Combining choice, quality and equity in social services

Ministry of Labour

1. Introduction

The organisation of social services in Italy must consider the implications listed below:

1. Institutional changes, why in 2001 the institutional reform redistributed responsibilities between the central, regional and local governments, assigning to regional and local governments the activities involved in the planning and implementation of welfare policies;

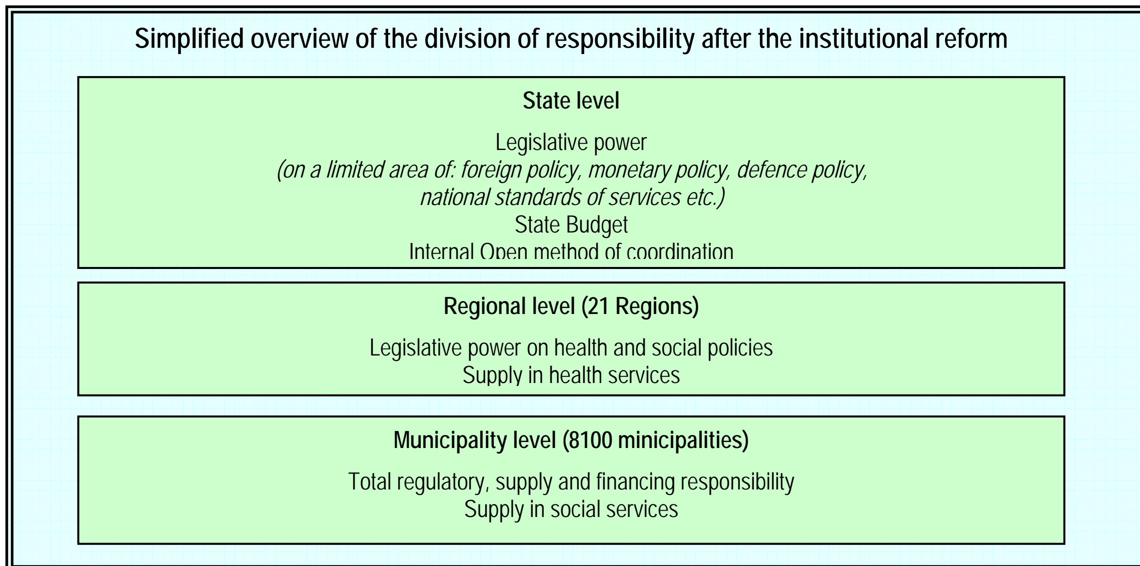
2. Demographical changes and, in particular, population ageing;

3. The need to reduce the gaps between regions, in terms of the noteworthy concentration in southern Italy of poverty and unemployment, as well as the uneven development of social, medical services and services for employment.

1.1 New governance on social services (federalist process)

The completion of the federal structure for Italian institutions, together with the definition of fiscal federalism, will require constant and gradual coordination not only of financial considerations, for the purpose of managing the national accounting system, but also of the subsequent institutional processes which must ensure uniform levels of guarantees for civil and social rights, doing so through local systems of social protection. Achievement of the objective of increased coordination of policies is facilitated by the current configuration of the Ministry of Labour, Health and Social Policies, which reflects the move in the direction of integrating in order to draw up programs of planning and guidelines that make it possible to overcome the fragmentation.

Within this framework, steps must be taken to reinforce an open method of internal coordination, through which – even in sectors where responsibilities and prerogatives are decentralised – joint objectives and national targets can be defined, strategies for financing the activities can be shared and procedures can be established for monitoring and controlling the results achieved, in addition to exchanging best practices.



1.2 Demographic trend

Italy is one of the countries in the world with the highest percentage of elderly population and, indeed, the number one in Europe. Moreover, in the forthcoming years the demographic old-age dependency ratio and the old-age index are set to increase further. It has been estimated that in 2030 over 65 year olds will account for 26.5% of the entire population, but the population of over 80 year olds, which already accounts for 5.3% of the Italian population, is the segment that will increase most of all. Therefore, as a result of the demographical trends, the number of disabled people can also be expected to rise (compared to 2,500,000 today), given the link between old age and disability, affecting one out of three over 80 year olds.

The above mentioned trends, combined with the transformation of the population structure, with a drop in the size of the age groups more frequently involved, within households, in looking after the elderly, the increase in the number of single-parent families, and the changed role of women within society tend to further amplify and boost the need for rethinking the present models of health care and developing new instruments for coping with change.

2. Elderly-care

In order to tackle the demographical and epidemiological transformations under way, and the serious related problem of financial sustainability, new models of governance are being implemented according to which:

a. the central government is responsible within a framework of loyal collaboration and sharing with the regional governments – for providing the financial resources for the National Health System (NHS), laying down the general health guidelines and strategies, and ensuring that all citizens receive the established levels of care, while it is the duty of the regional and local authorities to plan and implement the health system, in accordance with the principle of subsidiary and by differentiating and adapting services to respond to the new needs, while ensuring the applicable safety and quality standards;

b. the tools available to the local authorities for developing and implementing integrated policies are the so-called Area Plans, which encompass local social and health care projects, setting out – consistently with the guidelines set out by the local health and government authorities – the health and social care targets and activities.

Elderly people – due to their physical and functional disabilities – require more care, which in turn requires increasing economic, organizational and structural commitments. In this scenario, the need to culturally rethink the community approach to elderly patients can be kick-started by identifying several major criticalities:

- ensuring continuity of care between the community level and hospitals;
- properly targeting elderly patients in the various care settings;
- identifying the diseases and conditions that can be treated locally;
- providing geriatric training for the care professionals involved.

This can be achieved by:

- integrating health, social care and welfare policies;
- integrating the activities of the institutional (regional, local and health care authorities) and social stakeholders;
- integrating the available health, social care and welfare services;
- creating alliances between the public and private-sector service providers.

The first step consists in the overall reorganization of the different levels of care.
The latest Nationwide Collective Agreements signed by General Practitioners (GP) and Primary Care Pediatricians (PCP) are moving in this direction and encouraging the aggregation of health care professionals into forms of partnering aimed at promoting continuity of care, offering integrated services for up to 12 hours per day, exchanging and transferring knowledge and expertise and fostering professional growth. The forms of care for non-self-sufficient chronic patients remain those already provided for in the previous years' agreements:

- Planned Home Care (PHC) provided by GPs under schemes agreed to at the local level, targeting significant health needs, with periodical visits to patients;

- Residential Home Care (RHC) providing for periodical visits by GPs to residential care homes.

- Integrated Home Care (IHC), consisting of schemes aimed at meeting the complex care needs of persons who require social and health care on a continuous basis, with the provision of coordinated (medical, nursing and rehabilitation) healthcare and social care services (personal care, meals on wheels, domestic support) to the person's home, by a range of professionals, at the local level and under the general supervision of the GP.

The problem with the above system, however, is that the focus is still on the services provided and not on the needs of the person. Patients receiving PHC services, in fact, have needs of differing complexity that can only be met by implementing individually tailored plans, by a range of professionals, subject, however, to the ultimate responsibility of the GP. To achieve this, a project is under way, at national and regional level, aimed at breaking up the IHC system into uniform care subsystems and programs for terminally ill patients. The project provides for 3 levels of integrated home care, based on the complexity and intensity of the required care, in accordance with an Individual Care Plan (ICP), formulated on the basis of an overall multidimensional assessment and provided through a multidisciplinary and multi-professional team; the "palliative home care services for terminally ill patients" are characterized by an intensive approach to the

highly complex needs enshrined in the ICP, and are provided by a team of qualified professionals.

These services, together with:

- Home care services, featuring the provision of either individual nursing and/or rehabilitation services of an occasional nature, or treatment cycles that do not require special technical or professional arrangements, nor multidimensional assessments and the consequent formulation of Individual Care Plans;

- "Home hospitalization" schemes, according to which the hospital cares for the patient at home, providing the necessary staff, drugs and equipment, in the case of high-intensity needs. This is a form of "highly complex care, with a defined duration, provided at the patient's home by a team of hospital consultants, according to a global approach and typically hospital procedures and technologies".

cover the field of "home care", meaning the full range of medical, nursing and rehabilitation services provided to non-self-sufficient and frail persons, suffering from a disease or condition in progress or the effects thereof, with a view to stabilizing the patient's clinical condition, curbing functional deterioration, and improving the overall quality of daily life, through a care approach by a multi-professional and multidisciplinary team that also includes social care operatives, periodical monitoring and the assessment of results.

Another important sector for long-term care is that of **residential home care.**

Since the end of the 1980s (when measures were passed for building residential care homes for the elderly and non-self-sufficient), both public and private residential homes have increased up to the present estimate of 300,000 beds.

However, it is hard to make an accurate estimate due to the different ways in which these facilities are classified by the single regions. The current definition of Residential Care Home (RSA, *Residenza Sanitaria Assistenziale*) has, in fact, taken on considerably different meanings in the various regions.

This is why, at national and regional level, attempts are being made to define the activities of these facilities, allowing a distinction between the various types of residential care facilities, and between these and rehabilitation and long-term hospital care facilities, also with a view to ensuring fair costs, prevent the overlapping of competencies, and inappropriate admissions. Long-term care, or similar functions, in fact, can be provided:

a) in hospitals (in the low-care areas of multi-speciality hospitals);

b) in hospitals undergoing reconversion (community or "cottage" hospitals), providing diagnostic services and specialist outpatient units;

c) in non-hospital facilities qualifying as residential homes.

Within this framework of differentiated services a key role is played by **multidimensional assessment (MDA),** for defining the integrated set of patient needs, including health, social and psychological care, and social security and welfare services, provided by health and social

operatives, with a view to formulating the Individual Care Plan based on criteria of effectiveness and appropriateness.

Italy has not yet adopted a single multidimensional assessment tool and, until several years ago, in most of the country, the choices were made by the members of the teams of professionals involved. In the last two years, assessment tools are being increasingly adopted at regional level, which, however, still does not help the development of uniform nationwide systems for the assessment of non-self-sufficiency. While awaiting the development of a system focused on the specific needs of the person, rather than on his or her disability or condition, the International Classification of Functioning, Disability and Health (ICF) adopted by the World Health Organization, could turn out to be a precious tool for accurately identifying the functionalities of the person, pushing the diagnostic criteria for assessing the person's disability into the background.

In recent years, new means for supporting families caring for non-self-sufficient persons have been introduced, consisting of ***benefits*** for social and health care, or social care alone, to support patients in their homes or for broader care support (for example, the regional government of Veneto has set up a fund for home care services), besides providing ***social and health care vouchers*** for purchasing care services from accredited public and private-sector providers.