

National strategy for long-term care

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Introduction

The National Report on social protection and social inclusion policies is focused on some specific objectives tightly related to the development of a new effective long term care for the elderly Strategy.

Namely the National strategy indicates as priority:

- a. Determining the system of social rights in order to grant a better access to rights and services.** The objective shall be pursued by defining the basic levels of social assistance services, as provided by the institutional reform of 2001 but still missing, through a stronger cooperation with Regions. The Essential levels of Assistance (minimum standards), guarantee equality for all citizens in the social system. Their definition now appears to be increasingly urgent, bearing in mind the lack of territorial uniformity, which could be a cause of discrimination as regards access and the exercise of rights and the development that welfare systems have had in the different regions of the country without a common overview. The Constitution in fact sets out the "core" of welfare services that constitute a unifying factor for citizens against the risk of a fragmentation of society in various parts of the country.

National, regional and local institutions, as well as all the stakeholders, consider the determination of Essential level of care in the field of dependency, with special regard to ageing people over 65, the "priority in the priority", the real increasing emergency.

- b. The development of the services system** – strengthened and diversified – is essential for the construction of the system of rights. It is based on the framework of the welfare reform law (L. 328/2000), with the necessary "adjustments", due to the specific distribution of competences among central, regional and local governments. This means interpreting the concept of subsidiarity not as the indifference and disengagement of central Government, but as interaction between society and the institutions, and between different institutional competences: interaction aimed at providing services that can combine the universality of rights with the effectiveness of actual services. The aim is to develop a new model for governing the services system in order to promote actions for the cohesion, development and enhancement of competences and responsibilities of the local community, and that give priority to the individual and the family, taken as the real individual and his/her network of relations, with their corresponding, specific needs. The basic aim is to support the taking root of services in the reference community and the parallel ability to detect and handle all forms of hardship, via the reorganisation of the system to favour a qualitative and individualised

approach, capable of producing measures and actions to foment and support, through inclusion in rich, involved social relations, individual independence and capabilities.

As part of the development of the subsidiarity process, key importance is ascribed to organisational methods (such as *Single Point of Access*), which perform information, support and individual and collective activities to protect individual rights. It must become the real place for "taking persons into care" and consequently the first essential level of assistance. The "single point of access", in fact, is a service that aims to break down a number of barriers (psychological, cultural, and physical) to accessing the services due to the complexity of the system for offering such services, a lack of information and poor coordination of the agencies, institutions, and operating units responsible for offering these services, as well as a lack of transparency in terms of the criteria and procedures for gaining access to the same.

It is vital in this context to develop - corresponding with the essential level of care for dependency - determine, innovative services for taking care of persons in need of high level of support and their families, based on welfare/healthcare integration and the increase of home care services.

The services system must be built through the effective correlation of national, regional and zonal plans, with an increase in financial resources (from the National social policies fund) but also an improvement in cost savings and in the efficacy and efficiency of management, so that resources from the centre allocated to the periphery can boost the mobilisation of further public and private resources. The multiple good practices already in place nationwide will be valorised further, and the exchange of innovative experiences will be supported in order to bridge the gaps existing in different parts of the country.

There remain however considerable differences between different regions in the definition and supply of services. In addition to the lack of territorial uniformity, which causes the disparity of opportunities and real situations of discrimination as regards access to the system on the part of citizens, the National Report shows that the persistent shortage of services on offer, in particular those regarding child care and care for elderly people, also contributes to keep the rate of women's employment low (only 45 per cent of women are employed, 30 per cent in southern Italy), with negative effects on the potential rate of growth of the economy and with the consequence of a low birth rate.

1. Legal Framework

In the field of long care services for elderly people (over 65), specifically in condition of dependency, the actual national system and the organization of care services presents critical aspects, due essentially to the lack of integration between the social and health profiles, alongside with an increasing rise of very interesting and innovative practices at regional and local level.

First of all, we have to recall the law n. 328/2000 "Reform of social assistance system" which is built on some strong pillars. It has shaped a very innovative model of government of assistance anticipating in some ways the Constitutional reform of 2001 and inspiring most of regional development of care system.

Specifically:

- a. Reorganisation - on the basis of subsidiarity principle - of responsibilities among central, regional and local government, with a strong emphasis on regional competence in programming the interventions and in allocating financial resources; on local competence in providing the services and finally on the central competence in determining the Essential Level of Assistance;
- b. strong recognition of horizontal subsidiarity (not only in terms of participation but also in terms of supplying of services) defining also modalities of "accrediting " of private non profit organizations in the supplying of services and partnership between private and public sectors;
- c. urgency of realising a real integration between social and health profile;

Going deeply in the analysis, regarding the specific area of care services for elderly, the present situation is characterised by an asymmetry between assistance and health evident in terms of legal framework, of government responsibilities, of financial sources:

1. regarding the legal framework the Health system is regulated by the Essential Healthcare Levels (LEA), defined by the Decree of 2001 (D.P.C.M. 29.11.2001) which provide, inter alia, the services for elderly dependant people;
2. regarding the management of interventions and services, in the health sector it is responsibility of regional level (ASL) while the Municipalities are in charge of supply care services;
3. under the financial profile, LEA have defined the quota of expenses which is provided by the Health system (50%) and the rest is provided by municipalities and private citizens according to local determinations which can present strong differences from one area to another one, depending on the financial capacity of each local government.

This situation has stimulated the spontaneous growth of regional and local welfare systems different among them, characterized by different degrees of integration between social and health aspects. Some regions (specially in the north) are experimenting innovative and advanced integration models, other present models in which the barycentre is focused on the health government (by the ASL); others finally, are still experiencing a strong lack of integration (specially in the south). From an operational viewpoint, therefore, the problem is not so much the type and quality of services provided, rather the persistent fragmentation of healthcare and welfare paths facing the citizen within the healthcare and welfare system.

The supply system in the area of social and health integration is often comprehensive yet diversified over the territory. Diversification depends on the organisational and operational choices of the health authority's structures as well as the shortage in this area of welfare profiles and guidelines to steer the work of professionals towards appropriate paths to guarantee therapeutic continuity from the hospital to the territory.

However, the experience of some Regions of framework agreements with the system of local autonomies has made it possible to develop integrated social and health services. Reference should be made in this sense to the establishment of "ASL-Municipalities" programme agreements as set forth in Legislative Decree 267 of 18 August 2000, as an essential tool for achieving welfare and healthcare integration such as to ensure integrated homecare. Efforts are ongoing to make these experiences available to everyone, so as to really integrate, in favour of citizens, essential levels of social services and those of healthcare services included in EHLs,

setting aside for this purpose a portion of resources allotted for specific goals of the national health Plan.

2. The present development of long term care system

Italy's National Health Service (SSN) is a universalistic and solidaristic public sector system that guarantees healthcare to all citizens, ensuring access to services in compliance with the principles of personal dignity, the need for good health, equality in terms of access, quality and appropriateness of treatment and an economical deployment of resources.

Within the framework of Essential Healthcare Levels, the following services are particularly aimed at elderly people suffering from invalidating pathologies and patients requiring long-term assistance:

- a) integrated homecare: this is provided by district services of the local health authority and are aimed at elderly people or persons suffering from invalidating psychophysical pathologies. In addition to the regular presence of a general medicine physician, the service includes access at home to specialist services, nursing and rehabilitation services, welfare assistance and if necessary homecare with the contribution of Municipalities. The MMG (General health responsible – Meido cdi Medicina Generale) is globally responsible for intervention, coordinating the presence of other health and social workers and arranging specialist consultancy activity.
- b) assistance to non-self-sufficient or partially self-sufficient elderly persons in semi-residential and residential situations, at protected structures of varying levels of rehabilitation and care, which guarantee therapeutic, recovery and functional maintenance services, including relief actions (D.P.C.M. of 14 February 2001). Residential structures of particular worth in the healthcare sphere are RSAs (Healthcare Residences), defined as facilities for non-self-reliant persons that cannot be cared for at home.

The sending of workers to the above facilities is promoted by multiprofessional, multidisciplinary assessment Units – where present - operating within local health authorities. Guests of the structures in question are required to pay a contribution to cover a part of the charges, as payment for healthcare services and hotel-like comfort. The Municipality meets relative charges if patients have economic difficulties.

2.1. Provider body (public / private)

Both the social and health services, including all the area of integration of services, involve a wide range of suppliers including public, private profit and non-profit organisations, and voluntary associations. The internal composition of the welfare mix created by these changes over time and from one territory to another, and in Italy's case, is part of wide-ranging process of increasing local autonomy, which began in the early nineties, which gives exclusive competence for social assistance to the regional authorities. As part of this process, management of how services were offered also underwent "a trend that saw the role of local public institutions change, becoming less involved in producing the services directly and concentrating more on controlling the

relationship between planning for public services, controlling the allocating of provision of such services to a number of private subjects (companies and non-profit institutions), and assessing the quantity and quality of services supplied to the citizens”.

An analysis of the make-up of the social assistance services offered shows that there is a prevalence of private non-profit services nationally (nearly 60%), compared to public institutions and private profit organisations. This data varies from region to region, with a much lower percentage of non-profit organisations in the south (Basilicata is below 40%), and a very high percentage in the north (above 70% in Trentino – Alto Adige).

2.2. Healthcare accessibility and fairness

To ensure fair citizen access to services, there is firstly a patient evaluation conducted by the public authority on the basis of demand.

In light of this evaluation, the public authority indicates the services that the user is entitled to receive, methods for the delivery of said services and the structure called upon to provide them.

Types of services:

- personal services: these are traditional services provided directly to individuals by the Municipality or respective ASL;
- vouchers (or service vouchers): these are supplied by the public authority and guarantee the right to receive given services. The beneficiary will use them to “acquire” these services from one of the providers (public or private), authorised (accredited) by the public authority;
- treatment cheques: these are economic contributions supplied to elderly persons (or their families) to finance their healthcare needs. This contribution is provided as an alternative to personal, homecare or residential services, and is given to caregivers or used to acquire assistance from the private sector.
- “escort allowance”: this is the most important universalistic financial measure, provided by national fiscal resources, supplied to every person recognised in a high need of dependency due to non self sufficiency conditions and having a permanent disability . It is provided for 12 months for a medium income of 5.000,00 Euros circa, to 1.599.322 persons (70% of whom are elderly people) for a total amount of Euro 8.165.890.000, 00,

With reference to applications, the public authority gives priority to those who, on the basis of income level, cannot resort to other forms of support.

For persons suffering from disabilities, recognised on the basis of Law 104/92 or previous law provisions, the competent services assess the extent to which the service is suitable for the disabled person (D.M. 332 of 27 August 1999, “Regulations concerning prosthetic assistance services that can be provided as part of the National Health Service: delivery methods and charges”). Economic aspects and the user’s family situation are also taken into account. At the present time the income of the person recognised as being disabled is not accumulated with that

of the family, in order to assess the income only of the interested party and not the family's overall income.

The integrated system of social actions and services is aimed primarily at persons with serious needs.

The major access criterion is thus the actual needs of the patient.

3. The use of resources

3.1. Health resources

The 2005 finance law fixed, for the period 2005–07, the amount of funds to be allotted to the National Health Service. For 2006 the amount is 89,960 million Euros. Available resources, assigned on a priority basis according to the resident population per Region, translate to a quota per citizen of about 1,500 Euro (while the global amount is allotted, with reference to healthcare levels, as follows: 5% for prevention, 44% for hospital care and the remaining 51% for district care in the territory). The 2007 finance bill has set aside a figure of 96,000 million Euro for 2007.

Distribution criteria used to allot the per capita quota for 2006 basically refer to the total population, with some corrections basically to sections of the population that require hospital care. Funding for pharmaceutical expenses makes up 13% of total funding.

In recent years there has been an extraordinary increase in resources in absolute terms. The incidence of healthcare spending vis-à-vis GDP however has returned to levels last seen in the early 1990s, after a significant drop halfway through that decade. The GDP/health spending ratio, 6.3% in 1990, had fallen in the mid-1990s to 5.3%, before rising again in 2001 to 6.2%, and remaining at around 6.3% in the last few years. Current private sector healthcare spending grew considerably from 1990 to 1995, going from 17.4% to 26.2% of total healthcare spending, before falling in subsequent years and settling to an incidence of 21-22% from 2001 to 2004.

Despite the significant increase in resources, there have been and continue to be deficits, partly relating to historic phenomena, such as scientific and technological progress made in the field of medicine, the ageing of the population, a greater perception of the importance of health, the growing demand for services and inadequate investments in the sphere of prevention in previous years.

It must however be stressed that waste has continued to plague the sector in some areas. The savings that could be made in these areas are very considerable. It has accordingly been decided to accompany measures to raise financial resources with structural actions so that new resources made available by the State remain tied up with the fundamental goals of improving the National Health Service and its efficiency, objectives that are shared with the Regions.

For all Regions to abide by these constraints and provide the services included in EHLs, the rollout of plans is being controlled, and adequate corrective mechanisms are being put in place if conditions are not met. In other words, it is confirmed that if the services included in Essential Healthcare Levels are not provided or are provided poorly, if improvement objectives are not

pursued and if economic constraints are not observed, non-fulfilling Regions will be asked to draw up a verifiable recovery plan, which the interested Region must adopt to be able to obtain greater funding. In addition, adequate support will be given to help Regions that encounter significant difficulties in maintaining a stable budgetary equilibrium and in guaranteeing the delivery of services included in EHLs to raise their efficiency and ability to provide such services.

A number of committees have been created at the Ministry of finance and economics and the Ministry of Health, with the joint participation of Regions, to check the actual delivery of EHLs and regional healthcare spending.

The Health Ministry, in order to ensure that funding has actually gone to provide services for citizens, in accordance with efficiency and appropriateness criteria for the use of resources, has created a national healthcare control system (SiVeAS), which is designed to check the actual supply of services included in EHLs according to the above criteria, including checks on relative waiting times as well as on the achievement of established health goals.

3.2. The National Fund for Social Policies

This is the main tool for the centralised funding of social policies in Italy. Sums are determined annually by the finance law and distributed through a government decree, upon an agreement reached by the State with the regions, within the framework of a generic fund that allows Regions to set out their own specific priorities in keeping with social regional programming.

The distribution of financial resources is only the final stage of a complex procedure, dealing with the more difficult aspects of the State-Regions relationship, as outlined in the new title V of the Constitution. The Regions are responsible for establishing their investment priorities in the sector. It is worth noting that the monetary social services paid out by public and private operators in the assistance sector, account for about 70% of the total, and those in kind for about 30%. The latter drop to a little over 20% when one considers only public administration institutions.

More than half the cost of providing social services is paid out of the Municipalities' resources (which in turn are derived from bulk transfers from the state for all services and from local taxation), followed by the Regional Authorities (whose resources are obtained in the manner indicated for the Municipalities), while the State's contribution does not exceed 10%. The reallocation of the services among the various levels of government that took place in recent years had important repercussions on the forms of financing for services. As indicated by Istat, "The traditional Italian system of local finance based on the State's budget has been significantly changed in favour of a wider, more incisive granting of autonomy that was initially limited to the Municipalities, but has more recently been extended to regional governments and provincial administrations" For this reason the Government for the period 2007-2011 has placed emphasis on the importance of strengthening and reorganising the Fund in order to rationalise and raise the effectiveness of instruments needed for programming at both the state level and above all regional and local levels. In particular, state transfers for social ends must increasingly play a role in boosting the effective mobilisation of public and private resources in the territory¹. In this

¹ The report on the monitoring of social policies (I part, September 2005) (cf. chap.8) pointed out that transfers from the State and the Regions represented a minor but growing percentage of local expenditure, going from 15% to 18% from 1999 to 2003.

context, forms of financing are prepared that can reward initiatives undertaken by local autonomies. Confirming the primary aims of relaunching social policies – and relative expenditure – within a framework of macroeconomic equilibrium, the government has decided to intervene with a mid-year mini-budget², adding €300 million to the FNPS for the period 2006-08, thus taking it back to the 2004 level and ensuring a consequent reserve of resources in keeping with the set goals of social justice established in the DPEF.

For 2006 resources set aside for the Fund total approximately €1,625 million; and similarly for 2007.

3.3. Expenditure for Home-based services (Integrated Home care – ADI)

According to data collected by Ministry of Health – on one hand – and by Ministry do Social Solidarity and ISTAT we could have some ideas about the expenditure for long term care with specific regard to home-based services.

a. Ministry of Health:

1. In 2004 more than 314.000 ageing people benefited of ADI, the 16.4% of the ageing dependant population, but we register consistent differences among regions in terms of hours of assistance provided: 243 H in Valle d'Aosta and 12 of Friuli V. Giulia.

2005 the total amount of beneficiaries: 373.414 with a percentage of ageing people of 84.1.

Some analysis has contributed to the acknowledgment of expenditure:

Total amount: € 217 million.

The regional agency reports costs for home based services of 769 million €uros, comprehensive also of rehabilitation costs.

b. Ministry of Social Solidarity and ISTAT

Municipalities' expenditure in 2003

1. home care services: 401 million €
2. Residential structures: 502 million €
3. allowances, vouchers, ecc: 73,5 million €

Generally speaking 1:33 % out of GDP is allocated for long term care expenditure, but considering the persistent lack of integration also in terms of costs between sanitary and social aspects, these are the information available.

4. Quality: centrality of the patient and patient registration

The changing demographic situation has required an acceleration in the making of health policy choices in this field, also bearing in mind that the effects of an ageing population are compounded by changes to family set-ups, which have led to a drastic decline in the protective role of the

² L.D. 223 of 4 July 2006, concerning urgent provisions to boost the economy and society and to curb and rationalise public sector spending, as well as actions in the sphere of revenue and to combat tax evasion, converted into Law 248 of 4 August 2006, article 18, sub-section 2

family. Where present, the family, and women in particular, is/are weighed down by the difficulty in dealing with complex problems, sometimes alone, for which it is not always prepared, and that consume a considerable amount of time, energy and resources, especially in the case of “fragile elderly persons”, i.e. those capable of limited daily activities due to pathologies and slow functional recovery processes. The experience of some regions shows that if welfare and healthcare services can meet demand coming from chronic patients and non-self-reliant persons, then resources, especially female resources, are freed up for growth, and it becomes easier for women to take their full place in society and in the workplace.

Taking the experience of these years as a starting point, the priority aim of the SSN and the welfare system throughout the territory is to ensure that non-self-reliant elderly people are able to live in their homes, when the health, social, housing and social solidarity conditions allow it. Functional integration is being implemented between the various hospital and territorial components and healthcare and social services, with modalities provided for by existing legislation (local Plans implementing the recommendations of Zone Plans, and that form the basis of programme agreements between Municipalities and ASLs, and the Plan of territorial activities, breakdown of the programme agreement, etc.), to achieve common goals through the joint performance of actions and sharing of resources.

4.1. Quality standards

Of the various elements that go together to create the quality of the services offered to individuals in the social and health sectors (such as: needs analysis, adaptability to the individual beneficiary, transparency of information, involvement of the beneficiary in defining, monitoring, and evaluation tasks, the competence of operators, and other factors) Institutions highlight the relevance of the **Single Access Point** (Social secretarial service). This structure handles detailed, updated, and personalised information on the social resources in the territory and the procedures and means of access to them, as well as meeting the primary need of the citizens to:

- a) Be fully informed of their rights, the services, and the means of accessing the services, and
- b) Know about the social resources available in the territory in which they live, which may be useful in dealing with personal and family needs at various stages of life.

The purpose of the Social Secretarial Service is to guarantee the citizen’s right to be informed, in compliance with the universal logic behind our welfare system, in terms of the opportunities available and the social and social / health services offered in the territory, managed by public, private, and private social bodies, the procedures for gaining access to the same, and the relevant standards.

Currently, as part of the programme for reorganising the NHS action is currently being taken to implement “quality standards” and means of “social – health integration”.

Alongside these elements one can also list the mechanism of the most advantageous offer among the elements affecting quality, which is indicated by Law 328 as an “adjudication” criterion that public administrations can use in their procedures for externalising social services. Consequently, due to the fact that solidarity and competition go hand in hand, this area of exclusion brings about judgement criteria that are based solely on the price element. In compliance with the principles of publicity and transparency in action taken by the public

administration and free competition between private parties in dealing with it, limited, negotiated adjudication procedures are to enjoy precedence” and goes on to expressly indicate that in entrusting services the most advantageous offer in economic terms must be taken into account.

One important step towards creating a quality service is that of the accreditation institute, which involves a “... process by which an enabled subject evaluates an individual, an organisation, a programme or a group, and testifies to the fact that they comply with requirements such as essential standards or criteria for sound organisation. In the social services sector, *accrediting institutes* is one of the most important examples of the existence of market mechanisms for implementing social services since it presents itself as a regulating tool at the point of entry to the social market for subjects that intend providing services on behalf of the public, bringing about an on-going process of promoting and improving the quality of social services. By means of accreditation “the traditional instrument of authorisation to provide health and assistance services is abandoned, in favour of the use of structures offering the services that have shown themselves to be capable of operating in compliance with appropriate technical, professional, and organisational standards”³. In this way the person receiving assistance is given freedom of choice in approaching one of the accredited bodies, which are generally profit and non-profit organisations that fulfil the set requirements, and that have signed an agreement with the municipal administration.⁴ These requirements must have been laid down by law in the form of a legislative or administrative act on the part of the individual regional authorities, as indicated in art 5 of Law 328/00, and subsequently in the Decree of the President of the Council of Ministers of 30th March 2001, although to date this process has not yet been completed. In some territorial areas accreditation is up and running fully, while others are still at the stage of drafting regulations or in an experimental phase, while the authorisation process continues in all the other regions.

The main difficulty with these regulations lies in the fact that those in the social / health field that have to be accredited differ far more than in the health sector for example. Significant experience has been gained by Municipalities in defining accreditation standards and procedures at a municipal level, especially in the area of home-based services, where the use of vouchers it to be found. Currently there is a wide variety of solutions around the country, and these differ most of all in terms of the manner in which services are entrusted to others.

An other important tool that guarantees system-wide actions on the topic of subsidiarity is that of the *citizens charter*, which defines, documents and governs the rights and duties of citizens and administrations in terms of social services, reinforcing their identity and their sense of belonging to the community, establishing a veritable “pact” for the territory regarding the commitments and responsibilities for the participatory construction of social and welfare services. Special attention will also be paid to activities performed by the ombudsman, equal opportunities offices and anti-discrimination centres, with a view to optimising resources and integrating services.

³ Istat, page 38 op.cit.

⁴ In some cases, (Rome for example), the choice is made by the person assisted and is supported by the fact that the accredited subjects are listed in order of reliability.

4.2. In the health sector,

the Decree of the President of the Republic of 14th January 1997, which lays down the minimum structural, technological, and organisational requirements for public and private structures to provide health services, gives the regional authorities the power to determine the quality standards that constitute a further requirement for public and private structures that fulfil the minimum requirements for authorisation. In 1999 an agreement between the State and Regional Authorities was adopted on “determining the minimum standards to be met for authorisation to operate and accredit private assistance services for drug addicts”. These are used to provide guidelines that the regional authorities use as a basis for establishing the quality criteria and standards for accrediting bodies or associations to manage health or social services with a health aspect to them. Accreditation is a preliminary requirement for setting up a contractual and economic relationship between the bodies and associations and the National Health Service agencies, for purchasing health services to be provided to drug addicts. On completion of accreditation, the areas of the services that can be purchased (rather than types), based on the complete programme put forward by the body. The accreditation criteria proposed for both the public and the private sector in the understanding, include the obligation of adopting agreed auditing tools that have been checked scientifically and can be compared. Similar importance is given to gathering data on users, as one of a number of means of monitoring how the standards are applied. While allowing services to be purchased, in terms of the contract signed by the health agency and private subject, the accreditation system also defines limits in terms of the resources available, and the entire services system has to comply with these limits. This does not mean that private providers cannot provide services over and above those agreed with the agencies, but they may not ask for financing that exceeds the limits defined beforehand. In terms of the network logic, in defining regional programmes and the resulting resources, participation in the decision-making process by accredited bodies must also be provided for.

For the purposes of accreditation, the services offered by the bodies or associations that intend obtaining the same, the following service areas are grouped, based on the overall programme:

- 1) Acceptance services
- 2) Therapeutic / rehabilitation services
- 3) Specialist treatment services
- 4) Pedagogic / rehabilitation services
- 5) Integrated, multi-disciplinary type services.

Recently in the Health sector The State and the Regions have agreed on the need to:

- carry out the multiprofessional and multidimensional evaluation for patients suffering from more than one problem as an integrated approach to analysing their healthcare, mental, functional, relational and social needs in order to draw up the subsequent customised assistance plan, towards which all workers will contribute in their own field in accordance with certain responsibilities;
- identify the care manager for each patient;
- break down integrated home based services (ADI) into varying degrees of complexity, attributing responsibilities in terms of resources and results to the various actors involved;
- adopt the single homecare medical record;
- ensure continuous care, also making use of computer technologies and remote emergency service and remote care instruments for patients suffering from particular pathologies;

- promote and strengthen the coordination of healthcare structures and services forming part of the network of assistance for patients requiring long-term care in order to allow the global registration of the patient, the performance of actions within a single framework, the simple move from one node to another of the network as clinical and care needs change.

Some important initiatives of the past are continuing:

- the completion of the process to classify services/products and computerisation of homecare, carried out in a sweeping collaborative project between the State and Regions on the standardisation and classification of services (the "Bricks" Project) for epidemiological and managerial ends;
- the definition of service, process and outcome standards, in order to assess the supply of care to non-self-reliant elderly people throughout the country;
- the definition of authorisation and accreditation requirements for providers;
- the promotion of intermediate care (community hospitals, RSA units) for actions that are not appropriate for hospital and territorial levels;
- the promotion of fairness in relation to the access of elderly people to advanced medical technologies when necessary and appropriate, so as not to be guilty of "ageism" (i.e. age discrimination);
- relief actions in favour of families;
- the promotion of biomedical and clinical research into ageing, in particular on existing relations between fragility, pathology, co-morbidity, geriatric disabilities, also promoting the coordination of gerontological researches through greater cooperation among European countries.

5. Integrated planning: an effective system governance tool

Governance of the system can firstly be ensured through integrated planning, moving beyond sectoral programming, to capture new and different needs resulting from social, economic and cultural changes and prepare responses in terms of welfare and healthcare. An integrated approach adequately responds indeed to the complexity of health problems, starting with the analysis of needs and ending with intervention priorities.

In an area such as that of welfare-healthcare integration involving two different institutional sectors (S.S.R.s and Municipalities), the planning method is fundamental for defining strategy choices and priorities, with reference to cognitive bases, formed by needs present in the territory, the supply system and resources available in each sector.

Nevertheless, the preparation of planning instruments does not always lead in practice to a system of integrated actions coordinated at a territorial level, such as to steer within a single system the volume of existing resources in the welfare-healthcare area (social resources, healthcare resources, targeted regional funding, resources of local authorities, users' charges and other resources) towards areas of need and goals jointly deemed to be essential.

For the optimal organisation, management and deployment of resources in the sphere of social and health integration, it is accordingly necessary to identify and agree upon, at both a national and regional level, rules for inter-institutional cooperation at a local level, where different actors of

the system meet to discuss, from their own areas of expertise, and draw up programmes and projects in which to dedicate energies and resources.

6.1. The most recent commitment

In this context the crucial objective defined by the present Government since the very beginning and shared with regions in the framework of a renewed interinstitutional cooperation, is to enhance a new system for the treatment of dependency, starting from the elderly, through the determination of LESNA (Essential Level of care for the treatment of dependency) and the destination of specific financial resources for the implementation of new model of taking care of elderly depending people and their family when present. The enhancement of the integration and cooperation at the central level can ensure support to the development of innovative integrated model of "presa in carico" at the local level, specifically through the

- *Interinstitutional integration* which allow all the actors with political and high administrative responsibilities to work together,
- *Professional integration* allows workers in the different fields to meet the specific need of persons and families and to define effective and individual response tailored on the needs, granting coordinated and unitary.
- The financial law of 2007 has instituted the Fund for non self-sufficiency in the framework of definition of LESNA, with an initial budget of 500milioni euros for the 2007-2009 years.

The Government (the Ministry of Social Solidarity together with the Ministry of Health and Ministry of Family) is defining the bill for the determination of LESNA, for the allocation of financial resources.

It will provide specifically:

- a. Definition of criteria to define a person in condition of dependence, to assess the degree of disability and functioning conditions: it shall be provided according to a single scheme based on a multidisciplinary approach also adopting the classification of functioning and disability (ICF, WHO 2001);
- b. Definition of LESNA which shall refer specifically to the right to integrated information, to the creation of a "single point of access" to services, to the definition of the characteristics of "the taking care" through the definition of a personalised program of intervention in which is clearly shaped the typologies of assistance (that can have a more social profile or a more health profile according to the specific conditions of beneficiary, of his life conditions, and the specific need of his/her family), finalised primarily to allow ageing persons to remain at home or in case of high need of assistance to provide assistance in residential care services;
- c. Definition of criteria for the use of the Fund that will be divided among regions.
- d. Definition of a Plan of Action to support and to lead the implementation of LESNA respecting the autonomy of regions and local authorities in programming and organizing the services.
- e. Definition of the monitoring a informative system

7. From healthcare to health: health promotion, participation of citizens and healthcare as a resource

In recent years there has been a growing awareness of the need to foster a new vision of the country's healthcare policy, going from the concept of "healthcare" to that of "health". In this context social protection policies do not have the National Health Service as their only interlocutor. Health indeed is a marginal result (or unintended effect) of practically all the policies and actions relating to the goal of development. This effect however is almost always seen only after the adoption of said policies, and thus is not taken into consideration when the original decisions on single actions are taken nor when evaluating relative costs and responsibilities. In the environmental sphere alone the evaluation of the impact of different actions on health has been regulated by Health Risk Assessment procedures in Environmental Impact Assessment documents, even though these have quite a secondary role. Despite this, actual actions have produced numerous positive results, in the environmental sphere itself as well as in the field of human health. In the rest of the fields affected by development policies and actions (employment, welfare, town planning and infrastructures, education, technology, etc.), these unintended effects are almost always ignored, and do not serve to shape choices.

The adoption of correct lifestyles is also being promoted to promote health aimed at individuals. The general aim is to act on health determinants to reduce inequality connected with current socio-economic conditions, aware that combating poverty is the first instrument to be used to improve a population's state of health. Necessary actions are carried out by healthcare in collaboration with other institutions (schools, the business world, social, environmental, energy policies, road transport authorities, etc.), which are called upon to actively cooperate to achieve set goals, favouring citizen participation in health-related choices.

The SSN is aware of the importance of guaranteeing citizen participation, an instrument fostering the practice of democracy, in a broad sense, in terms of the direct participation of the patient in the choice of personal therapy and care and the participation of organisations representing the community, in particular associations of patients and their families, in deciding healthcare policies, and of enhancing the role of the so-called "third sector" as one of the elements that can supply welfare and healthcare services with costs met by the National Health Service. The SSN is aware of the need to form correct synergies between citizens and institutions to raise the quality of health services.

A communication tool that has been adopted is the Services Charter, a pact between the Health Authority and the community that sets out the quality and quantity levels guaranteed for services provided, the commitments undertaken and the instruments needed to dialogue with the institutions and express one's views and degree of satisfaction.

Then there is the Services Conference, a chance for discussion between the Health Authority and Citizen Organisations, so that the latter are given adequate space to be able to express judgements on services and proposals for their improvement.

In the stages of planning and evaluation of results achieved, and whenever relative matters are being discussed at a regional, authority and district level, consultations are carried out, including

forms of participation with citizens and their organisations, including trade unions and volunteer organisations.

An important instrument for participatory planning is the Standing Conference for regional healthcare and welfare planning. This ensures its connection with or inclusion in the body representing local autonomies. Taking part in the Conference are the Mayor of the municipality when the territorial ambit of the local health unit coincides with that of the municipality; the president of the Conference of Mayors, or the Mayor or the district presidents when the territorial ambit of the local health unit is larger or smaller, respectively, than that of the Municipality, and representatives of regional associations of local autonomies.

Institutions and non-profit organisations help, together with public institutions and similar bodies, to fulfil constitutional duties in the sphere of solidarity, ensuring the ethical-cultural pluralism of services offered to citizens.

The value added provided by volunteer groups is their ability to offer customised solutions to the needs of particular user categories, thanks to their greater flexibility and ability to integrate.

Finally, the role of the healthcare sector as a generator of economic development for the country has clearly emerged in recent times, with reference to four main aspects:

1. the health sector is a "business" engaged in managing a relevant number of human resources and relations with "correlated industries" formed by supplier firms;
2. the health sector encourages the creation of infrastructures in the territory, with the mobilisation of considerable financial resources and entrepreneurial concerns;
3. the health sector creates new economic entities, providers of healthcare and welfare services to cover growing demand resulting from demographic trends, i.e. the rise in life expectancy and the consequent increase in non-self-reliance and dependence at a territorial level and in terms of homecare;
4. the health sector gives impetus to technological innovation through the use of new medical and technological practices, equipment and innovative communication and telecommunication structures, and through the development of health-related biotechnologies.

Allegato

Regioni	Integrazione delle politiche
Abruzzo	Più assessorati e, dal 2000, due direzioni diverse (politiche sanitarie e politiche sociali). Pronto Abruzzo Sociale, Portale OSR. Gruppo di coordinamento per la definizione del modello distrettuale
Basilicata	Unico assessorato "Salute, sicurezza e solidarietà sociale, servizi alla persona e alla comunità". Unico dipartimento omonimo. Ciononostante, insufficiente integrazione politiche sanitarie e socioassistenziali e Piano Socioassistenziale 2000/02 non prevede interventi per l'integrazione. Fondo Regionale Politiche Sociali.
Bolzano PA	Piano sociale e piano sanitario. Unico assessorato alla sanità e al servizio sociale. Dipartimento alla sanità e politiche sociali. Altri Dipt. sono lavoro, innovazione e ricerca, cooperative, pari opportunità e formazione professionale italiana; formaz. prof. tedesca e ladina, diritto allo studio e università; famiglia, beni culturali e cultura tedesca; amministrazione del patrimonio, cultura italiana e edilizia abitativa. A livello territoriale, i distretti sociali si sovrappongono a quelli sanitari.
Calabria	Politiche sociali affidate ad un unico assessorato. Struttura organizzativa in cui le rilevanti responsabilità sono concentrate in un unico settore con un unico servizio. Distretti socio-sanitari, ma il PRS 2004/06 contrasta con quanto previsto dalla L.R. 23/03 in tema di integrazione delle politiche. In via di creazione il Tavolo Regionale integrato tra sanitario e sociale.
Campania	Debole integrazione tra Assessorato Politiche Sociali e Assessorato Sanità. Si rilevano quattro aree diverse competenti di politiche sociali. Esistono dei vincoli per la presenza di referenti ASL ai tavoli di concertazione e nel coordinamento istituzionale degli ambiti.
Emilia-Romagna	Assessorato politiche sociali e Assessorato sanità. Numerosi gruppi di lavoro interassessorili. A seguito dell'accorpamento delle direzioni generali, si è unificata la Direzione politiche sociali con quella della sanità. Coincidenza delle zone sociali con i distretti sanitari. Piano integrato Sociale e Sanitario 2005/07. Conferenza territoriale sociale e sanitaria e il Comitato di Distretto.
Friuli-Venezia Giulia	Unico Assessorato alla salute e protezione sociale. Indicazioni verso politiche integrate nelle Linee guida su PAT e PDZ. Unica Direzione centrale salute e protezione sociale. Conferenza permanente per la programmazione sanitaria, sociale e sociosanitaria regionale (ANCI, UPI, Federsanità-ANCI, terzo settore). Gli ambiti territoriali coincidono con i distretti sanitari.
Lazio	Previsti due distinti assessorati per politiche sociali e per politiche sanitarie. Un unico Dipartimento Sociale che include al suo interno diversi gruppi interdirezionali.

Regioni	Integrazione delle politiche
	La funzione di regolazione è trasversale alle varie direzioni. Identificato il distretto come dimensione privilegiata dell'ambito. Accordi di programma in ogni distretto tra Comuni e ASL sull'integrazione socio-sanitaria.
Liguria	Piano Socio-Sanitario dal 2004. Un unico assessorato alle politiche sociali, mentre sono tenute separate politiche sociali e sanitarie, oltre che quelle migratorie e del lavoro. A livello tecnico, un unico Dipartimento Salute e Servizi Sociali. Istituzionalizzazione delle zone nei distretti sanitari.
Lombardia	Assessorato alla Famiglia e Solidarietà sociale e Assessorato alla Sanità. Direzione Generale Famiglia e Solidarietà Sociale esercita funzioni in ambito socio-sanitario. Piano Socio-Sanitario Regionale. Attraverso gli obiettivi di governo regionale sono previsti momenti di collaborazione tra assessorati e direzioni generali.
Marche	Estrema frammentazione delle deleghe. Istituzione di un Comitato Tecnico Permanente tra servizi interni afferenti al sociale e al sanitario, tra soggetti privati. Piano Socio Assistenziale e Piano Sanitario. Integrazione socio-sanitaria su aree specifiche come anziani, ecc. Il Piano Sanitario riserva un posto importante all'integrazione socio-sanitaria. Gruppi di lavoro intersettoriali. Adeguamento dei distretti sanitari a quelli sociali.
Molise	Assessorati diversi per politiche sociali e sanitarie. Corrispondenza con le direzioni generali. Piano Socio Assistenziale Regionale (non ancora in pieno regime). Non esistono meccanismi di integrazione / coordinamento.
Piemonte	Piano Socio-Sanitario. Due assessorati diversi. Presenza di modalità concertative. Direzione regionale politiche sociali. Coincidenza distretti sanitari e sociali.
Puglia	Da poco approvata la legge, il sistema è in profonda evoluzione.
Sardegna	Unico Assessorato dell'igiene e sanità e dell'assistenza sociale. Direzione generale dell'igiene e sanità e dell'assistenza sociale. Piano Socio Assistenziale. Proliferazione di norme impediscono l'integrazione socio-assistenziale. Il distretto è stato riconosciuto ambito territoriale essenziale per l'articolazione delle politiche sociali e per l'integrazione socio-sanitaria. Si intende attuare una programmazione integrata tra ambito sociale e azienda sanitaria.
Sicilia	Linee guida per l'attuazione del Piano Socio-Sanitario. Assessorato famiglia, politiche sociali e autonomie locali. Assessorato sanità. A livello tecnico esiste alta suddivisione e difficoltà di integrazione. La funzione programmazione risulta integrata. Conferenza regionale socio-sanitaria (assessore sanità, province, AUSL, ANCI, Federsanità-ANCI). Commissione regionale socio-sanitaria. Scelto il distretto sanitario come riferimento territoriale per la costruzione ambiti territoriali. Città metropolitane

Regioni	Integrazione delle politiche (Palermo, Catania, Messina) determinano il proprio ambito quale Distretto Unico Socio Sanitario.
Toscana	Società della salute quali forme innovative di integrazione delle politiche sociali e sanitarie e di gestione associata dei servizi. Assessorato alle politiche sociali e Assessorato al diritto alla salute. Unica direzione del diritto alla salute e delle politiche di solidarietà. Gruppo di lavoro intersettoriale per la redazione dei piani integrati di salute. Definite le zone distretto socio-sanitarie.
Trento P.A.	Assessorato alle politiche sociali e assessorato alle politiche per la salute. Piano sociale e assistenziale con ottica interassessorile. Gruppi di lavoro su temi specifici.
Umbria	Piano sociale regionale. Unico assessorato sociale. Non sempre c'è corrispondenza tra deleghe e competenze direzionali. All'Assessorato Sanità e all'Assessorato Politiche Sociali corrisponde un'unica direzione regionale. Intenso lavoro interdirezionale che, insieme agli strumenti di programmazione regionale e locale garantisce un buon livello di integrazione. A livello territoriale, l'area dei servizi integrati socio-sanitari ha un duplice punto d'accesso (Centro di salute e Uffici di cittadinanza). Tavolo tecnico dei Comuni per l'integrazione socio-sanitaria su mandato della Conferenza permanente per la programmazione sanitaria e socio-sanitaria regionale. Ambiti territoriali coincidenti con i distretti sanitari.
Valle d'Aosta	Piano socio-sanitario. Un solo assessorato sanità, salute e politiche sociali ed un omologo dipartimento. Attualmente un distretto sanitario corrisponde a due comunità montane.
Veneto	Un Assessorato alle politiche sociali, programmazione sociosanitaria, volontariato e non profit e un Assessorato alle Politiche sanitarie. Piano regionale politiche sanitarie, sociosanitarie e sociali. A livello territoriale, trasformazione delle USL in Aziende unitarie locali per i servizi alla persona, che uniscono servizi USL e Comuni.