of the services received and improve the efficiency of the care provided.

2.3 Some experimentations

One attempt to improve the delivery of health and social care for dependent older people (although formally targeting people with multimorbidity) has been the CReG experience in Lombardy (Bussola Sanità 2016). The CReG (Chronic Related Group) system is designed as a health care reimbursement system, substituting the current per-capita fee system, where the GPs are reimbursed a fixed sum to provide comprehensive care plans for older

Box 1: Examples of interventions to reduce dependency cost-effectively by selected risk factors

Risk factor related to dependency	Example of targeted intervention
Lower extremity functional limitation	Exercise interventions to prevent falls
	Modifying the environment to prevent falls
Sedentary lifestyle	Community based programmes
Low frequency of social contacts	Community-based care programmes, home visiting programmes
Sensory impairment (e.g. vision impairment, hearing loss)	Assisted living solutions
Cognitive impairment/dementia	Action on modifiable risk (and protective) factors that can be addressed to prevent or delay onset of AD and dementia
Depression	Early detection of subjects with sub-syndromal symptoms
Elder abuse and neglect	Psychological programmes for perpetrators, intergenerational programmes
Malnutrition/unhealthy eating habits	Educational interventions, meal delivery services
Environmental hazards	Environmental interventions (repair cracked pavements, install adequate lightning, etc.)
Chronic illnesses (diabetes, chronic heart failure, and multi-morbidity)	Chronic disease management programs, educational interventions for subjects with chronic illness
Self-neglect (refusal to attend to one's health, hygiene, personal and environmental needs)	In-home assistance support programs
Noncompliance with medication	Reinforcement of the role of pharmacist, one-to-one support programmes, education and empowerment

Source: Cornwell et al. 2009; Taş et al. 2007; WHO – Europe 2003 and 2011.

3 Interventions and policy measures to support unpaid carers effectively

Giovanni Lamura

3.1 The context

3.1.1 Family care as the bulk of Italian long-term care

As mentioned in the previous section, unpaid carers – together with home care assistants privately hired by households (on which more details are presented below) – represent the bulk of long-term care provision in Italy. Although no recent precise figures are available in this respect, given the lack of a formal definition of this category at the national level, the number of family carers in Italy has been estimated at over 3.3 million among the population in working age (15–64), taking into account only those who care for an adult person (i.e. excluding child care) (ISTAT 2011). Since carers aged 65 and over represent about a fifth of all carers of older people (Quattrini *et al.* 2006), it can therefore be estimated that the overall number of carers of adult people in Italy is well over 4 million.

In comparative terms, the proportion of carers in the working age population in Italy is one of the highest in Europe, second only to Croatia according to the European Quality of Life Survey, and to France according to Eurobarometer data (Eurofound 2015). Italy's comparatively strong family-based approach is confirmed by recent studies on social innovations taking place in the long-term care sector (Leichsenring and Schumann 2016), albeit OECD data seem to suggest a more intermediate position, with 15% of the over 50-year-old population reporting to be a carer in Italy, compared to a range of 12% to 20% in most European countries (European Commission 2016).

3.1.2 Support for family carers

Italian unpaid carers have access to a variety of formal support, which can be divided into four main categories (Naiditch *et al.* 2013):

1. 'direct specific' support: to help carers in performing care tasks (e.g. training);
2. 'direct non-specific': primarily for carers, but also recipients of care (e.g. respite care);
3. 'indirect specific': improving conditions under which informal care is provided (e.g. reconciliation measures);
4. 'indirect non-specific': primarily directed at care recipients (e.g. elder care services).

In terms of '**direct specific**' support for carers, the supply of training opportunities to help carers to better perform everyday care tasks has been slowly increasing over the years. No current data are available in this respect. However, a nationwide survey carried out in 2004 showed only 3.5% of Italian carers of older people reporting use of any kind of support services, compared to 22.8% in Germany, 22.5% in England, and 20.5% in Sweden (Lamura *et al.* 2008).

In the meanwhile, courses and training for unpaid carers have become more widespread, especially in the central and northern Italian regions. An important clarification in this respect is, however, that long-term care provision (and support services for carers as a component of it) in Italy is a responsibility of regional health care systems, and there is great variation in both quantity and quality of service delivery. As regards training, this applies both to face-to-face courses and, increasingly, online opportunities, some of which might require a registration fee, sometimes covered by local health or social care authorities.

One major drawback of many of these courses is that they are usually open to both unpaid (mainly family) carers and to care workers who are privately employed by the care recipient's families to support

them in everyday care provision (see the next paragraph). As a result, they often do not address in-depth the emotional, psychological and social issues confronting unpaid carers, limiting their focus on how to technically perform care tasks.

A similar situation is likely to apply also to the category of **‘direct non-specific’** supports for carers (which includes services such as day-care centres or respite interventions), although, again, no reliable data are available for the national context.

‘Indirect specific supports’ are distinct from the previous two categories, in that central government plays a major role. This applies in particular to measures to improve the reconciliation of unpaid care and paid work responsibilities. Two main initiatives provide a relatively established framework for the support of carers who are also employed in the labour market (Socci *et al.* 2016):

1. law No. 104/1992: it entitles workers to three days of paid leave per month, to care for a ‘severely disabled’ relative. Of the 36 days of paid leave per year granted by this law, 25 also count towards social contributions for pension benefits purposes;
2. law No. 388/2000: employees may take up to two years of paid care leave (which can be split into shorter periods, even single days) to care for severely dependent relatives, while also drawing their wage or salary, up to a maximum of €47,350/year (www.handylex.org/schede/congretribuiti.shtml).

In comparative terms, this represents a generous set of schemes (Schmidt *et al.* 2015), as it represents a valid support for many carers in need. However, it contributes to deliver the rather ‘familistic’ message that long-term care should be performed mainly by family members, even when these are actively engaged with the labour market, no matter how much this costs in terms of public resources and impact on workers’ re-employability.

Finally, with regard to **‘indirect non-specific’** supports (primarily targeted at care recipients, not

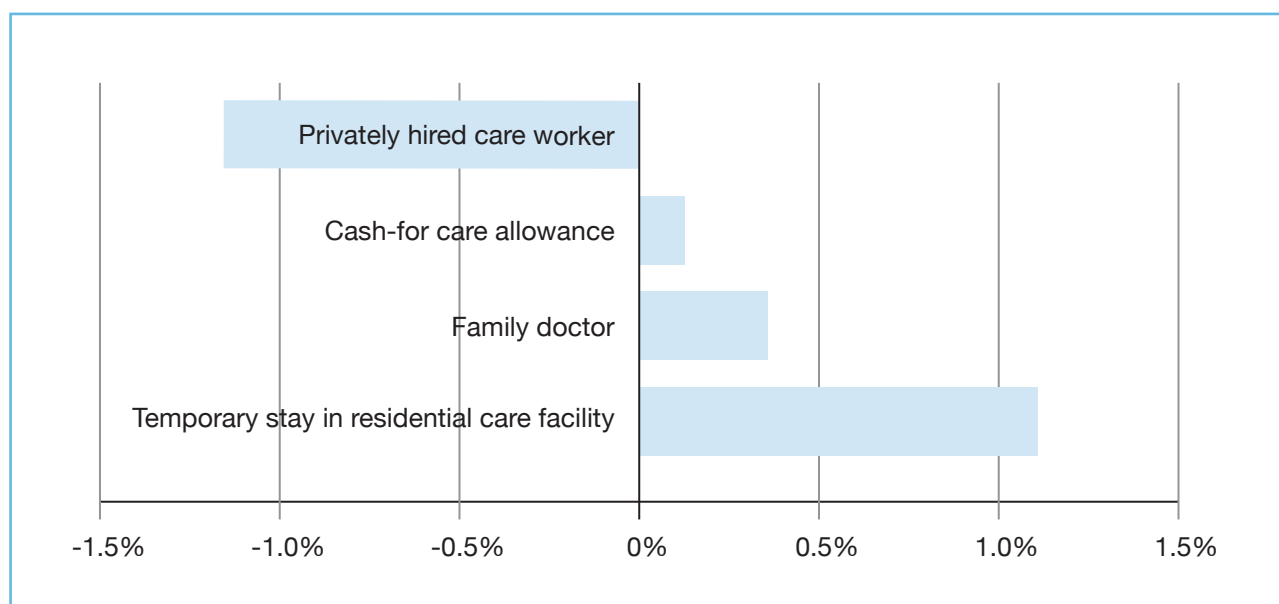
carers, who might nevertheless indirectly benefit from them), we limit our comments to the observation that the Italian long-term care system is largely based on cash-for-care benefits, rather than on in-kind service provision, as confirmed by most recent data (European Commission 2016:175). The most relevant contribution to this situation comes from the ‘attendance allowance’, a cash-for-care payment of over €500 per month received by 12% of the Italian population over 65 years old. This amounts to a total cost of over €10 billion, representing more than half of all Italy’s public expenditures for long-term care to older people (Barbabella *et al.* 2015). Given the lack of any restrictions concerning the destination of these large sums, the attendance allowance has been – used by most recipients to hire care workers privately to support them in everyday care provision. This component can therefore be considered as the real pillar of Italy’s long-term care system.

3.1.3 The crucial role of privately employed, primarily migrant care workers in household-based care

A few figures highlight the importance of this component in the Italian context (Di Rosa *et al.* 2015; Socci *et al.* 2016). In 2014, the number of domestic workers officially hired by private households was over 890,000 (after a peak of over 1 million in 2012); of these, around 364,000 were hired as care workers; 5.4% of the Italian population aged over 75 report employing a care worker. Given the large amount of undeclared work in this sector, estimates speak of a total number (including those irregularly employed) exceeding 830,000 care workers, of whom around 90% are foreign migrants (Pasquinelli and Rusmini 2013).

The relevance of this kind of support for unpaid carers is synthesized by Figure 1, reporting the findings of a longitudinal study showing that, among all the different forms of supports available to them, privately paid care workers represent the most – if not the only – effective means of reducing the burden experienced by family carers in the Italian context (Chiatti *et al.* 2013).

Figure 1: Impact of different supports on carer's burden (%)



Source: Chiatti *et al.* 2013

This phenomenon began as far back as the 1990s, and has since been supported by different measures and policies at local, regional and national level, including fiscal incentives and additional, locally organised cash-for-care schemes attempting to reduce undeclared labour, and by training and accreditation programmes.

3.2 Recent policy developments

3.2.1 The initiative of the National Agency for the Regional Health Services

In the early months of 2014, the National Agency for the Regional Health Services (or AGE.NA.S.) carried out a brief consultation with different stakeholders and experts in the field of family care, organised through an ad-hoc working group

(www.agenas.it/images/agenas/oss/assistenza/care%20giver/1_Gruppo_di_Lavoro_Caregiver_familiare.pdf). The main purpose of this initiative was to identify the main issues and problems concerning the role of family carers within the overall long-term care system, in order to formulate a series of

nationwide recommendations for the Regions (as the authorities in charge of delivering health and social care) to implement appropriate support for this target group at a local level.

The working group produced two main outputs. The first consisted in a series of scientific papers and contributions, highlighting how to define a family carer, their position in the delivery of everyday long-term care in the Italian context, and the possible role to be played by local health care authorities and third-sector organisations in supporting carers (www.agenas.it/contributi-scientifici). The second and more important output was a document – ‘Valuing and supporting the role of the family carer’ – in which the AGE.NA.S identified the circumstances under which the role of carers becomes so demanding, that it requires the adoption of support measures by public authorities and services (AGE.NA.S. 2014).

The importance of this document lies in the fact that it was approved in the same year by the inter-regional coordinating bodies for health and social care. While this did not imply a binding adoption of formal steps by regional authorities – it is effectively

a soft persuasion measure, rather than a strict policy intervention – it still represents the most significant official recognition so far at national level of the role of informal carers within long-term care provision in Italy. Furthermore, acknowledging that family care is an activity associated with a high risk of restrictions in terms of labour market participation, on the one hand, and of health and social exclusion, on the other hand, the document also identified a number of interventions and measures that Regions can adopt to support carers.

These are divided into two main groups: those aimed at *valuing* the role of informal carers, and those aimed at *supporting* them.

In the former category, the document identifies the following interventions:

- the formal recognition of the carer, ideally to take place in the context of the multidimensional assessment of the care recipient's needs;
- involvement of the identified carer in the definition and realisation of the 'Individual Care Plan' which is drafted for the care recipient (if the latter agrees with this), including a specification of the tasks performed by the carer and of the supports needed by the recipient;
- information for the carer on how to best deal with the condition of the care recipient, on his/her care needs, on possible treatments and on care services locally available and on eligibility criteria;
- training and empowerment for the carer on various care-related matters;
- training for health and social care staff and volunteers on how to best interact with family carers.

With regard to measure aimed at supporting carers (e.g. to reduce the burden of the caring role, isolation and burn-out), the AGE.NA.S. suggests the following:

- programmes to facilitate home adaptations (including home automation – 'domotic' – solutions);

- creation of direct channels allowing a constant communication between carers and care staff (using new ICT tools, where appropriate);
- programmes of psychological support for carers;
- respite measures provided by qualified staff;
- integration of institutional and voluntary networks to reduce carers' isolation;
- promotion of self-help groups;
- agreements with employer's organizations to increase work flexibility for carers who are also employed in the labour market.

Although the document called for a monitoring of the implementation of these initiatives over time – jointly by the Regions and AGE.NA.S. – so far no analysis has been carried out to quantify their effects.

3.2.2 Recent legislative activity at a regional and national level

In the early months of 2014, Italy's first regional law formally recognizing the role of family caregivers was adopted by Emilia-Romagna's regional council (Emilia-Romagna 2014). This achievement was reached primarily as a result of the longstanding engagement of 'Anziani e Non Solo', a social cooperative working in the field of elder care and support of family caregivers, which organizes among other things a yearly 'caregiver day' to promote the joint development of solutions to better support family carers (www.anzianienonsolo.it/about-us-english-versio). This initiative has been followed by moves towards formal recognition in at least six other regions, and in December 2016 a law in this regard was adopted by Abruzzo's regional council (Regione Abruzzo 2016).

At the national level, in the last year four different legislative proposals for a national act aiming at the recognition and support of family carers have been presented at the Italian Parliament, two at the Chamber of Deputies (Camera dei Deputati 2016a and 2016b) and two at the Senate (Senato della Repubblica 2016a and 2016b). The fall in December

2016 of the Italian government led by Matteo Renzi made the approval of any of such proposals by the Italian Parliament very unlikely in the near future, although it cannot be excluded that this might happen in the last months of the current government under the leadership of Paolo Gentiloni.

Apart from this general development, a recent comparative analysis of the four proposals (Lancioni 2016a) has also shown that, beyond a general, formal recognition of the role of the family carer, three of them do not seem to offer substantial and easily enforceable rights or protection to carers.

The one proposing more concrete supports (Senato della Repubblica 2016b) does indeed provide for pension benefits and other advantages to protect carers from health and other care-related risks, including insurance coverage. However, it has two main limitations: it applies only to carers of severely dependent care recipients (i.e. reporting a 100% degree of disability), thus excluding the very large number of carers supporting less dependent recipients; and it does not indicate where the financial resources to cover the costs of its application should come from. This proposal, which in any case is unlikely to be enacted owing to the current political uncertainty, can therefore only partially be welcomed as a step in the right direction (Lancioni 2016b).

One important criticism applies to all the national level proposals mentioned: they fail to challenge one of the cornerstones of the Italian approach to long-term care, the idea that the family should be the main provider of care. According to this vision, the State plays only a secondary role, supporting the care activities carried out by households, rather than stepping in as a primary provider of such tasks (Casalini 2016). The perpetuation of this familistic approach will therefore leave the main burden of care on family carers, taking for granted that they will continue to be willing and able to manage such a role, without any real assessment of the demographic, social, ethical and financial conditions on which this approach depends.

3.2.3 The role of vouchers as a payment tool for remunerating private care work

In 2003 vouchers were introduced as a form of payment for occasional work in limited sectors, including that of household care (INPS 2016). With a nominal value of €10, €20 or €50 (of which 75% is the net income for the workers, 25% going towards pension payments and workplace injury insurance), these tools were initially characterized by several restrictions (in terms of applicable sectors, intensity of work and upper amount per year) which until 2008 severely limited their use. In that year, no vouchers were sold in the household care sector, and only 500,000 in total (UIL 2016).

In the following years, these constraints have been gradually removed (up to the point that each beneficiary was allowed to receive up to €7,000 per year for almost any kind of activity), leading to a sharp increase in usage. For the household care sector alone, the number of vouchers issued has increased to over 1.8 million in 2014, and surged to 4.8 million in 2015, with the following year's figures estimated to have been similar. In March 2017, however, these vouchers were abolished by the Italian government, in order to forestall a referendum on this topic initiated by Italy's largest trade union (CGIL), which saw vouchers as a threat to regular work contracts (Balmers 2017). As a consequence, although vouchers can be used until the end of 2017, no more can be sold. To mitigate the difficulties this might create for the original recipients of this measure, seasonal workers and family-based care workers, the Italian government has introduced in July 2017 a new, more restricted form of vouchers. These can be used only by families and small enterprises (until 5 employees), or by those in the agricultural and building sectors (Senato della Repubblica 2017).

3.2.4 The recent trend to promote corporate welfare programmes

The Stability Law for 2016 (Legge 208/2015) has introduced a series of innovations concerning the promotion of welfare measures at company level,

aimed at strengthening the supply of services to support employees with care responsibilities, including informal elder care provision. These focus on three main areas: (a) fiscal incentives for companies which decide to grant welfare benefits for their own employees, (b) the adoption of the voucher system to access services (see also previous Section 3.2.3) and (c) the option to grant performance-related benefits in form of welfare services to employees earning less than €50,000 per year.

This latter innovation, in particular, is likely to have an expansive impact on the market of services for frail (older) people and their carers, as a result of the combined effect of following factors (Maino 2016):

- the company has a fiscal incentive to provide performance-related bonuses in the form of services, rather than as an addition to the salary (this incentive can be up to €470 per year, i.e. - 23.5% of the bonus value);
- the employee has a fiscal incentive to receive the bonus in services (up to €367 per year, i.e. +18.4% of the bonus value);
- these amounts can be further increased by 25%, if the company adopts approaches that directly involve employees in co-designing the organization of work;
- services for carers of frail (older) people are included for the first time as a possible component of company welfare schemes;
- and these services can be provided by means of vouchers, a solution which is likely to simplify the adoption of such schemes by small and medium enterprises.

The Stability Law for 2017 (approved in early December 2016) also moves towards a further strengthening of welfare measures at company level (Lodi Rizzini 2016)). This is promoted by a threefold strategy: enlarging the pool of potential recipients (by raising the employees' income upper limit for eligibility for performance-related bonuses from

€50,000 to €80,000 per year); increasing the potential benefit for employees (from €2,000 to €3,000 per year); and incentivizing the involvement of employees in the companies' organization (in which case the potential benefit per worker increases from €2,500 up to €4,000).

The first agreements are now being drawn up between trade unions and employers' organizations, and the number of working carers benefiting from support services provided through welfare measures at company level is likely to increase. At the end of 2015, this number was still quite low, as at that time only 3% of companies providing measures to improve work-life balance were addressing carers of dependent (older) adults (Mallone 2015). Another indicator in this respect is represented by services provided by 'bilateral bodies' (i.e. jointly organised by employers' organizations and trade unions), which addressed the needs of carers as a main target group in only 20% of cases (Razetti 2015).

That the situation is however rapidly changing is reflected by the establishment, in the last months of 2016, of the first network of company-based welfare services addressing employees with caring responsibilities for dependent adult family members, called '*Jointly Fragibilità*' (De Carli 2016). In a first phase, completed in October 2016, this initiative has established the availability of both profit and non-profit organisations interested in providing support services for carers through the initiative's national platform. During 2017, potential recipients will be able to choose, among the services listed online, those best fitting their needs, paying the provider directly, using the performance-based bonuses received through their own company. According to a preliminary study of 20,000 households, it is expected that the most frequently requested supports for carers will be from the following categories: information, economic benefits and breaks, respite services, psychological support, and help in selecting privately hired care workers to provide household-based assistance (see also Section 3.1.3 above).

4 Innovative care models and technologies to improve outcomes for people with LTC needs

Francesco Barbabella

Demand for LTC in Italy is constantly growing, pushing institutional actors to react to provide adequate support to older people. As described in more detail in the previous section, the Italian LTC system is characterised as a ‘migrant-in-the-family’ model (van Hooren, 2012), where most of LTC is provided privately by migrant care workers hired by older people and their families. Public in-kind LTC services are scarce, although some attempts at innovation can be seen at different levels across the country. The major areas of development concern technological innovation in terms of information and communication technologies (ICT) applied in health and social care, as well as organisational innovations aimed at improving aspects of patient-centeredness, care personalisation and management.

4.1 Technological innovation

In relation to the ICT in the healthcare sector, in recent years the national government introduced an explicit policy vision of eHealth in agreement with the 20 regions (the level of government holding responsibility for the provision and management of healthcare services to the population). A Pact for Digital Healthcare 2016–2018 (*Patto Sanità Digitale 2016–2018*) was approved in 2016, providing general guidelines for using ICTs as instruments enabling better care and organisation (Ministry of Health, 2016a). In particular, the guidelines say digital innovations in healthcare should be compliant with the principles of cost effectiveness, efficiency and quality, with the adoption of appropriate measures for monitoring and evaluating the application of measures.

The main strategic objectives and actions promoted by this plan are shown in Table 3 below. The plan is

to be funded ad hoc by instruments to be identified by healthcare actors themselves, for instance via the European Pre-Commercial Procurement (PCP) and Structural Funds, ad hoc funds provided by national and international authorities for research and innovation, and/or private initiatives for project financing and performance-based contracting. Relevant aspects of this policy are the workflow of eHealth introduction (structured in three phases: feasibility study, validation of conceptual models, and commitment by the regions to implement the solution in compliance with legislation), the involvement of a wide network of stakeholders, and facilitation of continuous care (by reinforcing integration of community and acute care, telemedicine and telehealth services, electronic health records, drug provision and monitoring, and packages of services).

Furthermore, in the National Plan for Chronic Diseases (*Piano Nazionale Cronicità*), mentioned in Section 2, eHealth tools are explicitly envisioned for supporting the Chronic Care Model (CCM) as well as patient education and empowerment (Ministry of Health, 2016b). This plan promotes an overall vision for chronic care that aims at overcoming the disease-oriented approach and fragmentation between care settings and providers typically seen in many contexts.

The plan outlines ‘care paths’ (*percorsi assistenziali*) which should enhance chronic care by means of a patient-centred care (with adjusted clinical groups and risk identification), using multidisciplinary competences, and empowering the patient towards self-care and self-management. In particular, people with LTC needs who are house-bound should benefit from increased integration and better implementation of professional care offered via telemedicine and tele-assistance services, tools which should lead to

Table 3: Main characteristics of national policies

National policy	Strategic objectives	Actions
Pact for Digital Healthcare 2016–2018	1. test solutions aimed at resource optimisation 2. evaluate healthcare system in terms of appropriateness, efficiency and effectiveness in relation to essential levels of assistance (LEA) 3. develop a vision of healthcare system based on attractiveness and competitiveness at international level 4. point out issues concerning the Pact for Digital Healthcare in order to find appropriate solutions	a) use new technologies for sharing health information in a transparent way b) collect data on processes for measuring return on investment c) control and validate experimental protocols and/or include the principles of cost-effectiveness, validity, efficiency and measurability d) collect a complete series of health data on care providers and care services to be shared among health professionals e) collaborate with training offices for preparing professionals on new procedures and ways to provide care
National Plan for Chronic Diseases	1. guarantee links between care for chronic diseases and primary prevention 2. obtain and maintain control over the chronic disease during the life course 3. prevent and care for complex effects, co-morbidities and disability situations 4. ensure quality of life, partly by means of 'community welfare' models 5. optimise economic, human, structural and organisational resources	a) promote healthy lifestyles among the population b) adopt interventions for early diagnosis of chronic diseases and risk factors c) train the patient in self-care d) establish adequate health and social care services which consider co-morbidities, complex needs, limitations in activities of daily living, frailty and social exclusion e) simplify procedures for facilitating access by patients to care and integrating different care settings and providers f) define care processes by means of available evidence-based medicine and guidelines g) monitor care processes through robust health information systems h) define roles, responsibilities, activities and expected results of all actors in all care settings i) allocate sufficient resources for reaching planned objectives

sustaining care management at home, limiting admissions to hospitals and other healthcare facilities, and better compliance with care plans (Ministry of Health, 2016b). In the bottom section of Table 3, an overview is provided of the main characteristics of the underlying policies of the plan.

Previously, the most important operative developments in eHealth concerned the creation of the technological infrastructure for collection, integration and analysis of health data in a single national health information system (*Nuovo Sistema Informativo Sanitario*, NSIS). This system, developed and implemented progressively in all regions from the 1980s, was renewed in the early 2000s in order to support healthcare governance and monitoring of both essential care levels (*livelli essenziali di assistenza*, LEA) and healthcare expenditure (Domenichiello 2015; Di Carlo & Santarelli 2012). The key pillar of this information system is the electronic health records (*fascicolo sanitario elettronico*, FSE), which include a patient summary and other information, available to professionals. The final step for initiating practical implementation began in 2015–2016, backed up by actions envisaged by the Agency for Digital Italy (Agenzia per l'Italia Digitale, AID, 2017).

The NSIS is oriented towards two directions: first, to support the governance of the healthcare sector; and second, to support care delivery to patients. Each objective can count on health information tools (e.g., sectorial information systems, ePrescriptions, telemedicine, electronic health records) that improve governance and services (Ministry of Health 2017a). The NSIS constitutes the overarching technological system that enables the digital integration of all health information concerning a single resident in Italy, the monitoring of patients, and the evaluation of healthcare interventions, and which will make available – according to specific regulations – to professionals and patients the data for further services and practices for telehealth or self-care purposes. For people with LTC needs, the integration of the information systems on home care (SIAD), emergency-urgency network (EMUR),

hospice care (HOSPICE), residential and day care (FAR) is crucial for assuring the design and implementation of comprehensive care tailored to LTC patients' needs.

In terms of practical technology-based services for older people with LTC needs, there is a range of services promoted by the eHealth Information Strategy of the Ministry of Health (2011, 2017b). This covers the implementation and improvement of the 'central booking point' (*centro unico di prenotazione*, CUP), FSE, digital disease certificates, ePrescription and telemedicine. These five areas have in common the underpinning principles of harmonising eHealth solutions across the country (avoiding discrepancies between regions) and digitalising healthcare documents (with less paperwork in clinical practice and quicker processes) (Domenichiello 2015):

CUP: a digitalised information system for booking secondary care services (by public providers and private providers subject to restrictions). By 2014, in half of the regions, CUPs were working for patients both as front offices and other communication channels (such as web portals, emails or digital kiosks or 'totems' in municipalities and pharmacies);

FSE: electronic health records integrating the information flows from all care settings and providers in Italy (in compliance with EU interoperability standards (Domenichiello 2015)), with health data available to professionals and patients. FSE are currently fully operative in six regions (Valle d'Aosta, Lombardy, Trentino-Alto Adige, Emilia-Romagna, Tuscany, Apulia, Sardinia), in progress towards full implementation in other ten regions, and still in planning process in three remaining southern regions (Campania, Calabria, Sicily) (AID 2017);

digital disease certificates: when a worker reports sick to a general practitioner, the GP can send a digital disease certificate to the National Institute for Social Protection (INPS) for registration and activation of eventual linked benefits;

Table 4: Main characteristics of telemedicine services according to national guidelines

Type of telemedicine service		Characteristics		
		Area	Patients	Interaction
Specialist telemedicine	Tele-visit	healthcare	chronic, acute, and post-acute care	patient–medical doctor
	Tele-consultation	healthcare	chronic, acute, and post-acute care	between medical doctors
	Tele-cooperation	healthcare	chronic, acute, and post-acute care	between medical doctors, with patient
Telehealth		healthcare	chronic care	patient–medical doctor
Tele-assistance		social care	older people, people with disability	alarms, emergency and monitoring calls

ePrescription: digitalised prescriptions by doctors which can be sent to pharmacies for prescribing drugs. This provides automatic calculation of the eventual co-payment by the patient and integration in the NSIS (for monitoring drug expenditure by public managers and supporting clinical decision making by professionals);

telemedicine: a range of remote care and consultation services that enables health professional-patient interaction at a distance. However, telemedicine, telehealth and teleassistance systems are still not widely available, despite national guidelines for telemedicine being issued in 2014 with the overall aim of promoting the design and implementation of such solutions for patients (especially for most complex health profiles). See Table 4 for a summary.

4.2 Organisational innovation

Most policy actions for practice innovation in the last decade have focused on addressing the issues related to specific chronic conditions, such as diabetes (e.g. via the IGEA project) and respiratory diseases (e.g. the national implementation of the Global Alliance against Respiratory Diseases) (Melchiorre *et al.*, 2015).

At a national level, apart from the general initiatives by the Ministry of Health included in previous National Health Plans (*Piani Sanitari Nazionali*) and in the latest Pact for Health (*Patto per la Salute*) 2014–2016, important developments have been the delivery of the National Plan for Chronic Diseases (*Piano Nazionale Cronicità*) in 2016 (Ministry of Health 2016b) and the National Plan for Dementias (*Piano Nazionale Demenze*) in 2015 (Ministry of Health 2015). As mentioned in section 2, the first plan sets out national guidelines for ensuring appropriate chronic care management to patients, including specific indications for a number of chronic diseases not yet explicitly considered by the health planning legislation. It represents an innovative policy, intervening for the first time in a comprehensive way in the field of chronic care. The core of this policy concerns the adoption of the Chronic Care Model – and, in particular, of different key aspects: the patient-centeredness approach, the recognition of the multidimensional needs of the patient (medical, psychological and social), the integration of different disciplines and services involved in care provision, the need for better health education and empowerment of the patient and his/her family, and continuous monitoring of the health situation. The declared, underpinning goal of chronic care is to maintain the patient at home,

avoiding or delaying as far as possible their institutionalisation.

As for the National Plan for Dementia, it constitutes an innovative step forward for the Italian context towards improving the network of healthcare actors engaged in the diagnosis, monitoring and treatment of dementias. The plan has four objectives which are seen as being achieved through related actions: to carry out health and social care interventions; to create and manage an integrated network of services for dementias; to implement strategies for monitoring the appropriateness of care; and to raise awareness and reduce stigma related to dementias in order to achieve a better quality of life.

In addition, at the beginning of 2017 new essential levels of assistance (*livelli essenziali di assistenza*, LEA) have been formally approved (President of the Council of Ministers 2017), after a consultation process with the regions and other institutional actors and stakeholders involved. The new LEA updated the list of healthcare services which all regions are obliged to guarantee to citizens (the previous list entered into force in 2001). They include a reorganisation of some aspects of LTC, involving better integration of health and social services through an individual care plans taking into account both health and social needs (art. 21); an enhanced list of the basic levels of community care services to be guaranteed nationwide (art. 3-20); better economic protection when people with high-intensity health needs are admitted to care institutions (the fees are to be entirely paid by the State) (art. 29); and a re-structuring of home care into four levels of intensity, with different characteristics and types of professionals (e.g., medical doctors, nurses, healthcare workers, social workers) involved (art. 22).

In the field of social care, which is the responsibility of the municipalities, the main policy innovation in recent years has been the progressive stimulus by the central government to foster cooperation between municipalities for the management and provision of social services. Policymakers established that small municipalities (under a

minimum number of inhabitants) should work together to organize social services (Banchero, 2015). This measure increased the agreements between municipalities, with more centralised services and expected financial savings and resource optimisation.

Furthermore, a common trend in LTC in many municipalities is the development of voucher systems and local cash allowances granted to older people with LTC needs or to their family carers. The overall goal of these instruments is to reduce the burden of this target group on formal social care services, which usually cannot be satisfied entirely by in-kind services due to budget and staff shortages. Vouchers and allowances do represent an innovative way to support older people and their families in covering the needs for assistance, used in practice either as a compensation measure (covering indirect costs of LTC resulting from the involvement of a family carer who forgoes earnings as a result) or a budget for paying for LTC services at home (mostly by migrant care workers) or in nursing homes.

4.3 Evaluation issues

In general terms all the innovations covered in this section represent either recent policy interventions or fragmented measures that have not yet been evaluated for their cost-effectiveness and impact at different levels. Indeed, it is difficult to provide specific evidence or recommendations on the possible benefits of these new and innovative policies.

The analysis of these policies is even more tricky, if we consider the possible range of side-effects that might be involved. For instance, the skewing of the LTC offer towards the provision of cash benefits such as vouchers and allowances instead of in-kind services might represent a threat to the employment of workers in the parallel market, who have low salaries, no social insurance and low skills in LTC, with consequences for the appropriateness and quality of care provided.

5 Strategies to maximise coordination in care provision

Georgia Casanova

5.1 Introductory remarks on the concepts of 'coordination' and 'integration'¹

Many studies underline how the need for more coordinated or integrated policies to facilitate the provision of health care, social services and related supports (Kodner & Spreeuwenberg, 2002) has been a recurring issue in developing and enhancing LTC systems across Europe over the past few decades (Ham & Smith, 2010; Kodner, 2009; WHO, 2015; Leichsnering *et al.* 2016). In this respect, integration in social and health care has been defined as 'a set of practices, tools, cultural and professional skills that tries to integrate the health sector with the social one to achieve common goals' (Billings, 2005, Armitage *et al.*, 2009). This is even more important in the LTC sector, which is structurally based on the mixed delivery of health and social care services (Leichsnering *et al.*, 2013).

Many definitions of coordinated or integrated care exist, conveying different meanings, depending upon the involved context, organization and/or professional group. Most definitions describe it as an act of bringing together inputs, delivery, management and the organization of services in such a way as to improve access, quality, user satisfaction and efficiency. The term 'integrated

care' is in this respect used to refer to:

- health and social services delivered by a single organization;
- the joint delivery of health and social services by more than one organization;
- the links between primary and secondary health care;
- combining care at different levels within a single sector (e.g. mental health services);
- coordinating prevention and treatment services.

Integration can therefore mean that services are jointly commissioned and/or funded, delivered by multidisciplinary teams in which team members are employed by more than one organization, or delivered by multidisciplinary teams in which members are employed by the same organization. The typologies of integration depend on the approach used to observe them. Integrated care can be patient-centric or organizational (Kodner and Spreeuwenberg, 2002). Patient-centric integrated care is concerned with aligning funding, management and organizational issues by cutting across multiple services, providers and settings to deliver the best possible quality of care, quality of life, patient satisfaction and efficiency (Robertson, 2011). Other definitions are focused on the levels at which integration takes place (Reed *et al.*, 2005): e.g. vertical (integrating care across different levels), horizontal (identifying multidisciplinary teams and/or stakeholders for each level), and at service level (when all care addressing a specific target is provided in a coordinated manner).

Several authors emphasize that, while innovation has been usually powered by the application of integrated care strategies, the adoption of an integrated approach itself can contribute to

¹ For the purposes of this country report, in this Section we will refer to the two concepts in a synonymous way, although there is a widely acknowledged conceptual distinction between integration and coordination, as applied in the field of service delivery (ASPE 2000): 'Integration is characterized by features such as common intake and 'seamless' service delivery, where the client may receive a range of services from different programmes without repeated registration procedures, waiting periods, or other administrative barriers. In contrast, coordinated systems generally involve multiple agencies providing services, but clients may have to visit different locations and re-register for each program to obtain services. Integrated services are sometimes, but not always, physically co-located'.

improving the appropriateness of services provided, by covering ever more complex needs of care, an important achievement in the light of the current and projected decreasing capacity of households to provide informal care (Leichsenring *et al.*, 2013; Colombo *et al.*, 2011).

Across Europe, recent studies stress how integration/coordination is a crucial driver in promoting the effectiveness of LTC delivery via social innovation (Kesselring *et al.*, 2016; Casanova *et al.*, 2016a; Leichsenring *et al.*, 2016). The large number of definitions and issues related to this concept underlines the complexity of implementing integration and coordination strategies, which are strongly influenced by the specific care regime characteristics. For this reason, it is very important to define clearly the care regime profile of a country.

In this respect the model of care in Italy, as with most Mediterranean countries, is usually labeled as ‘familialist’, in which a fundamental role in LTC delivery is played by informal family care provided at home (Da Roit, 2007; Da Roit, 2010; European Commission, 2011; CIRT, 2012).

Other studies, however, starting from broader definitions of care demand and provision (Lamura *et al.*, 2007), indicate that there are important differences between care regimes even within the group of Mediterranean countries (Lamura *et al.*, 2007; Nies *et al.*, 2013; Bettio and Verashchagina, 2010), with a trend towards an increased hybridization that reveals some specific national characteristics.

In this regard, the Italian low level of formal care appears to be characterized by a mixed (i.e., formal-informal) care system, in which the integration issue has a growing relevance in meeting both increasing LTC needs – in 2013 more than 2.5 million older Italians reported a functional limitation in terms of Activities of Daily Living, reduced mobility and confined living (Istat, 2014) – and their broadening complexity (Barbabella *et al.*, 2015). Indeed, for many years the debate on LTC in Italy has focused on the urgent need for more integration and

coordination in different areas of LTC (Pavolini *et al.*, 2015), and it is not by chance that integration has been identified by many Italian stakeholders as one of the main tools to promote social innovation in the country (Casanova *et al.*, 2016b).

In the following paragraphs, we will describe how integration and coordination strategies have been applied in Italy and analyze their potential contribution – in particular as innovations – in the LTC system. Section 5.1 focuses on issues related to governance; Section 5.2 on the integration of different (health and social) care services, types of care (formal and informal) and nature of providers (public and private); and Section 5.3 describes integration and coordination strategies as forms of social innovation. Finally, in the closing remarks make some suggestions and policy recommendations, against the background of a critical examination of the status quo.

5.1 Integration and coordination in Italy’s LTC governance system

In recent decades, an increasing trend to reorganize the LTC system via a ‘decentralisation’ of the health and social care functions from the national to the regional/local level can be observed in Italy. In the social care sector, this development has made local administrations the core governance centres of the system, as they are able to define their own LTC policies and instruments. As for health care, the devolution of competences to regions has allocated to them the political, practical and financial responsibility of managing this crucial sector of welfare provision. All this means that Italian regions have the overall welfare legislative competence within a governance model which involves several levels of institutional actors in terms of management, organisation and decision-making.

5.1.1 Governance and institutional coordination

The Italian care system remains somewhat fragmented (Casanova *et al.*, 2016a, Pavolini *et al.*, 2015). This is partly due to the different funding

Table 5: Integration in Italian LTC system

	Main characteristics	Integration and coordination features
Type of LTC governance	• Separation between the health care system and the social care services • Plurilevel (local + national) and ‘fragmented’ governance	National regulations define the general integration strategy Regions define their integration strategies, policies and tools
Regulation of integrated care services	• Within health care sector: yes • Within social care sector: limited • Between health and social care services: no	Integrated health care services aim to optimize the results of health care Integration between health and social care services is included in the national strategy, but not yet implemented

Sources: elaboration by authors

sources: Italian public LTC is funded by the National Health System (for the health care component), the National Institute of Social Security (for cash-for-care benefits) and by regions and municipalities (for the provision of in-kind care services).

Italy’s LTC fragmentation is also related to the fact that the essential functions (such as health and social care as well as basic care training) are decentralized and managed at regional level. The only body in charge of ensuring inter-institutional coordination in this context is the State-Regions-Conference (which can address any issue concerning the relationship between State and regional competences, not only LTC concerns). While local health authorities provide health care service and municipalities are the main institutions responsible for social care, regions are in charge of enacting national recommendations into regional laws. Thus in the context of social and health care they define how quality assurance is carried out, by setting minimum standards of care and the multidimensional assessment tools to be used for evaluating health status and care needs of older people. Consequently, it would be more appropriate to talk of 21 different regional care systems, and many integration and coordination strategies, rather than a single Italian system.

In this fragmented context, twenty years of debate have produced policies and laws that promote integration and coordination services, but maintain a structural separation between health and social care policies (Table 5).

5.1.2 Integrated tools and policies

Since 1992, the Italian national health system has promoted by law the integration between health and social care services², on the assumption that ‘a set of integrated services to meet the person’s health needs that require health care and social protection measures can ensure, even in the long term, the continuity between the nursing actions and those of rehabilitation’ (Agenas, 2011). This definition stresses the relevance of the contribution from social care as a complementary component supporting the effectiveness of health care services.

In reality, however, such integrated care is still too often a label and a wish, rather than an achieved goal. Indeed, Italy’s integrated health services include two typologies of services: the ‘health services with social relevance’ – such as nursing

² The main regulatory references in this respect are the Legislative Decrees No. 502 of 1992 and 229 of 1999 and the Prime Minister’s Decrees of 14 February 2001 and 29 January 2001.

care, psychological support services and rehabilitation services – and the ‘social services with health relevance’, which aim at removing the social obstacles which might prevent the achievement and maintenance of good LTC results. Since the optimization of health care results is the main aim of health integration, social support services are provided by local health authorities. As a result, older people with reduced ADL autonomy are included as a specific target group of health-integrated care. Using theories of services integration (Armitage *et al.*, 2009) we can view Italy’s system of health integrated services as carried out at three main levels of integration:

1. Institutional: involving all relevant institutional stakeholders and different care providers;
2. Organizational: promoting integration between different services provided by the same care provider;

3. Professional: emphasizing the importance of collaboration between different professional profiles to optimize care delivery (Agenas, 2011).

In working towards integration between health and social care services, each region defines its own strategy and related tools. The ‘Integrated Health and Social Plan’ is the most used tool in Italy: 18 out of 21 regional/provincial authorities have adopted one or another form of such an integrated plan, based on tools with different characteristics, as indicated in Table 6. Generally speaking, the regional plans reflect a health-centered vision of care: few regions stress the social component in their strategic plan (e.g. Liguria, Puglia and Sardinia) or focus action under the plan on LTC provision as well (e.g. Abruzzo, Basilicata). However, it should be noted that the first experiences of a ‘health promotion plan’ using a holistic framework have recently been reported, for instance in the Piedmont and Marche Regions (Agenas, 2013).

Table 6: Integration in Italian LTC policy tools

Tools	Characteristics	Integration and coordination aspects
LTC fund	- LTC national fund (amount is defined year by year) - Types of regional LTC funds	LTC national fund results by addition of health and social resources, but maintains internal fragmentation. Some versions of local funds provide integrated health and social resources, and add local resources.
National minimum level of services	- Health services (LEA): yes - Health and social services (LIVEAS): no	LEA include the national minimum standards of health services, considering social support services as complementary to health services. LIVEAS were planned by Law 328/200 but never implemented.
Integrated Action Plans	As regional implementations	Based mainly on a health-centred approach to care. Few implementations also include social or LTC services.
Integrated Health Houses	As local implementations	Integrated primary health services and social services. Private care providers.

Sources: elaboration by authors

One major institutional tool to overcome the risk of inequalities in care provision across regions is the so-called ‘essential care levels’ (*Livelli Essenziali di Assistenza*, LEA). Formally introduced by Law 328 in 2000 with the aim of ensuring common minimum standards of healthcare delivery across the country, the LEA have faced criticism since their inception with regard to several issues, including the lack of focus on LTC needs and on systematic (and properly funded) responses to them (Tediosi and Gabriele, 2010). After a first, partial, revision in 2008, the LEA were formally revised at the beginning of 2017 (following an agreement reached in Summer 2016 at the State–Regions conference), incorporating for the first time the classification of different levels of home and residential care (based on intensity and complexity):

Home care:

1. basic home care services for health, nursing or rehabilitation purposes;
2. integrated home care at first level (requiring up to five days per week of care delivery);
3. integrated home care at second level (requiring up to six days per week of care delivery);
4. high intensity integrated home care at third level (requiring up to seven days per week of care delivery);

Residential care (according to the main features of care facilities and to the ratio between care staff and residents) provided by facilities delivering:

1. extensive long-term care (with 50% coverage of costs by the NHS);
2. extensive care to persons with dementia (with 60% coverage of costs by the NHS);
3. intensive and extensive care to support life functions (with 100% coverage of costs by the NHS).

While it is still too early to provide an assessment of the implementation of these new LEA, current criticism mainly focuses on the lack of appropriate funding, which is likely to endanger their

effectiveness (Cartabellotta 2017; Cecconi 2016). Also, there is still no sign of implementation of the so called LIVEAS (*Livelli Essenziali di Assistenza Socio-Assistenziale*), that is of the ‘essential levels of social care’, originally planned by law 328 of 2000. There has been no follow up to realize them in practice, thus helping to maintain marked regional inequalities in this area of care provision.

More than a decade of debate on the LIVEAS did achieve was the establishment of national and regional LTC funds. The ‘National LTC Fund’ (NLTCF) was established in 2007 to guarantee a more homogeneous LTC provision across the country, including home care and support for family carers. NLTCF resources – which in 2016 reached the relatively modest amount of €450 million – are distributed to regions according to their proportion of dependent older people and other socio-economic indicators.

This experience was in parallel to the regional LTC funds pioneered by some regional administrations (Liguria, Lazio and Puglia), which have since become available in most regions. A considerable level of fragmentation is evident here as well, due to the high political autonomy regions enjoy in this area: each of them has built its own fund with distinctive objectives, budgets and eligibility rules (Casanova *et al.*, 2016a).

5.1.3 Room for innovation in Italian governance models

Despite the lack of significant developments at national level highlighted above, the push towards stronger care integration has recently led to a new model of implementation in the ‘Health Communities’ founded by the region of Tuscany (Agenas 2013). These are public non-profit consortia, bringing together local health authorities and municipal social care services to ensure a joint management of their health and social care functions. So far, five such communities have been implemented since 2002.

With regard to the ‘integrated’ policies and tools highlighted above, it should be emphasised that all

Table 7: Integration in Italy's governance and regulation system: obstacles and opportunities for innovation

Obstacles	Opportunities
• Fragmented system • Separation between health and social care • Lack of national LTC reforms and/or of specialized integrated policies • Core focus on health components of care and correspondingly lower relevance of social care.	• Local integrated plan implementation • Importance assigned to mixed networks in health and social care policies • National regulation on integrated tools in health and social care (integrated plans, LTC funds, etc. • Presence of integrated health care and LEA.

Sources: elaboration by authors

derive mainly from initiatives from the health care sector, so they often end up paying less attention to the social and LTC components of service delivery. Their main relevance lies in the fact that they all stress the need for an improved, more systematic integration, an approach which is gaining ground in Italy's governance of care services.

There are two final points to highlight. The fragmentation of the system due to the 'institutional' separation between health and social care, and the prevailing health-driven approach to care represent significant obstacles to more widespread and structural implementation of innovations in Italy's integrated care (see Table 7).

On the other hand, the Italian context presents some unique characteristics which might represent opportunities to support improvements in terms of integration in the LTC system. Indeed, for over twenty years the promotion of national integrated health care and the related national minimum level of care services (LEA) have contributed to mainstream the issue of care integration among organizations, policymakers, care providers and professionals, and this can be certainly seen as a crucial aspect of innovation in this field (Pavolini *et al.*, 2008).

Furthermore, integrated tools for planning health and social policies, used at local level, have increasingly supported the collaboration between

different stakeholders, this being one of the main factors promoting management, organizational and social innovation (Casanova *et al.*, 2016b; Leichsenring *et al.*, 2016).

5.2 Integration and coordination of services

5.2.1 Coordination in formal services

The provision of LTC services reaches in Italy 8% of the over 65-year-old population. This amount is composed by those served by the Integrated Health Home Care (IHHC) provided by the Local Health Authorities, represented by 4.1% of the elders, those benefiting from the Social Home Care (SHC) provided by municipalities (1.4%) and those in Residential Care (RC) facilities, equal to 2.5% of older Italians (Barbabella *et al.*, 2015). Table 8 provides in this regard an overview of the integration and coordination components characterizing these three different LTC service typologies.

Coverage by formal care services is relatively low compared to the actual LTC needs of older Italians, since in 2013 19.8% of them reported at least one functional limitation in performing their daily life activities (Barbabella *et al.*, 2015). In this regard, Italy's cash for care schemes play a major role in addressing this high care demand. Overall, 12.8% of older Italians receive the so called 'attendance

Table 8: Formal care typologies in Italy: integration and coordination aspects

Care typology	Coverage	Integration and Coordination aspects
IHHC	4.1%	There are a few local experiences of integration and coordination between IHHC and SHC. IHHC is part of the National Health System.
SHC	1.4%	Provided by municipalities, usually without any integration or coordination with other services.
Residential care	2.5%	No integration with home care services. There are cases where professional roles have been combined or integrated in residential care contexts.

Source: elaboration by authors, based on Barbabella *et al.*, 2015.

allowance', a monetary benefit which has been labelled Italy's 'main' LTC policy measure (Casanova *et al.*, 2016a; Barbabella *et al.*, 2015). In practice, the attendance allowance works as a facilitator of integration and coordination between different typologies of services within the Italian LTC system.

Thanks to cash-for-care benefits, older Italians and their families are able to cover to a large extent the indirect costs of informal care provided at home by caregivers or the cost of care services bought from the private market (Di Rosa *et al.*, 2015, Da Roit, 2010). In order to properly understand the role played by these cash benefits in the whole system, and in terms of integration and coordination among different LTC services, it is necessary to take a more in-depth look at the relationship between formal and informal care, on the one hand, and between public and private care, on the other.

5.2.2 The relationship between public and private care and between formal and informal care

In Italy 10% of older people receive only informal care, 8.7% private care only, 3% public services only, while 7.5% opt for the mixed services solution (Di Rosa *et al.*, 2015). However, private care in Italy means two different categories of care services bought by families: the social care and support

provided by individual, mainly migrant, home helpers directly hired by households; and the out-of-pocket services supplied by private care provider organizations. While for many years private home helpers represent the largest professional group involved in Italy's LTC, the role of private care providers has been growing only more recently (Colombo *et al.*, 2011). The reasons for the increase in provision by private organizations are manifold and only partly related to the mismatch between growing care needs and continuing low supply of public services; a major role is also played by national and regional regulations encouraging a bigger private sector contribution, through various measures promoting the involvement of private providers (Casanova *et al.*, 2016b; Leichsenring *et al.*, 2016).

This is particular evident in the light of the regional policies adopted to promote the strengthening of specialized local networks of LTC providers (e.g. those adopted in Piedmont, Tuscany and Emilia Romagna), or to establish a regional accreditation procedure for private care providers (e.g. in Piedmont and Lombardy). Older Italians spend 6% of their health expenditure on care services, but this amount does not include the cost for the private home helpers employed by as many as 5.4% of all Italians aged over 75 (Pasquinelli, 2013; Di Rosa *et*

et al., 2015). Considering that estimates suggest that in Italy there are over 830,000 home helpers, it can be safely stated that families and care recipients are themselves the main agents integrating and coordinating function among different services, in particular between public home care services and the private social care provided by home helpers. This is not surprising, given the widespread role played by informal care in Italy, where more than 8% of the active adult population is involved in family care (Casanova *et al.*, 2016a; Di Rosa *et al.*, 2015).

5.2.3 Room for innovation from the point of view of services

The situation described above highlights that the lack of communication between different services is one of the main obstacles for services coordination. However, the involvement of formal actors – (including private care providers) and informal ones (including families and care recipients' organizations) also represent an opportunity to promote an innovative strategy for achieving more integrated services (Table 9).

Numerous local initiatives in recent years with the aim of establishing accreditation systems have contributed to support the involvement of private care providers as active actors in local LTC system, with a specific role and responsibility to ensure its effectiveness.

Table 9: Obstacles and opportunities for innovation in integration and coordination at service level

Obstacles	Opportunities
- Fragmented services and initiatives. - Lack of communication between different typologies of services	- Valorisation of role of cash benefit and families as drivers. - Local networks for LTC. - Local initiatives for accreditation purposes.

Sources: elaboration by authors.

5.3 Examples of innovative integration and coordination initiatives in the LTC sector

The current fragmentation of Italian services has been identified as a crucial issue for the definition of appropriate strategies to promote innovative ways of improving LTC integration and coordination. From a different point of view, this situation and the wide variety of regional projects initiated to mitigate evident shortcomings in LTC provision also represent a high potential for innovation in this respect.

5.3.1 Findings from the MoPAct project: examples of integration and coordination creating social innovation

Many Italian stakeholders, experts and policymakers stress the importance of integration and coordination strategies and their positive impact on Italy's LTC system (Pavolini *et al.*, 2015; Casanova *et al.*, 2016c; Leichsenring *et al.*, 2016; Schulmann *et al.*, 2015). It is not by chance that many Italian local initiatives of social innovation are oriented to promote integration and coordination in three different ways, identified by using the typologies of integration proposed by Reed *et al.* (2005) and by Robertson (2011) to build a specific classification (Leichsenring *et al.*, 2016):

Integration and coordination of policy areas, in particular social support and health policies. This type of integration is linked to a policy design phase. At the political level, the social and health care systems are fragmented and poorly connected. Promoting integrated planning and permanent monitoring and evaluation of public policies and measures is thus crucial to achieve integrated governance and to ensure sustainability of projects and services;

Integration and coordination of stakeholders to create mixed networks where public institutions and private enterprises (in particular not-for-profit organizations) work together to design and provide services. Often these networks are built at local level;

Integration using multidisciplinary staff: Case management and the multidisciplinary team care are the most common expressions of this typology of integration. The design of care policies need to be adapted to the diversity of profiles of dependency and social profiles, and to be conceived through a prevention logic and with a long-term perspective.

The MoPAct project, carried out in 2013-2016 (www.mopact.group.shef.ac.uk), has analysed a selection of case studies of social support and LTC initiatives across Europe, including three Italian experiences (Table 10). An in-depth examination of these case studies confirms that the integration and coordination issue is crucial for the improvement of

Table 10: Innovative experiences in the area of LTC integration and coordination

	Description	Policy	Stakeholder	Professional
Family Nurse Programme	The private company Finisterre provides health care services in many local health districts in the Lombardy region. The Family Nurse Programme idea is to create a group of LTC professionals able to respond more effectively to the various care needs related to chronic health conditions. The programme began in 2013 in the district of Saronno. The main activities of the family nurse are: direct hands-on assistance to patients in their homes through technical nursing interventions and rehabilitation; education and information to raise the awareness of patients and their primary care networks about specific requirements and options pertaining to their case; technical support to help family members in managing patients independently. The family nurse collaborates with municipal social services and primary care physicians, creating a network of interdisciplinary care.			■
Regional programme for the certification of informal care skills	Despite the lack of structured training, many informal carers and privately hired (mainly migrant) home helpers have often nevertheless accumulated important skills that are also required in professional care. Since 2008, the Piedmont region has run a programme focused on recognition and certification of care workers' skills, training programmes and activities to support formal employment contracts. The initiative aims to enhance the effectiveness of home-based care by privately paid migrant care workers. The programme includes an assessment tool to identify (informally acquired) skills and establish services to support and organize this process through certification and mentoring. It supports local networks of services for people with home care needs: including information, reception and orientation training, matching demand for home care with skilled carers and helping with administrative management of employment contracts. The programme also includes subsidies to households for temporary replacements of carers during training sessions.	■	■	
Up-Tech project	The Up-Tech project aims to reduce the burden on family carers of older Alzheimer's Disease (AD) patients through technology, in order to allow patients to live at home for as long as possible. It is currently being implemented in five health districts of the Marche region in Italy. The targets are AD sufferers and their carers. The main components of this project are: (a) employment of a case manager/social worker; (b) use of second-generation telecare devices at home; (c) establishment of a collaborative working group including different stakeholders.	■	■	■

Source: elaborations by authors based on Leichsenring et al., 2016 and Schulmann et al., 2015.

Italy's LTC system. Moreover, each experience often matches two typologies of integration and coordination.

This means that in Italy innovation in LTC tends to take shape if the integration and coordination strategy is applied on a multi-level basis, and if it grows up through a bottom up process, starting from local/regional experiences to reach the national level, and from professional coordination to policy integration.

5.3.2 Innovation Health Grants 2016: – findings emerging from the funded initiatives

The Forum of Italian Public Administrations organizes an annual event to discuss innovations in the health care sector (www.forumpa.it/sanita/s-at-lute-2016-il-forum-dellinnovazione-per-la-salute). In 2016, **ten** initiatives (from over 50 applications) were awarded funds to implement innovative solutions to improve integration and coordination in the area of LTC policies, services and care paths (Table 11).

Table 11: Initiatives selected for the 'Innovation and Health Award 2016' in the area of care integration and coordination

	Keywords	Declared focus on LTC	Integration and coordination areas		
			Policy	Stakeholder	Professional
Fiaso networks - (www.retefiaso.it)	Local networks, stakeholder collaboration, sharing experiences, observatory		■	■	■
Wildix (www.wildix.com/it/soluzioni-verticali)	Technology, case management, sharing information and emergency calls	■			■
Health agency in central Tuscany (ex Azienda sanitaria 10)	Case management by nurses; integration between social and health services			■	■
Badaplus (www.badaplus.it)	Technologies, smart phone app, communication and shared care data; integration between formal and informal care; support for care workers	■		■	■
Ac3	ICT solution for case management in residential care	■			■
Dotcuore	Vertical community social network; support to care workers in dementia care; shared experiences, materials and help desk with care professionals	■			■
Proactive networks for a chronic care model (health agency south east of Tuscany)	Case management; networks of local stakeholders; local governance		■	■	■
Like Home NGO (www.likehome.eu)	Online platform to match care demand and supply between families/care recipients and care workers/other professionals (physicians, nurses etc.).	■		■	■
FOR (training and opportunities for recovery) p(sychiatric unit, Brescia)	Training for caregivers, care workers and care recipients on mental care path; network of local stakeholders (including volunteering associations); integration between formal and informal care.	■		■	

Source: own elaboration by authors, based on unpublished manuscripts prepared for the MoPAct project.

The desk analysis of these initiatives largely confirms the findings emerging from the MoPAct case studies, in particular the following results:

- innovation in the field of integration and coordination is a bottom up process, often starting from specific experiences or organizations and involving policies and local regulation;
- case management is seen as the most effective tool to implement integrated strategies in Italy's LTC, but mainly if it is used via professional or stakeholders' networks;
- new technologies are often employed as a facilitating factor to promote communication and coordination between different stakeholders involved in care delivery;
- innovation in LTC coordination takes place more frequently in the area of home care than in that of residential care;
- the new 'Health Communities' mentioned earlier, promoted by the Tuscany Region, effectively support the widespread adoption of a coordinated strategy for care integration as regards local policies, services and professional profiles;
- the goal of coordination in LTC is mainly applied in the health care sector alone; only in a few cases is the social care sector also involved, while support services addressing informal carers are hardly ever included.

5.4 Conclusions

The challenges characterizing the integration and coordination of Italy's LTC services derive mainly from three structural divides: between the health and the social care sectors; specific partitions in the existing governance and delivery structures; and, above all, between formal and informal care. While the high level of fragmentation and the strongly healthcare-centered approach represent, on the one hand, difficult obstacles to improvement in this area, on the other hand the examples of innovative schemes promoted in many local and regional contexts show fertile ground for future developments in this area.

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