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LONG-TERM CARE IN ITALY

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1. The LTC system of Italy

1.1 Overview of the system (summary) (including the philosophy of the system)

In Italy social care and integrated social-health services are assuming an increasingly relevant role due to: a) the rapid growth of demand for long term care services and, more generally, for health and social services for elderly people, caused by the rapid ageing of Italian population; b) the changes in the family structure; c) other socio-economic changes – namely the increase in female labour participation.

The LTC system in Italy is characterized by high institutional fragmentation, as sources of funding, governance, and management responsibilities are spread over local (municipalities) and Regional authorities, with different modalities in relation to the institutional models of each Region. The actors directly involved in the organization of LTC services are 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*), but other players are involved in planning and funding these services – i.e. the central State, Regions and Provinces. Additionally, in Italy a significant part of LTC expenditure is funded directly by households. Moreover, a large part of care giving is still provided by informal carers, especially in the Regions where public services are less advanced and in families which can not afford the cost of private services. Privately purchased home care is often supplied by immigrants.

In Italy, public LTC for older people includes three main kinds of formal assistance: community care, residential care and cash benefits. The Italian National Health Service (*Servizio Sanitario Nazionale - SSN*) plans and manages, through Local Health Units (*ASL, Aziende Sanitarie Locali*), home health services – the so called integrated domiciliary care (*Assistenza Domiciliare Integrata – ADI)*- and other health services provided in residential settings. Personal social services - domestic and personal care tasks provided at home (*Servizi di Assistenza Domiciliare, SAD)* and institutional social care - are managed at a local level by Municipalities, though this should be planned in coordination with ADI. LTC is delivered both by public and accredited private providers of health and personal social care. Health services provided by the *SSN* are free of charge whereas social care is means-tested and users can pay up to the full cost of it. National and local taxation are the main funding sources of public LTC.

The National Institute of Social Security (*INPS*) provides a cash benefit (*indennità di accompagnamento*) to disabled persons, independently from their economic conditions. This cash benefit is not directly linked to an obligation to purchase goods or services aimed at improving the personal condition and can thus be used to compensate household for informal care. Nevertheless the *indennità di accompagnamento* is usually considered part of LTC expenditure in Italy, unlike invalidity pensions. Other cash benefits are provided by some municipalities, but these are usually means tested.

LTC in Italy is also characterized by a wide variability among Regions and areas in both funding levels and structure of services supply. In Italy, thus, rather than one national LTC system there are many regional LTC systems. Municipalities' expenditure is, for instance, very heterogeneous, though information available is poor. For instance, data coming from the National Institute of Statistics (Istituto Nazionale di Statistica, ISTAT) survey, report that in Italy municipalities' expenditure on social services was, in 2005, on average around €117 per capita, ranging from €34 in Calabria Region up to €253 in Friuli Venezia Giulia region[1]. This data presents many limitations and can thus only provide an indication of the interregional variability. Total expenditure per person institutionalized in residential institutions for elderly people vary widely by regions, as the proportion funded by public institutions, namely the SSN and municipalities. The structure of LTC services supply varies widely by Region too. For instance, the number of elderly persons institutionalized varies from 500 per 10,000 inhabitants aged 65 and over in Trentino Alto Adige down to 48 in Region Campania (see Table 9 in paragraph 3.4). The number of elderly persons receiving home health services ranges from 2.7 up to 89 per 1,000 inhabitants aged 65 years and over (see Table 10 in paragraph 3.4).

Generally speaking, in Northern Italy the culture of public service in LTC is rather widespread, also due to the high female participation in labour market. These Regions – and Municipalities – have been making an effort to improve their LTC system, thanks also to their more developed management capabilities and their larger economic resources. In the South, on the contrary, the care burden rests mostly on families, with poor public support. Anyway the demand for a general, national LTC integrated system – though with a decentralised management responsibility - seems to be strong all around the country and the debate on possible reforms have been going on since the early '90s.

The law 328/2000 determined the main objectives of LTC policies, requiring setting up a minimum level of social care services to be provided throughout the country. The National

Health Plan 2006-2008 identified strengthening home care – instead of institutional care - as a first priority and claimed to reinforce cooperation between institutions and formal and informal groups in order to improve care. Nevertheless, the regional objectives differ as their commitment is different, and a national reform is still lacking. Even the "essential levels of services" (LES) - i.e. the national standards – have not been set, and therefore the entitlement has not been settled. The main obstacle to a comprehensive national reform of LTC is the funding, given Italy's high public debt, together with the political preference for different policies to support households, such as fiscal benefits and/or cash benefits, with a more direct and immediate impact on people perception.

1.2 Assessment of needs

In Italy there is not a single national legal definition of persons in need of care to refer to. In order to obtain the Cash benefit provided by *INPS (Indennità di accompagnamento)* a claimant must apply to the *ASL* in charge of deciding whether the health requirement (in term of disability and non self-sufficiency, see next paragraph) is present through its Medical Commission. If this is the case, the claimant is referred to a *INPS* Commission, which makes the final decision.

ASLs of the *SSN* are responsible to assess the degree of disability of citizens living in their catchments area, but their criteria are not homogeneous. For most health and social services assessment of needs is carried out by a multidisciplinary team of *ASL* – in most of them the Geriatric Evaluation Units (UVG, *Unità di Valutazione Geriatrica*) -, including doctors, nurses, social workers, sometimes administrative employees. This team in some cases classifies the claimants into different levels of need, set the care plan and chose the kind of provider. On the contrary, in Lombardia the citizen freely chose the providers, which can classify claimants according to their need.

The severity of need is assessed differently by Regions. Each Region has a specific classification system and sometimes the Regions present some differences inside them. Usually these multidimensional evaluation processes are built on validated international standards, for example SVAMA[1] (Veneto) and VAMA (Trento province) which include the BARTHEL ADL standard; VAOR (Abruzzo, Basilicata and Calabria); BINA (Emilia Romagna and Friuli Venezia Giulia); SOSIA (Lombardia); AGED PLUS (Liguria);

[1] S.VA.M.A. ("Scheda per la Valutazione Multidimensionale dell'Anziano") includes the following dimensions: health, self-sufficiency, social relationships, economic condition.

"Scheda VITA" (Bolzano Province); MDS (minimun Data Set) ADL LONG FOMR (Toscana). In all of these processes instrumental abilities have a secondary role, they are not taken into consideration or they are evaluated but not used to calculate the level of need.

Starting from ADL, the classification is supported by other evaluation systems, for example the “health condition” as CIRS –Cumulative Illness rating Scale-, or ICD IX - International Classification of Diseases- o ICPC- International Classification of Primary Care-. From a regulatory point of view, there is a renewal of all the evaluation procedures, oriented to a multidimensional approach, after the creation of the LTC National Fund, but there is no indication carrying a classification and evaluation system homogenization[2].

1.3 Available LTC services

In Italy the LTC system, including health and social care services and cash benefits, consist of three components:

- Health services to elderly and disabled people, including both outpatient and home services, semi-residential and residential services, psychiatric services and those to drug and alcohol addicted patients.
- Cash benefits (*indennità di accompagnamento*) provided (and funded) directly to all disabled persons by *INPS*, independently from their age and economic conditions. This monetary aid is not directly linked to purchasing of LTC services, but is generally considered part of LTC system. In fact, the *Ragioneria Generale dello Stato* (State General Accounting Department), Italian Ministry of Economy and Finance, includes this item in the public expenditure for LTC in order to estimate the long term projections on public expenditures, as agreed in the EPC-WGA (Economic Policy Committee – Working Group on Ageing), following the OECD guidelines[3].
- Social care services provided at local level: group of interventions, mainly in kind, managed by municipalities; these interventions are provided in institutions such as nursing homes for elderly people or in semi-residential institutions or as home care services. In addition to in kind interventions there are some limited cash benefits provided by municipalities.
- In addition to these three components invalidity pensions provided by *INPS* could be included in the LTC system as they are, de facto, a long term income support tool to non self sufficient persons. However, invalidity pensions are not included in

the *Ragioneria Generale dello Stato* and EPC-WGA assessment of public LTC expenditure, since they are not social benefits, but rather they belong to the pension system.

The national cash benefit scheme, funded by the central government out of general taxation, is a universalistic intervention, neither linked to the payment of social security contributions nor means-tested. Persons eligible for this cash benefits must be: a) assessed as being 100% disabled and non self-sufficient - i.e. being unable to walk without the permanent help of a companion or not being able to carry on the actions of every day life, and being in need of continuous assistance; b) not in residential institutions with costs charged to the public administration. This cash benefit is provided every month, beneficiaries are free to use it to purchase LTC services or not, and in 2009 the monthly benefits was €472.04.

Regions, Provinces and, most frequently, Municipalities fund also other types of cash benefit to households of non self sufficient persons but there is high variation in both level and nature of this cash benefit across Italian geographical areas. These cash benefits can be either linked to purchasing of services or not. These types of cash benefits are increasingly relevant in some Northern Italian Regions, and started to be provided at the end of the 80s and during the 90s became more widespread, mainly supporting home care.

Italy does not have any national legislation concerning cash benefits to households in order to support the care of their relatives. These cash benefits were originally thought as a measure to support relatives – typically spouses or daughters/sons of the elderly person - while now are mainly targeted to co-fund private home helpers and carers[4]. These cash benefits are provided both as mere monetary support or integrated with the other personal and social services provided by the local authorities[5].

Regional and local LTC services and cash benefits eligibility criteria are not homogeneous. In general the Evaluation Units, besides the multidimensional assessment of the need, decides on the accessibility to some home or residential services. Members of the Municipality (or municipalities associations), in charge of the social services, are included in the Evaluation Unit, or work in agreement with the ASL. The evaluation concerns both the health and the social factors. The economic situation is often valued through ISEE (Equivalent Economic Situation Indicator, a tool to assess the economic household condition that combines income and assets). For cash benefits the access criteria in some cases are set at the local level (Municipality or ASL), in some other cases

are fixed by the Regions, sometimes are mixed (the Regions set an ISEE threshold and some broad evaluation criteria)[6, 7].

1.4 Management and organisation (role of the different actors/stakeholders)

The organisational structure of the Italian LTC system is split between the two sectors involved in LTC, *SSN* authorities and Municipalities.

Services provided by the SSN

Under the Italian Constitution, health is a guaranteed right and the *SSN*, founded in 1978 (replacing a system of health insurance funds), aims at providing uniform and comprehensive care, financed by general taxation.

The *SSN* has undergone major reforms in the last 15 years, including decentralization of health policy responsibilities to the intermediate level of government (21 Regions, in average with a population of 3 million people). The Central government has exclusive power to set system-wide rules and the health services that must be guaranteed throughout the country—i.e. the *SSN* entitlements. Regions have responsibility for the organization and administration of publicly financed healthcare through the *ASL[8]* and for capacity planning, even if the central Government often imposes bonds and parameters (like a maximum ratio bed/residents, a ceiling for pharmaceutical expenditure, etc). Nevertheless, Regions with high debt and unable to contain *SSN* deficits must undergo Budgetary Balance Plans to be agreed with and to be implemented under strict control by the central Government. The central Government is responsible for monitoring the provision of services, but actually there is a lack of concrete actions in this field. Regions are also responsible for quality control on private accredited providers.

ASL are in charge of delivering or purchasing health-related home services (nursing, physiotherapy, specialists and GPs' visits etc), residential health care and other long-term care services for the elderly (e.g. hospital long stay and rehabilitation stay in hospital or other residential settings). Health community services are in most Regions managed by health districts, local articulation of *ASL*.

ASL fund health services provided to patients by public providers and by private accredited providers (e.g. residential services). Regions set the payment system in

residential services that in most cases is based on a fee per day of stay. Patients are in principle free to choose among public and private accredited health service providers.

Personal social services

In Italy personal social services are still under funded by the public sector and there are huge differences between areas of Italy in the quality and quantity of the services provided.

According to Law 328/00 Regions exercise the functions of planning and coordination of social services, as well as of implementation checking. In the 2000' many Regions have approved or modified their framework laws on social services and other planning documents, sharing the planning and management responsibilities with the Municipalities (or their associations) in various and different ways and measures[9].

The delivery of services is mostly regulated by regional legislation, but even within the same Region the services provided differ widely among Municipalities. The latter are responsible for planning and managing personal social services, either delivering them directly or contracting them out to private providers. LTC services provided by municipalities are home help (care) services and residential social care.

1.5 Integration of LTC

In Italy, health services and social services are still divided into two sectors. Responsibilities for social services are with the Municipalities under the control of Regions. Regions are responsible for health services, run by the *ASLs*. The integration between the two sectors, envisaged by the regulation, has never been defined nationally, and in fact it remains a regional responsibility. Only in some Regions health and social services are managed on an integrated basis, usually by *ASL* - mainly in regions in Northern and Central Italy such as Emilia Romagna, Toscana, Liguria.

2 Funding

In Italy LTC services are funded by the *SSN*, Regions/Municipalities, *INPS*, and by users. Funds provided by the *SSN*, Municipalities and *INPS* come all by general taxation.

Data on LTC expenditure in Italy are limited and incomplete. The *Ragioneria Generale dello Stato*, as part of the mid and long term forecasts of the pension and health systems, estimates current and future public LTC expenditure. According to the latest available data, public LTC was in 2007 around € 25.6 billion, that is about 1.66% of the GDP (Table 1)[3]. The main components of public LTC expenditure are those related to health services - €12.5 billions, 0.81% of GDP- and the cash benefits provided by INPS – €10.8 billions, 0.70% of GDP - , while personal social care services are only €2.5 billions, 0.16% of GDP. Around 68% of public LTC expenditure is for services provided to persons aged 65 years or more (57% of the health component, 77% of cash benefits provided by INPS, 75% of other personal social care services). Around 30% of public LTC expenditure is for home and semi-residential care, 27% for institutional care, while 43% is accounted for by cash benefits. Health services included in the LTC public expenditure are for 65% of it related to home and outpatient services (23%) and institutional services (42%), while 24% is due to psychiatric services (including also services at home, in outpatient and in residential settings), and the rest is due to services to drug and alcohol addicted persons and long term hospital admissions.

The Ragioneria Generale dello Stato estimated that in 2050 public LTC expenditure will reach 2.8% of GDP, mainly due to population ageing. This increase will be mainly due to cash benefits provided by INPS[3].

These figures do not include expenditure for invalidity pensions provided by INPS. The expenditure due to cash benefits – also in the form of invalidity pensions - of INPS that could be considered part of the LTC system in 2005 are estimated to be around €23.1 billions[10], more than two times that for cash benefit considered part of LTC (*indennità di accompagnamento*).

As for private expenditure, all LTC health services funded by the *SSN* are free of charge and patients do not pay co-payments. Home help (care) provided by social services (*SAD*) and institutional long term care is funded by municipalities and users are charged co-payments based on means-testing. Co-payments is required not only from users but also from their relatives.

Co-payments should, in principle, be based on criteria defined by each Region (art. 8, Law 328/2000) consistently with those of the National Social Plan - according to the D.Lgs.

109/1998 that has introduced a means test system based on ISEE (see par.1.3). However, in practice, few Regions defined these criteria and therefore they leave ample space to Municipalities to define co-payment modalities.
In fact, co-payments can be up to the full service cost depending on the type of service. In institutional settings, if any health care is provided the *SSN* will cover the costs, usually on the basis of a daily tariff set at regional level. The other costs of institutional care are covered by municipalities and users. The co-payment can vary according mainly to the level of disability and the family economic condition.

There is no official data on private expenditure, that should include user payments for institutional care, the costs of private insurances and those paid by users for privately purchased home care and co-payments. A recent attempt to estimate total and private expenditure for residential care (on the basis of ISTAT data) highlighted that almost half of the cost of it is borne by users[5, 11]. On average the monthly expenditure per person admitted in residential institutions was estimated to be €2260, ranging from €1528 for residential care institutions, to €2454 and €2702 for the two types of nursing homes present in Italy (Table 2). On average users pay €1065 per month (range €929-1194 by type of institution), which is around 47.1% of the total costs (range 60.8%-39.6% by type of institution). The total expenditure for institutional care was estimated to be around €6.268 billions in year 2004, 43.6% covered by the SSN, 9.4% covered by municipalities, and 47.1% by users. Thus the private out of pocket expenditure for institutional care was estimated to be €2.95 billions (Table 3). Besides, 56.7% of elderly people in residential care pay entirely the cost of it, 35.5% pay only part of the costs and 8% do not pay due to its poor economic conditions.

The estimates available for insurance premiums for LTC are around €50 million for the year 2008[12]. There is not official data on private expenditure for home social care. A recent study tried to estimate private home social care provided to elderly people on the basis of various sources, and came to the conclusion that it should be around €9.8 billion, €9.3 billion for services purchased in the market (both grey and regular) and €0.5 billion for co-payments of publicly funded services[12]. The same study estimated that the value of informal home care would be around €4.8 billion. Putting together all these estimates, the private expenditure for LTC would be around € 12.8 billions. However, this data are very uncertain, and it is in practice hardly possible to estimate the private contribution to LTC expenditure.

Table 1 Public expenditure for LTC year 2007

LTC expenditure	*Total in million €*	*In % of GDP*	*Total in million € for citizens 65+*	*In % of GDP*
Health services (component)	12.513,8	0,81	7.106,6	0,46
Cash benefits (from INPS)	10.814,4	0,70	8.342,5	0,54
"Other LTC services" (social care services)	2.471,9	0,16	1.853,9	0,12
Total	25.800,1	**1,66**	**17.303,0**	**1,13**

Source:)[3]

Table 2 Average expenditure per person admitted in residential institutions, year 2004 – monthly values in €

	€ covered by						
Type of institution	SSN		User		Municipality		Total
	€	%	€	%	€	%	€
Residenza assistenziale	398	26%	929	60.8%	201	13.2%	1528
Residenza socio-sanitaria	1036	42.2%	1194	48.7%	224	9.1%	2454
Nursing homes (RSA)	1418	52.5%	1071	39.6%	213	7.9%	2702
Average	983	43.5%	1065	47.1%	212	9.4%	2260

Source: [5]

Table 3 Estimated total expenditure for residential care, year 2004 – millions €

	Millions € covered by						
Type of institution	SSN		User		Municipality		Total
	€	%	€	%	€	%	€
Residenza assistenziale	307.31	26.0%	717.31	60.8%	155.20	13.2%	1179.81
Residenza socio-sanitaria	1010.93	42.2%	1165.11	48.7%	218.58	9.1%	2394.62
Nursing homes (RSA)	1413.67	52.5%	1067.73	39.6%	212.35	7.9%	2693.75
Total	2731.91	43.6%	2950.15	47.1%	586.13	9.4%	6268.19

Source: [5]

3 Demand and supply of LTC

3.1 The need for LTC (including demographic characteristics)

Italian population has been ageing rapidly due to both the slow down of fertility rates and the increase in life expectancy. In 2007, almost 20% of Italian population (59.131.287) was aged 65 years or more (11.792.752), while 5.3% was over 85 years old. In the same year, the age dependency ratio was 32.2% (considering persons over 65 years old), while that considering people aged 80 and over was 6.75%. The parent support ratio for those aged 80 and over (ratio between population aged over 80 and population 50-64) was close to 28% (Table 4). ISTAT forecasts that in 2050 the number of persons aged 65 and over will raise up to be 33% of the population and those aged 80 and over will be 13.5%.

For the estimation of the population in need of LTC, it has to be underlined that no national legal definition of "LTC care needs" is available in Italy. In fact, the National Institute of Statistics does not define the persons in need of LTC, it only defines disable people2. A person is considered to be disable if he/she has limitations in at least one of three dimensions (physical dimension, autonomy in activities of daily living, and communication dimension), taking into account the eventual use of devices. ISTAT derives from this classification four typologies of disability, one of them including persons forced to remain in bed or in a chair. The number of people in need of LTC leaving at home can be estimated from the Indagine multiscopo sulle famiglie (Households multi-purposes survey) conducted by ISTAT. According to ISTAT data referred to 2005, the number of people with one or more serious limitations in ADL is 2.608 million, 2.079 million of which aged 65+[13]. Moreover, 6.3 million people present one light limitation – not a very serious one[14]. Considering the population in 2007 and applying ISTAT serious disability rates the number of people in need aged 65+ would be about 2.3, whereas with SHARE rates, used in the AWG Ageing Report 2009[15], the estimate would be almost 2.5 million people 65+.

A recent study on the health costs of LTC, using data coming from the ISTAT survey as well, estimated the number of persons in need of LTC service[16]. Considering only people with three or more limitations with activities of daily living, the number of persons in need in Italy would be around 882179, of which 712775 are over 65 years old – around 6.5% of people aged at least 65 years (Table 4).

[2] Anyway, ISTAT definition has a statistical interest, but is not a legal definition, linked to any entitlements.

These figures do not include people admitted in residential institutions. The number of elderly people in institutional care is available from ISTAT for the year 2005. The total number of elderly people in institutional care was 229628, and 70.3% (161328) of them were considered to be non self sufficient, in 2005 (Table 5).

Combining the two estimates thus the total number of persons in need would be around 874000, but this is not appropriate due heterogeneity in definitions used by ISTAT's surveys.

Table 4 Share of older persons in the population and number of persons in need of LTC – year 2006

	Total (in % of total pop)	*Males (in % of total pop)*	*Females (in % of total pop)*
Share of persons 65+	19.73	8.21	11.52
Share of persons 80+	5.12	1.7	3.42
	Total (in % of pop 65+)	*Male (in % of pop 65+)*	*Female (in % of pop 65+)*
Share of persons 80+	25.95	8.62	17.33
	Total (in % of population 20-64)	Males (in % of population 20-64)	Females (in % of population 20-64)
Age dependency ratio 65+	32.3%	26.7	37.6
Age dependency ratio 80+	6.75	4.59	8.82
Parent Support Ratio 80+	27.91	9.27	18.64
Persons in need of care of "long term care" (including only those living at home)	882179		
Persons in need of care of "long term care" 65+ (including only those living at home)	712775		

Source: ISTAT - http://demo.istat.it/pop2006; [17] [16]

Table 5 Elderly people (aged 65+ years) in institutional care by health condition *(values per 1.000 inhabitants aged 65+ years)* 31/12/2005

Persons in institutional care	*Males*		*Females*		*Total*	
	N	*%*	*N*	*%*	*N*	*%*
Health status						
Self-sufficient	18.309	33.7%	49.991	28.5%	68.300	29.7%
Non self-sufficient	35.9706	66.3%	125.358	71.5%	161.328	70.3%
Total	**54.279**	**100%**	**175.349**	**100**	**229.628**	**100%**

Source: ISTAT - L'assistenza residenziale e socio-assistenziale in Italia: anno 2005[18]

3.2 The role of informal and formal care in the LTC system (including the role of cash benefits)

Informal care is extremely important in the Italian social protection system, but data available are limited and uncertain.

A study on ISTAT Households multi-purposes survey[19] shows that, in 2003, 34.2% (30.6% in 1998) of households with at least one person with serious self-sufficiency limitations received informal help by non co-habiting individuals in the last four weeks (28.4% non economic aid), whereas 20.3% received aid by the private sector (15.9% in 1998) and 21.7% by the public sector (14.2% in 1998). Moreover, 48% of these families did not get any kind of aid and 18% received only informal aid.

3.3 Demand and supply of informal care

If households with at least one person with serious self-sufficiency limitations that received informal help by non co-habiting individuals in the last four weeks are a little more than 30%, the number of people who gave at least one aid for an adult person non co-habiting in the last four weeks is 2.2 millions, according to ISTAT. Unfortunately, ISTAT databases do not include any information on demand and supply of informal care received by co-habiting carers. The EUROFARMCARE National report on Italy[20] estimates a number of 3-3.5 millions of people providing care to a dependent relative, started from the ESAW survey results, which show that 11% of people 50+ (about 2.35 millions) provide care to a dependent older relative.

3.4 Demand and supply of formal care

Institutional care

In Italy there are three different kind of residential services: Residenze Assistenziali (accommodating 28% of old persons), with mainly hotel services, for self-sufficient persons; Residenze Protette, with a more health character, aimed to obtain as much recovery as possible of psyco-motor capability of the guests; Residenze Sanitarie Assistenziali (Nursing homes), with a more health character, for non self-sufficient guests. Between 2000 and 2005 the latter have increased their role in the supply system, with 24.400 more beds. The total ratio of beds of the system on the total number of old people is 2,3%.

The total number of beds available is 265326, 28% in Residenze Assisenziali, around 36% in Residenze socio sanitarie, and around 36% in Residenze Sanitarie Assistenziali (Table 6). There is a wide variability in the total number of beds in residential care institutions across Italian regions and also in the type of institutions. Only 35% of residential care available beds are public, whereas 43% belongs to private not for profit institutions and 22% to private for profit (Table 7) ones.

The number of elderly people in institutional care is still relatively low by international standards, being 19.8 per 1000 inhabitants aged 65 years or older. This average hides a huge interregional variability, from around 4 per 1000 elderly people up to 49 (Table 8 and 9).

Table 6 Number of beds in institutional setting by type of institution and region – 31/12/2005

Regions	*Residenza Assistenziale for self-sufficient elderly people*	*Residenza. socio-sanitaria for elderly pleople*	*Residenza sanitaria assistenziale (Nursing homes)*	*Total*	*% of total*
Piemonte	24.085	13.311	6.092	**43.488**	16,4%
Valle d'Aosta/Vallée d'Aoste	53	728	148	**929**	0,4%
Lombardia	1.653	2.790	50.668	**55.111**	20,8%
Trentino-Alto Adige	19	2.958	5.269	**8.246**	3,1%
Veneto	6.471	23.026	4.921	**34.418**	13,0%
Friuli-Venezia Giulia	2.263	7.437	1.709	**11.409**	4,3%
Liguria	718	8.962	2.732	**12.412**	4,7%
Emilia-Romagna	8.469	17.773	2.149	**28.391**	10,7%
Toscana	3.180	1.689	10.783	**15.652**	5,9%
Umbria	631	1.281	286	**2.198**	0,8%
Marche	3.430	3.120	1.479	**8.029**	3,0%
Lazio	7.541	1.070	4.109	**12.720**	4,8%
Abruzzo	1.219	2.036	799	**4.054**	1,5%
Molise	281	1.022	20	**1.323**	0,5%
Campania	3.889	643	1.020	**5.552**	2,1%
Puglia	3.777	2.587	301	**6.665**	2,5%
Basilicata	387	248	0	**635**	0,2%
Calabria	628	340	1.157	**2.125**	0,8%
Sicilia	3.713	4.235	910	**8.858**	3,3%
Sardegna	1.565	365	1.184	**3.114**	1,2%
TOTAL	**73.972**	**95.620**	**95.734**	**265.326**	100%

Source: [18]

Table 7 Institutional care – number of beds by provider type

	Places / Beds (N)	Beds (%)
Institutional care, total	265.326	100%
Institutional care by provider type		
Public institutional care	92.864	35,0%
Private not-for-profit institutional care	114.090	43,0%
Private for-profit institutional care	58.372	22,0%

Source: [18]

Table 8 Persons receiving institutional care

	Total		Male		Female	
	N	%	N	%	N	%
Persons receiving institutional care	298.250		92.491		205.759	
Persons receiving institutional care by age group						
0-14	11.983	4,02%	6.351	6,87%	5.632	2,74%
15-19	5.815	1,95%	3.082	3,33%	2.733	1,33%
20-24	4.772	1,60%	2.529	2,73%	2.243	1,09%
25-29						
30-34						
35-39						
40-44	20.222	6,78%	11.527	12,46%	8.695	4,23%
45-49						
50-54						
55-59						
60-64	25.830	8,66%	14.723	15,92%	11.107	5,40%
65-69						
70-74	31.404	10,53%	13.391	14,48%	18.013	8,75%
75-79	40.169	13,47%	12.540	13,56%	27.629	13,43%
80-84	158.055	52,99%	28.348	30,65%	129.707	63,04%
85+						
Total	298.250	*100%*	92.491	***100%***	205.759	*100%*

Source:[18]

Table 9 Elderly people (aged 65+ years) in institutional care by type of institution and setting (values per 1.000 inhabitants aged 65+ years) 31/12/2005

	Per 1000 inhabitants aged 65+		
Region	*Males*	*Females*	*Total*
Piemonte	21,20	47,84	36,78
Valle d'Aosta/Vallée d'Aoste	19,69	48,60	36,71
Lombardia	13,58	35,76	26,77
Trentino-Alto Adige	29,16	56,69	45,45
Bolzano/Bozen	*26,22*	*52,04*	*41,28*
Trento	*31,77*	*60,54*	*49,00*
Veneto	16,96	42,57	32,15
Friuli-Venezia Giulia	19,62	49,23	37,41
Liguria	15,71	33,89	26,53
Emilia-Romagna	14,65	30,63	23,95
Toscana	8,35	21,25	15,87
Umbria	6,57	15,42	11,69
Marche	10,95	24,49	18,74
Lazio	7,20	15,46	12,02
Abruzzo	8,56	16,28	12,99
Molise	11,72	23,95	18,80
Campania	3,41	5,34	4,53
Puglia	5,20	10,11	8,02
Basilicata	3,80	5,21	4,60
Calabria	4,11	6,84	5,66
Sicilia	5,03	8,62	7,09
Sardegna	10,09	17,49	14,33
TOTAL	**11,26**	**25,90**	**19,81**

Source: [18]

Home care

Home care services funded by the public sector are home health care (*Assistenza Domiciliare Integrata - ADI*), funded by the SSN, and home personal care (*Servizi di Assistenza Domiciliare -SAD*), funded by local authorities (mainly municipalities).

ADI, formally introduced in Italy in the early 1990s at national level, includes in principle both home help (social care), and health home care (home nursing, physiotherapy, specialists' and GPs' visits), but most of ADI users receive only health care inputs. Needs assessment is generally done by the *Unità Valutativa Geriatrica (UVG)*, an assessment and planning unit composed of social and health professionals (responsibility lies with the latter), that defines a care plan.

According to the latest national data available, referred to year 2003, in Italy the number of elderly people that used home health care (ADI) was 27.3 per 1000 residents aged 65

years or more (Table 10) with huge variations across regions (range 5.8-89.4 users per 1000).

Municipalities provide home help through their social services (*SAD*) without any integration with health care services. In some regions the enforcement of regional provisions has allowed the social services offered by Municipalities to be integrated with those supplied by the *ASL*. The supply of *SAD* is inadequate to meet the populations' needs and is extremely variable across Italian Regions. On the whole, 4.9% of persons aged 65 years or more receive home care, 3.2% health home care (0.6% of which receive also social services) and 1.7% social services (only).

Data on the number of hours of care per recipient are limited too. The number of hours of health home care received per year is, on average, 24, showing the limitations of the public services[21]. A recent study estimated the cost of health home care in Italian Regions, showing that, if the average expenditure is € 88.6 per person aged 65 years or more, the variability is wide, with values ranging from € 16 to € 235 (Table 11).

Data on home social services intensity are not available. The only information that can be used as a proxy is the average expenditure per user, which is estimated to be € 1728[5].

Private home care is increasingly important in the Italian LTC system, although there are no official data on this aspect. According to the few data available 6.6% of people aged over 65 years[5] received home care privately. Private home care is provided mainly by migrant workers on individual base: in 2008 it was estimated that around 700,000 migrant workers were employed to provide home care to elderly people[5].

Table 10 Users of home health care (ADI) aged 65+ years (number of users / 1.000 65+ years) – by region, year 2003

Region	ADI users 65+ per 1.000 residents 65+	ADI users as % 65+	SAD users as % 65+
Valle d'Aosta	2,7	0.3	3
Piemonte	16,8	1.8	1.5
Liguria	19,5	3.2	1.2
Lombardia	26,8	3.6	1.7
Trentino - Alto Adige	Nd		
Bolzano		0.5	4
Trento		1	3.2
Friuli Venezia Giulia	79,1	7.2	2.6
Veneto	37,7	6.4	1.8
Emilia – Romagna	46,6	5.7	1.9
Toscana	30,7	2.1	1.2
Umbria	24,6	4.3	0.6
Marche	27,8	3.9	0.9
Abruzzo	17,9	3.6	2.6
Lazio	18,9	3.8	1.2
Molise	89,4	3.7	4
Puglia	11,8	1.6	0.8
Campania	9,1	1.6	1.5
Basilicata	41,8	4.3	1
Calabria	5,8	2.7	1.5
Sicilia	7,1	1	2.8
Sardegna	5,7	1.2	2.5
ITALY	27,3	3.2	1.7

Source: [22] [23] [24]

Table 11 LTC Health care costs – year 2007 by type of care and region

	Per person aged 65+ in €				
Region	Home care (ADI)	Health and personal care	Semi-residential care	Residential care	Total
Piemonte	76.01	10.94	13.25	253.45	353.65
Valle d'Aosta/Vallée d'Aoste	99.44	43.22	0	51.76	194.42
Lombardia	75.04	7.65	16.21	426.9	525.8
Bolzano/Bozen	187.28	*207.66*	*102.35*	*931.44*	1428.73
Trento	16.49	*0*	*0*	*1167.26*	1183.75
Veneto	98.58	83.03	7.36	501.08	690.05
Friuli-Venezia Giulia	234.98	24.87	11.28	338.94	610.07
Liguria	83.59	38.92	5.06	176.16	303.73
Emilia-Romagna	157.12	3.47	13.11	315.69	489.39
Toscana	110.06	15.92	8.06	219.36	353.4
Umbria	152.89	14.15	4.47	203.47	374.98
Marche	130.45	13.38	1.23	157.1	302.16
Lazio	Na	Na	Na	Na	Na
Abruzzo	89	11.09	16.76	145.92	262.77
Molise	71.45	6.56	1.74	77.93	157.68
Campania	40.04	40.9	18	14.45	113.39
Puglia	53.75	1.7	11.98	50.28	117.71
Basilicata	139.27	12.45	3.42	16.66	171.8
Calabria	Na	Na	Na	Na	Na
Sicilia	35.66	17.72	30.2	54.2	137.78
Sardegna	53.46	8.24	6.14	31.16	99
TOTAL	**88.66**	**22.21**	**13.92**	**252.85**	342.44

Source: [16]

Cash benefits

The cash benefits provided by INPS are an important part of the LTC system in Italy. According to the latest available data, 9.5% of persons aged 65 years and over received the cash benefit in 2008. This percentage increases from 2.1% of persons aged 65-69 years, to 5.3% of those aged 70-79 years, up to 23.8% of those aged 80 years and over (Table 12).
Cash benefits funded by local authorities – mainly Municipalities, but also Provinces and Regions – vary widely across Italian Regions. Table 13 shows the percentage of population aged 65 years and over receiving cash benefits by local authorities - which range from 3.5% in Bolzano Province to zero in some southern Regions - and the average monthly amount.

Table 12 National cash benefit

Year	*Number of INPS cash benefit's beneficiaries (000)*	*% on persons ages 65+*	*Age groups (%)*		
			65-69	70-79	80+
2001	577.4	5.5	1.4	3.1	16.1
2002	639.3	6.0	1.5	3.5	16.8
2003	708.6	6.5	1.6	3.8	17.7
2004	796.0	7.2	1.7	4.1	19.1
2005	880.6	7.7	1.8	4.4	20.4
2006	971.3	8.4	1.9	4.8	21.8
2007	1051.9	8.9	2.0	5.1	22.8
2008	1131.7	9.5	2.1	5.3	23.8

Source: [5] Population: ISTAT (*http://demo.istat.it/*); Cash benefits up to year 2004: database INPS *(http://servizi.inps.it/banchedatistatistiche/vig9/index.jsp*),

Table 13 Cash benefits funded and provided at regional and local level

Region	*Year of establishment*	*% population 65+ receiving cash benefits*	*Average gross monthly amount €*
Provincia di Bolzano	2007	3.5%	515
Veneto	2007	2.2%	200
Emilia-Romagna	2006	1.9%	246
Liguria	2008	1.6%	330
Friuli-Venezia Giulia	2007	1%	375
Lombardia	2006	0.9%	
Provincia di Trento	2006	0.6%	345
Umbria	2005	0.4%	418
Toscana	2006	0.3%	
Piemonte	2006	0.2%	
Abruzzo, Calabria, Sicilia	2003 (Sicilia e Calabria) and 2006 (Abruzzo)	<0.3%	
Puglia, Sardegna	2007 (Puglia) 2008 (Sardegna), data na	-	

Sources:: [5].

4 LTC policy

4.1 Policy goals

Various governmental dispositions regulate the LTC system in Italy. The first Parliament Act related to elderly people is the Finance law n.67/1988, that scheduled the creation of 140.000 beds for non self-reliance people; the D.P.C.M. December, 22nd 1989 gave the rules to implement Nursing and residential care facilities (*Residenze Sanitarie Assistenziali*). The Objective Project "the healthcare for elder people" (POA), approved in the National Health Plan 1992-1994, has been the first reference for intervention on people over 65 years for Regional and Local governments, designing the local network of services and giving a key role to Evaluation Units (within ASL) for needs assessment.
A framework national law was enacted in November 2000 (law 328/2000) and it included a number of aims. It declared that the objective was to establish a minimum level of social care services to be provided throughout the country. The actual tools (financial and normative) provided to pursue this goal were, nevertheless, weak.
The most recent provisions are included in the National Health Plan 2006-2008, which identified strengthening home care as a first priority as opposed to institutional care. This plan points also to strengthening cooperation between institutions and formal and informal groups in order to improve care. The previous National Health Plan (2003-2005), mentioned "cash and care" approaches implying transferring money to families for purchasing health and social services by qualified providers, aimed at supporting home care. The same document addressed two other important targets: to re-organize the service net fostering integration between health and social services; to create a specific financing mechanism for LTC, that was subsequently established by the finance Law for 2007 (law 296/2006) assigning symbolic amount of resources to be shared among Regions and Autonomous Provinces according to the number of elderly non self sufficient people and some socio–economic indicators.

4.2 Integration policy

The whole sector is characterized by a strong regionalization and municipalism (mainly in the service planning and management stage) which creates significant differences among areas, both in terms of resources invested in the system and in terms of access to service, selective criteria for service beneficiaries, type of services available, etc. In particular, the system aspects that show significant differences among the Regions (19 regions and 2 autonomous provinces) are the following:

- Different choices regarding the decision of merging or not health and social care components of LTC, in terms of establishing a unique department and planning path at regional level.
- Different strategic decisions on the net of services features (cash transfers vs home and/or residential services strengthening; vouchers; higher presence of public vs accredited private providers; etc.).
- Implementation or not of an ad hoc regional fund for LTC and the rules adopted to finance and manage it.
- Tools adopted to plan, coordinate, and manage care: the presence or not of a unique access point; different evaluation unit settlement and location; presence (or not) of the case need assessment tools and their different contents; presence or not of means testing.
- Different residential, semi-residential or home service arrangements. For example, analyzing residential services it is possible to notice considerable differences regarding the following dimensions:
    - coverage targets (e.g beds/over 65 people);
    - beneficiaries' categories - elderly (also with dementia), disabled, vegetative states, AIDS patients, etc.;
    - management of private services accrediting system - structural and organizational standards required to obtain the authorization and/or accreditation;
    - adopted financing systems - entity of resources, covered and not covered expenditures, delivery procedures, health and social coverage percentage.

4.3 Recent reforms and the current policy debate

Since mid of the 90s there has been a debate on a national reform of LTC in Italy - with various proposals being advanced regarding contents, interventions and funding modalities. However, a national reform of LTC has not been implemented yet.

A potentially important recent change is the establishment of a new ring-fenced fund for LTC services that was approved by the Finance law for 2007 – budgeting a symbolic amount of €100 million for the year 2007 and €200 million for each of the following two years. The Finance law for 2008 has then increased this funds with additional €100 million for year 2008 and €200 million for 2009. This LTC fund aimed, in the long run, towards guaranteeing the implementation of essential levels of care to non self sufficient persons over the whole country. It was seen as a way to provide Italian Regions an incentive to

increase the resources made available for LTC, establish themselves regional LTC funds. Additionally the former central government had agreed on a framework law aimed at reforming LTC and social policies for families, but this has not been passed by the Parliament due to the change in the national government. Although the amount of resources allocated by the LTC fund was small, this was the first attempt to explicitly allocate resources to LTC from the national level that might serve as a leverage to reduce fragmentation of responsibilities and funding. In fact, in some Regions, following the establishment of the national LTC fund, regional LTC funds have been established. The current government has confirmed the LTC national fund, following an agreement with the Regions (Agreement for the New Health Pact 2010-2012, signed on October 10th, 2009), but it has made available resources only for the year 2010 (€400 million).

The very recent important reform introducing fiscal federalism (the delegation law 42/2009 approved on May 2009) suppresses all financial transfers from the center to the decentralized governments, but requires the integral funding of the essential functions (as health, social care, education) in every Regions. This should be guaranteed through financial equalization aimed to assure the "essential levels of services" (LES) - i.e. the national standard -, set with national law. As the LES for LTC have not been set till now - probably because of lack of resources to fund them - , it is not clear what will happen. Indeed the implementation of fiscal federalism might further increase institutional fragmentation of LTC exacerbating the already wide differences across Regions and municipalities.

4.4 Critical appraisal of the LTC system

In Italy the LTC is still underdeveloped, with significant differences among Regions, and it is characterized by high institutional fragmentation as sources of funding and governance, with management responsibilities spread over local (municipalities) and Regional authorities, according to different modalities in relation to the institutional models of each Region.

The Italian LTC system presents a number of unresolved issues.
First, the residual role played by social care services compared to the rest of social security and health interventions. The Italian welfare system has always preferred cash benefits. For example, in 2008, the 386.678 millions of euro spent by the General Government, went into three system macro-areas[10]:

- 66% on social security (pensions and other cash contributions);

- 26% on health expenditure (services);
- 8% on care expenses (services and money contributions).

Second, social rights (juridical) weaknesses. As opposed to health policies, social policies cannot appeal to guaranteed rights by constitutional or other kind of laws. Policies for elderly people have always been vague and only focused on some, though important but not essential, aspects (for example the structural requirements for Nursing and residential care facilities). The law 238/2000 focused on the institutional aspects of local policies, instead of focusing on defining the essential levels of care (a basic benefit package). The 2007 proposal of delegation law also failed. The outcome of the delegation law 42/2009 on fiscal federalism is uncertain and the LES that should be funded have not been set. Third, a supply side of care fragmented at a local level.

References

1. **Spesa per interventi e servizi sociali dei comuni singloli e associati per area di utenza e per regione. Anno 2004**
2. Gori C e: *Le riforme regionali per i non autosufficienti, .* Roma; 2008.
3. Ragioneria Generale dello Stato (Ed.). **Le tendenze di medio-lungo periodo del sistema pensionistico e socio-sanitario.** Roma; 2008.
4. Beltrametti L: *Il Finanziamento. In: Il governo delle politiche regionali, (Gori C.eds). Le riforme regionali per i Non Autosufficienti, Carocci, Roma.*; 2008.
5. N.N.A. Network Non Autosufficienza (eds): **L'assistenza agli anziani non autosufficienti in Italia. Rapporto 2009.** In *Maggioli Editore* (l'invecchiamento RpdI-IplAnp ed.; 2009.
6. Bertoni F Caffarena C Riboldi B: **Il quadro delle riforme. In: Il governo delle politiche regionali, (Gori C.eds). Le riforme regionali per i Non Autosufficienti, Carocci, Roma,** 2008.
7. Cicoletti D: **Il percorso assistenziale. In: Il governo delle politiche regionali, (Gori C.eds). Le riforme regionali per i Non Autosufficienti, Carocci, Roma.** 2008.
8. Tediosi F Gabriele S Longo F: **Governing decentralization in health care under tough budget constraint: what can we learn from the Italian experience?** *Health Policy 2009 May;90(2-3):303-12 Epub 2008 Dec 5* 2009.
9. Giorgi G Ranci Ortigosa E: **Il governo delle politiche regionali. In: Il governo delle politiche regionali, (Gori C.eds). Le riforme regionali per i Non Autosufficienti, Carocci, Roma.** 2008.
10. Ministero dell'Economia e delle Finanze: **Relazione Generale sulla Situazione Economica del Paese per il 2008.** 2009.
11. ISTAT: *L'assistenza residenziale e socio-assistenziale in Italia, Roma, Istat.* 2007.
12. Rebba V: **Long-term care in Italy. Presentation iHEA 2009 Beijing, July 14th 2009.**
13. Solipaca A: **La disabilità in Italia: il quadro della statistica ufficiale, ISTAT collana Argomenti.** 2009.
14. Tozzi M: **I disabili in Italia, una platea più differenziata che uniforme.** *In ISAE Quarterly Report (Rapporto Trimestrale ISAE), Politiche Pubbliche e Redistribuzione* October 2009.
15. European Commission (DG ECFIN) and the Economic Policy Committee (AWG): **The 2009 Ageing Report: Underlying Assumptions and Projection Methodologies for the EU-27 Member States (2007-2060).**
16. Agenas: **"Rilevazione dell'attuale spesa pubblica per l'assistenza sociosanitaria agli anziani non autosufficienti e quantificazione del fabbisogno finanziario per garantire livelli standard".** *Progetto Ricerca Corrente 2006 Relazione Finale* 2009.
17. ISTAT: **Condizioni di salute e ricorso ai servizi sanitari.** 2006.
18. ISTAT: **L'assistenza residenziale e socio-assistenziale in Italia, Roma, Istat.** 2005.
19. Fabroni R: *in La disabilità in Italia: il quadro della statistica ufficiale, (Solipaca A eds) ISTAT collana Argomenti,* 2009.

20. Quattrini S Gabriella Melchiorre M Balducci C Spazzafumo L Lamura G: **Services for Supporting Family Carers of Older Dependent People in Europe: Characteristics, Coverage and Usage. The National Survey Report for Italy.** In *The project EUROFAMCARE is supported by the European Union - Contract: QLK6-CT-2002-02647 http://wwwukede/extern/eurofamcare/deliphp;* February 2006.
21. Ministero della salute: **Attività economiche e gestionali delle Asl e Aziende ospedaliere – anno 2006, Roma, Ministero della salute.**; 2008.
22. CENSIS: **Analisi comparativa dei principali servizi per gli anziani non autosufficienti. .** 2005.
23. Ministero dello svilupp o economico: **Obiettivi Servizio – Quadro Strategico Nazionale. Aggiornamento indicatori, Roma.** 2009.
24. ISTAT: **L'indagine censuaria sugli interventi e i servizi sociali dei Comuni – anno 2005, Roma, Istat.** 2008.

ANCIEN

Assessing Needs of Care in European Nations

FP7 HEALTH-2007-3.2-2

Launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

1) How will need, demand, supply and use of LTC develop?

2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (http://www.ancien-longtermcare.eu).