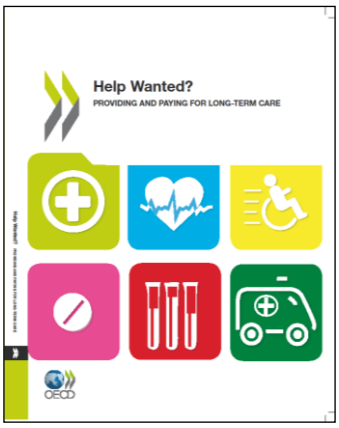
Italy

Long-term Care

18 May 2011

Highlights from
Help Wanted? Providing and Paying for Long-Term Care, OECD Publishing, 2011.



- Nearly one every seven persons in Italy will be aged 80 years or over by 2050, the fourth highest proportion in the OECD after Japan, Germany and Korea. In light of no clear signs of reductions in disability among elderly populations across the OECD, this is likely to drive a growth in the demand for long-term care (LTC).

- Italy relies to a large extent on caring provided by family. However, growing female participation in the labour market and other social changes will challenge this model. The share of the working-age population relative to the total population in Italy will be the third lowest in the OECD by 2050, reducing the pool of both potential family carers and paid care workers.

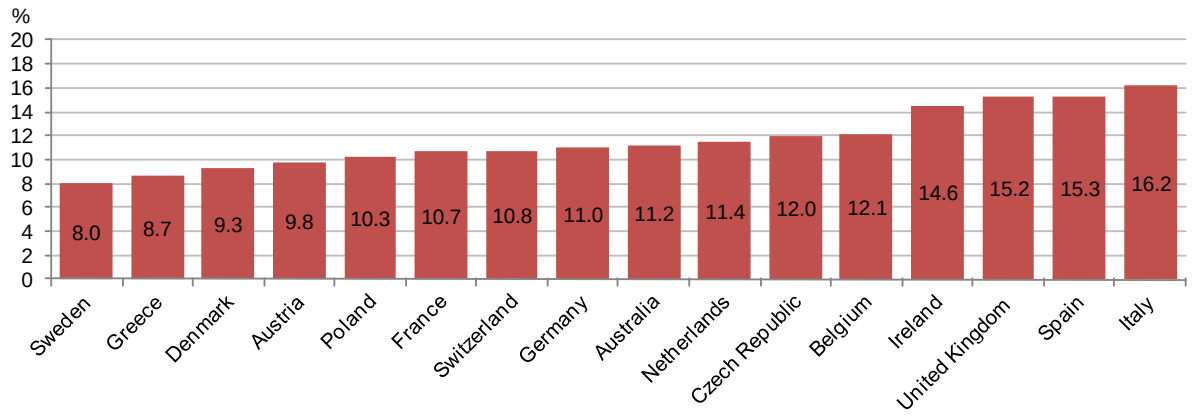
- Italy public expenditure on long-term care as a share of GDP, currently estimated at 1.7%, could reach 2.6, and up to nearly 4% of GDP by 2050.

- Italy could better encourage reconciliation of caring duties with work. Family carers is Southern European countries are more likely not to be in work than those in other parts of Europe, Australia or the United States. Supporting carers will be beneficial for carers, the care recipient, and public finance.

- In Italy, LTC services are provided through multiple institutional arrangements and level of governments, with no general legal frameworks. Considerations could be given to improving co-ordination across social and health care services and across different authorities. In France, for example, the *Caisse nationale de solidarité pour l'autonomie* was established to facilitate co-ordination and common standards.

- Cash-for-care benefits, such as the *indennita di accompagnamento*, maximise choice and independence for the people needing care. However, the lack of uniform need-definitions across Italian regions may generate unmet needs in some places. Making the level of the *indennita* contingent upon both need and ability to pay would help to ensure fiscal sustainability while providing fair protection in the long run. Better regulation on the way cash benefits are used would also help control the development of irregular or black care labour markets. In light of the large number of migrant care workers, Italy should also consider providing work permits in number commensurate with the labour needs. Developing sufficient, quality in-kind care services would also help to avoid the use of hospital services for LTC needs.

Italy has the highest share of the population providing family care to an elderly or disabled person



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OECD (2011), *Help Wanted? Providing and Paying for Long-Term Care*, Paris
www.oecd.org/health/longtermcare and www.oecd.org/health/longtermcare/helpwanted

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Key Facts

- Italy is one of the oldest countries in the OECD. About 20.4% (OECD average 15%) of the Italian population is aged over 65 and about 5.8% (OECD average 4%) over 80.
- In 2007, Italy's public expenditure on long term care was estimated at 1.7% of GDP (EUR 25.6 billion), of which 27% is devoted to institutional care, 30% to home and semi-residential care, and 43% to cash benefits (Tediosi and Gabriele, 2009).
- In 2008, there were 6 long-term care recipients per 1000 population in institutional settings, and 8 per 1000 population in home settings (a comparable figure to that of Spain and below the OECD average). (OECD Health Data 2010)
- In 2008 approximately 4,9% of Italy's population over the age of 65 received LTC at home; and 3,0% of the population over the age of 65 received LTC services in institutions (IRCCS-INRCA, 2010).
- In 2007, there were 16 long-term care beds in institutions per 1000 population aged 65 and over (one of the lowest in the OECD) (OECD Health Data, 2010)

Background

The long-term care (LTC) system in Italy is characterised by significant institutional fragmentation. This would also be true for the health care system. In principle, the idea of a general national framework within which the Regional authorities set up their system is not necessarily a bad thing. Indeed, they can better shape the system with respect to the characteristics of the population located in the different Regions. The main requirement however is a proper and well designed "general framework" that in Italy is quite silent on LTC.

The funding, governance and management responsibilities are spread over local and Regional authorities, with varying principles regarding the institutional models of each Region. The organisation of LTC services is directly determined by the Municipalities, Local Health Authorities (*Aziende Sanitarie Locali*, ASL), Nursing homes (*Residenze Sanitarie Assistenziali*, RSA), and the National Institute of Social Security (*Istituto Nazionale Previdenza Sociale*, INPS). Other actors, such as the central State, Regions and Provinces, are involved in the planning and funding of these services. LTC is delivered by both public and accredited private providers of health and personal social care. Thus, there are many regional LTC systems rather than one national LTC system in Italy (Tediosi and Gabriele, 2009).

Benefits and Eligibility Criteria

Since 1980, INPS provides a national disability cash-benefit scheme, funded by the central government out of general taxation (*indennita di accompagnamento*). This universal benefit is neither linked to the beneficiaries' payment of social security contribution nor to a means' test, and it is not subject to age restrictions. There are no requirements or restrictions in the use of the cash benefit for the purchasing of LTC services, which can be used as income support, to pay a home-based LTC workers, or compensate family caregivers. The cash benefit is provided every month.

To be eligible to receive this cash benefit, beneficiaries must be assessed of being 100% disabled and non self-sufficient and must not reside in institutions with costs charged to the public administration. The ASL together with the Italian National Health Service (Servizio Sanitario Nazionale - SSN) are responsible for the needs' assessment, which is carried out by multidisciplinary teams. The need severity, however, is assessed differently across Regions, resulting in different number of recipients across regions. Each Region has a specific classification system and differences may even be observed also within each Region. After the needs' assessment, the individual is referred to an INPS Commission, which makes the final decision.

Over the years, the number of recipients of the cash benefits has grown significantly, from 2.7% of the over 65 years old population in 1984 to an estimated 11,9% of this population group in 2007 (IRCCS-INRCA, 2010). Nearly a fourth of the recipients are aged over 80 years (2008) and 70% are women. In 2009, the

monthly allowance was equal to EUR 472.04, and the total estimated cost for this benefit was EUR 12,6 billion in 2010 (IRCCS-INRCA, 2010).

In addition to the *indennita di accompagnamento*, since the early 1990s ASL and local authorities provide means-tested care benefits (so-called "assegni di cura"), without restrictions in the use. The monthly amount of this benefit varies from EUR 240 to EUR 515 depending on the region, and the share of over 65 years old receiving this allowance is generally below 2%.

The Italian health system (*Sistema Sanitation Nazionale, SSN*) also provides in-kind health services to the elderly and disabled individuals, including outpatient and home services (*Assistenza domiciliare integrata, Adi*), residential and semi-residential services (*Presidi sociosanitari and Centri diurni)*, psychiatric services and services for those with alcohol or drug addiction problems.

Social care services are provided at the local level, including in kind interventions managed by municipalities, both home-based (*Assistenza domiciliare sociale, SAD*) and in institutions (*Presidi socio-assistenziali*). Similar to the cash benefits (*assegni di cura*), the eligibility criteria for these regional and local care services are quite heterogeneous. The needs' assessment, generally, is under the responsibility of the Evaluation Units, which are composed of members of the Municipality in charge of social services. An income assessment also takes place, based on an Equivalent Economic Situation Indicator (ISEE). This is a tool combining income and assets, used to assess the economic household condition of the beneficiaries. The eligibility criteria may be set at the local level, or fixed by the Regions, or sometimes they may be mixed.

Finally, INPS provide invalidity pensions as an income support to non self-sufficient individuals. These are not social benefits, but rather they belong to the pension system (Tediosi and Gabriele, 2009).

Funding and Coverage

LTC services in Italy are funded by the SSN, the Regions/Municipalities, the INPS and by users. Funds provided by the SSN, the Municipalities and the INPS come from general taxation. All LTC health services funded by the SSN are free of charge and patients are not required to pay co-payments.

Home care provided by social services (SAD) and institutional LTC are funded by the municipalities and beneficiaries are charged a co-payment, based on a means test. Co-payments may be required from both the users of LTC services and their relatives (Tediosi and Gabriele, 2009). According to IRCCS-INRCA (2009), nearly half of total spending for LTC was accounted for by the universal cash benefit in 2008, 40% was for health-related LTC services and, 11% was for local social benefits.

Family caregivers

A significant part of LTC is still provided by family caregivers, particularly in the Regions where public LTC services are less developed and families cannot afford the cost of private services. The ESAW survey results show that 11% of people over 50 years (about 2.3 million) provide care to an older dependent relative (Tediosi and Gabriele, 2009).

There is a strong north-south divide. An interesting indicator in this respect could be the number of beds per inhabitant in Care, Residential and Nursing Homes, which can be difficultly explained only by the different age structure of the population in northern and southern regions. This, in turn, determines an over-hospitalisation of the elderly and stronger inappropriateness of the treatments.

LTC workforce

Formal LTC workers consist to a large extent of foreign-born, home-based caregivers working on a 24h schedule. This is due to a combination of factors, including the universal cash-benefit system, a fast ageing population with increasing female labour participation, and geographical proximity to low-wage countries, coupled with entry via legal channels, illegal border crossing and overstay.

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In 2010, approximately 72% of all care workers were foreign-born; and of the privately-paid home-based caregivers, 90% were foreign born (IRCCS-INRCA, 2010). Recently, some regions implemented registers for family-care assistants, while local councils installed social care helpdesks.

Home-tutoring initiatives and training courses to further educate and train the migrant care workers have been started at local level. Their content varies and certification has no wider value. Regions such as Abruzzo and the Veneto Region introduced further incentives for legalisation of foreign-born LTC workers.

References

IRCCS-INRCA (2010), *L'assistenza agli anziani non autosufficienti in Italia, 2o Rapporto IRCCS-INRCA 2010*, Maggioli Editore.

OECD 2009-2010 Questionnaire on Long-Term Care Workforce and Financing

OECD (2010), *Health Data 2010,* Paris

OECD Social and Labour Demographics Database 2010.

Tediosi F. and Gabriele S. (2009), Work *Package 1: Overview of long-term care systems. Country report: Italy*, Project "Assessing Needs of Care in European Nations (ANCIEN), Istituto di Studi e Analisi Economica,Rome.
http://www.ancien-longtermcare.eu/sites/default/files/WP1_countryreport_Italy_2%20(2).pdf