WELFARE INNOVATIONS AND FEDERALISM: THE FAILURE OF REFORMING LONG TERM CARE IN ITALY

STEFANIA GABRIELE, FABRIZIO TEDIOSI

Welfare innovations and federalism: the failure of reforming Long Term Care in Italy

Stefania Gabriele[1], Fabrizio Tediosi[2,3]

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[2] Università Bocconi, [3]Swiss Tropical and Public Health Institute, University of Basel

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Abstract (323 words)

Among the new social risks there is the increase of non self sufficient people in relation to the process of population ageing. The view that a comprehensive reform of LTC systems in the industrialised world is needed is popular and scholars are trying to understand the reasons of the failures to intervene in many countries. Among the reasons for failures to reform LTC are budget constraints, political weakness of the involved constituency, and a negative interaction with federalism/devolution reforms. The present article describes the Italian LTC system, in the wider context of the Italian welfare system, in light of the increasingly relevant need to take into account new social risks.

Despite it is widely recognized that the Italian LTC system would require a comprehensive reform, this hasn't happened yet. Previous analysis suggests that a LTC reform was not implemented due to the strict fiscal policies and limited political representation of elderly people, that prevented this claim to become politically relevant, and the unwillingness of Italian Regions to bear the costs of a system of LTC not funded by the central Government. We only partially agree with this analysis. In Italy the LTC constituency is not only large and growing as a result of rapid population aging, but it is also quite strong and unionized. Nevertheless, there has certainly been a degree of "short-sightedness" in risk assessment, along with a difficulty to conceive forms of support other than traditional ones. Moreover, we suggest that LTC and other welfare reforms in Italy have been held back by the ongoing and unfinished process of federalism. This process is proving long and tortuous: two constitutional reforms were passed – the second suppressed by a referendum - and two fiscal reforms – the first failed. When institutional reform process is too slow and uncertain, it tends thus to block other reforms. The presence of large territorial differences makes hard implementing federalism and at the same time can break the commonality of intents among local institutions in favour of welfare reforms.

Background

The debate on social policies and welfare has recently highlighted some relevant changes in socio-economic conditions of high income countries, including the rise of the so called "new social risks" (Armingeon K & Bonoli G, 2006; Taylor-Gooby P, 2004b). These risks would depend on a combination of factors, such as tertiarization, households' structure changes, globalisation and ageing (Armingeon K & Bonoli G, 2006; Esping Andersen G, 1999; Paci M, 2007; Taylor-Gooby P, 2004a), with a decrease in male breadwinner resources, an increase in women participation in labour market and a rise in care services demand.

Among the new social risks there is the increase of non self sufficient people in relation to the process of population ageing. In fact, the rise of dependency is not certain, because of the improvement in health status following the increase in life expectancy[1]. Although it is to be considered that the traditional informal care supplied by relatives, in particular women, is endangered by households' structure changes.

In Nordic states, Long Term Care (LTC) services were made available since the 1960s and 1970s (Campbell AL. & Morgan KJ, 2005), while some other European countries introduced reforms in the 1990s and the 2000s, such as Germany (1994) and Spain (2008). In many other countries LTC is still heavily inadequate and comprehensive reforms of LTC are needed (Coyte C, Goodwin N & Laporte A, 2008).

Improving LTC systems is also in the scope of the European open method of coordination, with objectives concerning access, quality and sustainability, as the systems of LTC are judged inadequate in many countries with labour shortages and low quality problems. According to Eurobarometer (European Commission, 2007), European citizens consider that non self-sufficient people have to rely too much on their relatives (71%), and there is a large support to the idea that public authorities should provide appropriate care (home and\or institutional) for elderly people in

need (93%) and family carers should receive (financial) support from the State (about 90%). Most Europeans also agree on a compulsory insurance scheme to finance care (70%).

It has been noticed that a concern about the issue "to finance *care* rather than *cure* in the senior population" (Kraus M, Riedel M, Mot E, Willemè P, Röhrling G & Czypionka T, 2010) has been juxtaposed to the challenge of health systems financial sustainability. The view that a comprehensive reform of LTC systems in the industrialised world – inter alia in the EU member states – is needed is popular and some scholars are trying to understand the reasons of the failures to intervene in many countries (Campbell AL. & Morgan KJ, 2005; Costa-Font J, 2010). Among the reasons for failures to reform LTC are budget constraints, political weakness of the involved constituency, and a negative interaction with federalism/devolution reforms.

In general it is believed that social risks are concentrated in some population groups, which often lack political mobilization and representation, and that this phenomenon could hinder a quick adaptation of social security systems (Bonoli G, 2001). This is especially the case for LTC, because non self-sufficient people and their caregivers may be a weak constituency, dispersed and unorganized, and poorly aware of the personal level of risk[2]. Without a strong political pressure, policy makers, who have to cope with budget constraints, are inclined to avoid the introduction of new expenditure programs (Campbell AL. & Morgan KJ, 2005).

Moreover some scholars have highlighted the relationships between institutional factors and welfare reforms, wondering whether federal systems, or a process of devolution, can hamper the introduction of reforms and favour the retrenchment of the welfare system. The debate on welfare state and federal systems interaction has firstly highlighted the obstacles posed by federalism to social policies[3], including the introduction of a sort of veto points[4], the sub-national governments being subject to competitive pressure and budget constraints (Campbell AL. & Morgan KJ, 2005). It has been noticed that, in the phase of the welfare state expansion, fragmented political systems and federalism would have tended to limit the growth of the welfare state, but the outcomes might be different in the present phase of restructuring and retrenchment (Bonoli G, 2005; Obinger H,

Castles FG & Leibfried S, 2005). The welfare outcomes would depend on the specific characteristics of the single federal system (Obinger H et al., 2005) and in certain conditions sub-national levels of government support to welfare reforms can be decisive. Campbell and Morgan (2005), analysing the reasons why Germany succeeded in reforming the LTC system, unlike the United States, notice that in both countries local governments favoured the introduction of new social programs[5], but only Germany had the institutional tools to exert a sufficient political pressure, through the veto in the Bundesrat. In Germany a new insurance program funded by social security contributions was considered as a way to reduce the increasing burden of LTC falling on the local governments. Moreover, in the German fiscal federalism an extensive revenue-sharing provision occurs, with equalisation mechanisms, implying thus strong interdependence. This encourages a collective action to face growing burdens at local level and intensify intergovernmental bargaining about resources allocation. The situation is different in the US where, due to a greater States independence and the possibility to raise taxes, the States try to maximize their own share of federal resources, while the federal government attempts to shift burdens on them, in a game which does not promote a collective solution[6]. As to two Mediterranean countries, according to Costa-Font (Costa-Font J, 2010), in Spain – thanks to the progressive decentralisation of social care - the role of some key regional governments (Catalonia and Galicia, ruled by coalitions of left-wing parties) as ally of the socialist central government was important to make possible LTC reform and its financing. On the contrary, in Italy the regional governments were not strongly committed to LTC reform, scared by the risk of having to fund it, while they were rather devoted to safeguarding the funding for health services. This was due to a lack of resources and a weak political pressure from the frail elderly, more than balanced by other groups interested to maintain the status quo. Costa-Font also underlines the importance to consider how the mechanisms of fiscal blame avoidance are working in different institutional contexts, as federalism/decentralization could in some circumstances favour reforms, helping to achieve a

balance in the responsibilities and credits sharing and on spreading the fiscal blame among the different layers of government.

The view according to which the effects of federalism/devolution on LTC reforms depend on the specific features of the federal systems seems to be fertile, as it is investigating the countries' institutional organisations impact on their chances of reform. The case of Italy is particularly interesting because of the ongoing federalist reform. The Italian "laboratory" can in fact provide new evidence on the "side effects" of institutional changes.

In general, in Italy the welfare state is not covering the new social risks[7], owing to its categorical tradition and its focus on male breadwinners (Armingeon K & Bonoli G, 2006; Esping Andersen G, 1999; Esping Andersen G, 2002; Obinger H et al., 2005). Moreover, the ongoing process of devolution has complicated the situation, casting uncertainty on both competences allocation among different administrative tiers and funding.

And yet, according to Eurobarometer data, in Italy 75% of citizens believe that non self- sufficient people have to rely too much on their relatives, and 88% of them think that public authorities should provide care to elderly people (European Commission, 2007).

This article aims at analysing the reasons why in Italy reforming LTC failed, and the interaction between this failure and the devolution process.

The Italian LTC system

In Italy the need for LTC has been increasing over the last decades due to population ageing and changes in household's structure and habits. Italian population has in fact been ageing rapidly due to both the slowdown of fertility rates and the increase in life expectancy. In 2010, 20% of Italian population (60.3 million) was aged 65 years or more (12.2 million), while 2.2% was over 85 years old. In the same year, the age dependency ratio was 33.3% (considering persons over 65 years old).

By 2050 the number of persons aged 65 and over is expected to raise up to 33% of the population and those aged 85 and over to 7.6% (ISTAT, 2011b).

The information available on the need for LTC in Italy is, however, limited. In 2005[8] the number of people with one or more serious limitations in Activity of Daily Living (ADL) was estimated to be 2.6 million, most of them (2.1 million) aged 65+ (Solipaca, 2009). These figures do not include people admitted in residential institutions, who were (ISTAT, 2010) 230.468 in 2006 (70.4% of them were considered to be non self-sufficient) (Table 1).

The Italian LTC system consists of the following components:

a) Health services to elderly and disabled people, including outpatients and home services, semi-residential and residential services, psychiatric services and those to drug and alcohol addicted patients. *Health home care (Assistenza Domicialare Integrata, ADI)* 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. According to the latest national data available, referred to year 2009, in Italy the number of elderly people that used home health care (ADI) was 36 per 1000 residents aged 65 years or more (Ministero per lo Sviluppo Economico, 2010) with huge variations across regions (i.e. 21 users per 1000 residents in Mezzogiorno, 63 in North-Est). See next point for some details on residential health services.

b) 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 home care services. Personal social services - domestic and personal care tasks provided at home (*Servizi di Assistenza Domiciliare, SAD*) and institutional social care - are funded by local authorities and managed at a local level by Municipalities, though this should be planned in coordination with ADI. 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 and 1.7% social services (Solipaca, 2009).

In Italy there are three different kinds of residential services: *Residenze Assistenziali*, with mainly hotel services, for self-sufficient persons; *Residenze Protette*, aimed to obtain as much recovery as possible of psyco-motor capability of the guests; *Residenze Sanitarie Assistenziali (RSA,* Nursing homes), with a more health character, for non self-sufficient guests. The total ratio of LTC beds on the total number of old people is 2,3%, 28% of beds are in *Residenze Assisenziali*, around 36% in Residenze Protette, and around 36% in RSA (ISTAT, 2008). Only 34% of residential care available beds are public, whereas 47% belongs to private not for profit institutions and 17% to private for profit ones (ISTAT, 2010). The number of elderly people in institutional care is still relatively low by international standards, being 19.7 per 1000 inhabitants aged 65 years or older. This average hides a huge interregional variability, from around 5 per 1000 elderly people in Regions Basilicata, Calabria, and Campania, up to 38 in Piemonte and Valle d'Aosta, and 49 in Trento province.

c) Cash benefits (*indennità di accompagnamento*) provided directly to all disabled persons by the National Institute of Social Security (*INPS*), independently from their age and 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 households for informal care. This cash benefit is provided every month, and in 2010 the monthly benefit was €480.47. According to the latest available data, 9.5% of persons aged 65 years and over received the cash benefit in 2008 (Lamura & Principi, 2010) (Table 2). Regions, Provinces and, most frequently, Municipalities fund also other types of cash benefits to households of non self sufficient persons but there is high variation in both level and nature across Italian geographical areas. These cash benefits can be either linked to

purchasing of services or not and are increasingly relevant in some Northern Italian Regions. The percentage of population aged 65 years and over receiving cash benefits by local authorities ranges from 3.5% in Bolzano Province to zero in some southern Regions (Lamura & Principi, 2010) (Table 3). Regional and local LTC services and cash benefits eligibility criteria are not homogeneous. The access criteria in some cases are set at the local level (Municipality or Local Health Units - *ASL, Aziende Sanitarie Locali*), in some other cases are fixed by the Regions, sometimes are mixed (Bertoni F, Caffarena C & Riboldi B, 2008; Cicoletti, 2008).

d) Informal care is extremely important in the Italian social protection system, though hard to quantify due to lack of data. A study on ISTAT Households multi-purposes survey (Fabroni, 2009) shows that, in 2003, 34.2% 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, whereas 20.3% received aid by the private sector, 21.7% by the public sector and 48% did not get any kind of aid. The EUROFAMCARE National report on Italy (Quattrini S, Melchiorre G, Balducci M, Spazzafumo C & Lamura L, 2006) estimates a number of 3-3.5 millions of people providing care to a dependent relative, started from the European Study of Adult Well-being (ESAW) survey results, which show that 11% of people 50+ (about 2.35 millions) provide care to a dependent older relative.

e) Private home care is increasingly important in the Italian LTC system. According to the few data available 6.6% of people aged over 65 years received home care privately (Gori C & Casanova G, 2010). Private home care is provided mainly by migrant workers on individual base: in 2008 it was estimated that more than 700,000 migrant workers were employed to

provide home care to elderly people, and only 1/3 with a regular contract (Gori C & Casanova G, 2010).

The unresolved issues in the Italian LTC system

The LTC system in Italy is characterized by high institutional fragmentation, as sources of funding, governance and management responsibilities are spread over local (Municipalities), Regional and National authorities, with different modalities in relation to the institutional models of each Region.

The main unresolved issues of the Italian LTC system can be grouped in four areas.

First: the residual role played by social care services compared to other areas of social security and health care. The Italian welfare system has always preferred cash benefits. For example, in 2010, the 412.255 millions Euro spent by the General Government went into three system macro-areas (ISTAT, 2011a):

- 66% on social security (pensions and other cash contributions);
- 26% on health expenditure (services);
- 8% on care expenditure (2% services and 6% money contributions).

Second: in Italy funding for LTC services is limited and fragmented. LTC is funded by the Italian National Health Service (*Servizio Sanitario Nazionale*, *SSN*), Regions/Municipalities, *INPS*, and by users. Funds provided by the *SSN*, Regions/Municipalities and *INPS* come all from general taxation. The *Ragioneria Generale dello Stato*, (*RGS*, State General Accounting Department), Italian Ministry of Economy and Finance, as part of the mid and long term forecasts of the pension and social - health systems, estimates current and future public LTC expenditure. According to the latest available data, public LTC expenditure was in 2010 around € 28,4 billion, which is nearly 1.9% of the GDP (Ragioneria Generale, 2011). Around two third of public LTC expenditure was for

services provided to persons aged 65 years or more. About 45% of public LTC expenditure was accounted for by cash benefits (*indennità di accompagnamento*), 28% by institutional care and 27% by home care. Health care represented 0.86% of GDP% (0.55% excluding psychiatric services, drug and alcohol addicted persons support and long term hospital admissions).

Considering the total cash benefits for the function disability – including social security invalidity pensions - in 2010 the expenditure was over €23 billions, about 1,5% of GDP (ISTAT, 2011a).

All LTC health services for non self-sufficient people are free of charge and patients do not pay co-payments. So in institutional settings, if any health care is provided, the *SSN* will cover the costs, usually on the basis of a daily fee set at regional level. The other costs of institutional care are covered by Municipalities and users are charged with co-payments based on means-testing. Co-payments are required not only from users but also from their relatives. In fact, co-payments can be up to the full service cost depending on the type of service. The co-payments can vary according mainly to the level of disability and to households' economic condition. 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 a composite indicator of the household economic condition. However, in practice, few Regions defined these criteria, leaving thus ample room to Municipalities to define co-payment modalities.

There is no official data on private expenditure. 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 (ISTAT, 2007; Pesaresi F & Brizioli E, 2010). 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. 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). 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 (Table 4).

The estimates available for insurance premiums for LTC are around €50 million for the year 2008 (Rebba, 2009). There is not official data on private expenditure for home social care. Rebba (Rebba, 2009) 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. The same study estimated that the value of informal home care would be around €4.8 billion.

Third: a fragmented institutional and service delivery structure. Health 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 *ASL*. 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, and Liguria.

Health community services are in most Regions managed by health districts, local articulations of ASL, which fund health services provided to patients by public providers and by private accredited providers (e.g. residential services). Patients are in principle free to chose providers, although the choice is in practice limited due to supply side shortages.

There are wide differences among areas, in particular, in the following system aspects:

- 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.

- 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.).
- 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, there are differences regarding: coverage targets; beneficiaries' categories; management of private services accrediting system - structural and organizational standards required to obtain the authorization and/or accreditation; adopted financing systems coverage percentage.

Fourth: 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 (e.g. the structural requirements for nursing and residential care facilities).

LTC reform and federalism: an unfortunate combination

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 framework national law on social care 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 law 328/2000 focused on the

institutional aspects of local policies, instead of focusing on defining the essential levels of care (LES), a basic benefit package. According to law 328/2000 Regions exercise the functions of planning, coordination, and monitoring social services. The implementation of this law through national regulations was blocked by the Constitutional reform of 2001[9], giving the exclusive responsibility on social legislation to Regions, apart from the essential levels of services, which remained in the responsibility of the State. That was the first time that the federal process overlapped with social care reform slackening its pace. The Constitutional reform on federalism implies that the only way for the Central Government to introduce a national reform aimed to guarantee LTC services on the whole national territory is now to set the LTC entitlements, the benefit package.

In any case, during the years 2000s many regions 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 ways and measures (Giorgi G Ranci Ortigosa P, 2008).

According to the law 328/2000 the main source of financing for social policies is the *Fondo Nazionale per le Politiche Sociali* (National Social Policy Fund – NSP Fund)[10], which includes resources for elderly and disable people. The amount of the NSP Fund assigned to Regions and Autonomous Provinces was less then €800 million in 2001 and increased to almost €1,000 in 2007. Nevertheless, since 2002, according to the Constitutional reform, Regions can allocate resources to the sectors they prefer.

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 (law 296/2006) – though with only a symbolic amount of €100 million for the year 2007 and €200 million for each of the following two years (then increased with additional €100 million for year 2008 and €200 million for 2009[11]). This LTC fund aimed going towards, in the long run, guaranteeing the implementation of essential levels of care to non self sufficient persons over the whole country. Although the amount of resources

allocated was small, this was the first attempt to explicitly allocate resources to LTC from the national level, and might serve as a leverage to reduce fragmentation of responsibilities and funding. It was also seen as a way to provide Italian Regions an incentive to increase the resources made available for LTC. In fact, in some Regions, following the establishment of the national LTC fund, regional LTC funds were established pooling funds from national and regional sources.

In 2007 the former central government had also agreed on a delegated law to reform LTC and social policies for families, but this has not been passed by the Parliament after the change in the national Government in year 2008.

The current Government did not fund the LTC national fund for 2011, while the NSP Fund for Regions was further cut down (less than €400 in 2010 and €300 in 2011)[12]. Instead, the rationalization of health and invalidity pensions' expenditure is seen as the first step to find resources for LTC (Ministero del Lavoro e delle Politiche Sociali, 2011). The Scheme of National Health Plan 2011-13 calls for strengthening home care[13] and reducing inappropriate hospitalisations and admissions in residential non hospital institutions. As a consequence of the strong increase in the number of benefits supplied to the "civil invalids", including the *indennità di accompagnamento*, between 2003 and 2010 (from 1,8, to 2,8 millions)[14], and the inhomogeneous territorial distribution (Ministero dell'Economia e Finanze, 2009), more stringent allocation procedures have been introduced. The second step aims at developing, through public subsidies, so called (private) integrative health insurance funds (*Fondi Sanitari Integrativi del Servizio Sanitario Nazionale*)[15]. To obtain subsidies (tax concessions), 20% of the resources raised by the integrative Funds have to be bound to specific sectors (Ministerial Decree of 31 March 2008), among which non self sufficient care (Ministerial Decree of 27 October 2009). The enrolment in integrative health insurance funds will be voluntary, while it is envisaged that in the future it might possibly become mandatory (Ministero del Lavoro e delle Politiche Sociali, 2011).

Nevertheless, the main priority of the current Government is the federalist reform. The very recent important measure introducing fiscal federalism - the delegation law 42/2009 approved on May

2009[16] and its delegated decrees - suppresses all financial transfers from the central to the decentralized governments, and from the Regions to the Local Authorities, but requires the integral funding of the essential levels of care - including health and social care - and the Municipalities basic functions in every Regions. This should be guaranteed through financial equalization aimed to assure the provision of LES. The latter have to be set with national law[17], as required by the Constitution.

To allocate the resources, the criteria of "standard" requirements and costs to provide services would have to be applied, i.e. the public action should be compared and evaluated through efficiency and efficacy indicators. Nevertheless production costs are difficult to measure and the necessary data often are not available or reliable. Therefore, in the health sector the old financing system, based on a pre-determined overall funding allocated on a per-capita basis[18], has been essentially confirmed[19]. For social care, mostly supplied by the Municipality, the process is much less advanced. Good information on the services locally supplied on the entire National territory is still lacking. Besides, the LES have not been determined yet - probably because of lack of resources to fund them. The law 42/2009 establishes to take into account the LES already set by the legislation, while waiting for the new definition of LES by National law. The legislative decrees establish that, in the meantime, the services to provide and the respective requirement are set through agreement achieved in "Conferenza Unificata"[20]. With the involvement of this Conference, in the transitory period (2012-2016), the central Government can activate compensative mechanisms and dynamic coordination rules for the public finance aimed to the convergence of standard costs and requirements, and a pattern of convergence to the service objectives to the LES and basic functions[21].

As for the Municipalities basic functions, the standardized expenditure will be calculated on the basis of a uniform per-capita share, corrected to take into account population size, territorial, demographic, social and productive characteristics, the need of infrastructures, the staff employed, efficiency, efficacy and quality of the services supplied and users satisfaction degree[22]. Statistical

techniques will be adopted, taking into account the clusters and using data on past expenditure (with some correction). Given the complexity of the process, the actual enforcement is foreseen only for 2017. As the social care is mostly a task of the Municipality, it is worth wondering whether and how this methodology is coherent with the setting of the essential levels of care by law.

Up till now the legislative decrees aimed to apply law 42/2009 have characterised the taxes which will finance Regions and Local Authorities and the equalization. Nevertheless, the issues of LES and the results in terms of resources distribution among the different Regions and Local authorities are still uncertain – apart from the health sector. A fiscal federalism without essential levels of care is a lame federalism, and a delay in LES determination weaken the equalization based on needs.

The law 42/2009 and its legislative decrees affirm and confirm that the implementation of fiscal federalism, the determination of LES, standard requirements and costs must not cause additional deficit, must comply with public finance obligations assumed with UE and international agreements. Moreover, the Government committed to avoid any increase in the overall fiscal pressure even in the transitory period. Finally, as seen, the funds for social spending have been cut off. The obligation to rebalance the public finance, plus the commitment on the fiscal pressure, plus the transfer decrease[23] can jeopardize any attempts to introduce a coherent reform of LTC. Cutting national funds, the amount of resources to devolve is reduced and the determination of the essential levels of care – or at least of some transitory minimum standard objectives – seems to become unrealistic (Marano A, 2011). The implementation of the law on fiscal federalism instead might further increase institutional fragmentation of LTC, exacerbating the already wide differences across Regions and Municipalities, if a real process of convergence is not set up in the transitory period.

Why Italy failed to reform LTC?

The present article described the Italian LTC system, in the wider context of the Italian welfare system, in light of the increasingly relevant need to take into account new social risks. Despite it is

widely recognized that the Italian LTC system would require a comprehensive reform, this hasn't happened yet. This section tries to explain why attempts to reform the LTC in Italy have failed, how this failure is related to the institutional conditions of the country and, in particular, to the ongoing, and unfinished, process of federalism. It will then draw some conclusions on what other countries may learn from the Italian case presented.

According to Costa-Font (Costa-Font J, 2010) a reform that would increase spending and the role of in-kind services, reducing also regional differences, was not implemented due to the strict fiscal policies and limited political representation of elderly people, that prevented this claim to become politically relevant. Italian Regions were unwilling to bear the costs of a system of LTC not funded by the central Government, and did not push for reform. They were rather focused on protecting the funding for the health sector, which has always been considered more politically relevant. The different levels of government failed to agree on sharing the financial costs of a reform. In addition, the rationalization of LTC would involve a review of current monetary benefits, with possible "resistance " to change of those groups (blind and deaf, on the one hand, groups of poor and unemployed in poor areas of the country, on the other) that currently benefit from it.

This analysis may be only partially right. In fact, the LTC constituency is not only large and growing as a result of rapid population aging, but it is also quite strong and unionized. The main trade unions in Italy have strong structures dedicated to retired people (with nearly 6 million members for the three largest Trade Unions)[24]. So, it is hard to say that elderly people are not politically represented. Nevertheless, there has been certainly a degree of "short-sightedness" in risk assessment, along with a difficulty to conceive forms of support other than traditional ones. The defence of the pension system (with particular attention to the level of treatment obtained by current retirees) and of the *SSN* was considered the first priorities even by the Unions. On the other hand, savings due to cost containment measures in social security and health, substantial since the nineties, have served mainly to contain the budget deficit, if not, ultimately, to cover income tax cuts. Thus, protecting traditional welfare components may be even considered a rational behaviour,

both by the elderly and their unions. Anyway, recently unions have started to be more active in supporting the case for LTC reform. They presented, for example, a bill of popular initiative in 2006 (A.C. 11, XV legislature, 28/4/2006), and supported the establishment of the LTC Fund.

As to groups likely to be hostile to reform LTC, it does not seem that the blind and deaf people are playing a relevant role, since spending on treatments that affect them is limited, less than 10% of total expenditure on civil invalid. Instead, the support to the *indennnità di accompagnamento* for non self-sufficient people, which covers 10% of people aged 65 and over, could gather a rather strong constituency, by a composite group including deprived persons and non self sufficient persons.

In addition, it should be noted that, in Italy, the parliamentary left largely supports not only the need to respect financial constraints, but more generally the dominant culture in the European Commission on the micro and macro-economic priorities. As this approach places emphasis on the possible non-Keynesian effects of fiscal policies, on the low "quality" of spending on welfare, on moral hazard and on the need to promote individual responsibility (Marano A, 2011), it ends up giving rather low priority to social spending. As a consequence, the latest centre-left governments focused more on tax cuts, deferring instead, and then failing to implement the reform of the LTC, apart from the establishment of the national Fund for non-self-sufficiency - that was largely under-funded.

The right-wing Governments have been concerned with the expansion of welfare expenditure and the state monopoly on spending decisions on social services. The current centre-right Government promotes an increased role of private and third sectors[25], focusing on individual responsibility at family level (Ministry of Labour and Social Policy, 2009) - a sort of “big society” Italian style. It is supporting the spread of voluntary integrative insurance schemes and, at the same time, it cuts funds for social services, introducing also measures to reduce spending on cash benefits paid by the central level. In addition, that part of the center-right coalition that represents the local interests of the northern areas of the country tends to channel any social demand or protest to the demand of

devolution and territorial protection of residents from all other subjects. Reforming the public LTC is thus not in the political agenda.

Regions do not have a strong incentive to push for a reform of LTC, because the costs of the shortcomings of the current system only partially fall on them, since there is no obligation to provide certain care services. Nevertheless, the main risk for Regions is that the unmet demand can be redirected to health services (e.g. inappropriate hospitalizations).

Regions are also in rather different situations, thus making more complicated to coordinate and push for LTC reform. On the one hand, Regions with *SSN* deficits are under pressure to cut health expenditure, leaving no room for anything else, and often have weak administrative capacity. On the other end, more affluent regions manage to offer better services, with their own resources, leaving behind the other Regions. Nor is believed that a LTC reform, as in other countries, could bring new resources, given the emphasis of national policies on fiscal discipline and the widespread perception of a tax burden already too high, which does not offer space to introduce new taxes or contributions (fiscal blame avoidance).

As for federalism, it is supported by: a) the central level, which aims at containing costs – through making Regions and local authorities accountable for expenditure, shifting also the fiscal blame to them; b) the affluent northern regions, willing to reduce re-distribution of resources to the poorest Regions, and to gain further autonomy. Southern regions are worried about federalism and appeal to the notion of solidaristic federalism, supported by the left-wing; with new LES they could even obtain more resources, if resources would have to be allocated taking into account the need. This complex situation is still unresolved.

Welfare reforms have thus been held back by the ongoing and unfinished process of federalism. This process is proving long and tortuous: two constitutional reforms were passed (one failed and the other not yet fully implemented), and two fiscal reforms (of which one failed and the other not yet implemented).

The possibility of central intervention has been limited by the new Title V of the Constitution, which has given the regions concurrent jurisdiction with the State on health services and exclusive on care services, eliminating constraints on how to allocate resources. The way to introduce a reform in the social field is now the definition of the so called LES (the basic benefit package), and this requires inter-institutional negotiations to implement them. Even approaching the problem of LES gradually, it is likely to prove unrealistic if funds for social policies are seriously cut (Marano A, 2011).

Currently, the second attempt at tax reform is being implemented through a long series of decrees which however do not really address allocative (i.e. which essential services should be fully funded) and distributive (i.e. redistribution across regions) problems yet, given also the wide territorial variation making the process highly controversial. While in Germany the distribution mechanism for taxing and spending powers implies a strong interdependence and encourages a collective action among Länder, in Italy the federalist revenue-sharing provision and equalisation mechanisms are not implemented yet, and only in the health sector intergovernmental bargaining about resources allocation seems to work.

Conclusions

In Italy thus there is a need to resolve the contradiction between competitive federalism and solidaristic federalism in a country with strong regional differences. The federalist reform is in fact stopping any other welfare reform.

This shows how announced but never implemented reforms can be paralyzing for the whole country. It is not the fact that changes are implemented step by step that blocks the country on one single reform. It is rather that the basic choices are never defined. Pretending to implement big innovations, rather than incremental changes, not addressing allocative and distributive nodes, bring the country to focus on a never ending unresolved issue, making it difficult to address the others.

The second point is that the division of Regions makes them unable to push for reforms. While in the health sector Regions and Central government worked collectively with a view of Nation-Building[26] - i.e. building a national identity –, for LTC prevailed an approach based on regional identity.

When institutional reform process is too slow and uncertain, it tends thus to block other reforms, and the presence of large territorial variations makes hard implementing federalism and at the same time can break the commonality of intents among local institutions in favour of welfare reforms.

Table 1. Elderly people (aged 65+ years) in institutional care by health condition *(values per 1.000 inhabitants aged 65+ years)* 31/12/2006*

Persons in institutional care	*Males*		*Females*		*Total*	
	N	*%*	*N*	*%*	*N*	*%*
Health status						
Self-sufficient	18.338	33.9%	49.850	28.3%	68.238	29.6%
Non self-sufficient	35.874	66.1%	126.355	71.7%	162.229	70.4%
Total	**54.262**	**100%**	**176.205**	**100**	**230.468**	**100%**

* The data on Bolzano are lacking
Source: (ISTAT, 2010)

Table 2. National cash benefit

Year	*Number of INPS cash benefit's beneficiaries (000)*	*% on persons ages 65+*
2001	577.4	5.5
2002	639.3	6.0
2003	708.6	6.5
2004	796.0	7.2
2005	880.6	7.7
2006	971.3	8.4
2007	1051.9	8.9
2008	1131.7	9.5

Source: (Lamura & Principi, 2010) Population: ISTAT (*http://demo.istat.it/*); Cash benefits up to year 2004: database INPS *(http://servizi.inps.it/banchedatistatistiche/vig9/index.jsp*),

Table 3. 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 and Calabria) and 2006 (Abruzzo)	<0.3%	
Puglia, Sardegna	2007 (Puglia) 2008 (Sardegna), data na	-	

Sources: (Lamura & Principi, 2010).

Table 4 Average expenditure per person admitted in residential institutions, year 2004 – monthly values in €

Type of institution	*€ covered by*						
	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: (Pesaresi F & Brizioli E, 2010)

REFERENCES

Armingeon K, & Bonoli G (2006). The politics of post-industrial welfare states. London: Routledge.

Bertoni F, Caffarena C, & Riboldi B (2008). Il quadro delle riforme. In: Il governo delle politiche regionali, (Gori C.eds). Le riforme regionali per i Non Autosufficienti, Carocci, Roma.

Bonoli G (2001). Political Institutions, Veto Points, and the Process of Welfare State Adaptation. In Pierson P (Ed.), *The New Politics of the Welfare State* Oxford: Oxford University Press.

Bonoli G (2005). The politics of the new social policies: providing coverage against the new social risks in mature welfare states . *Policy and Politics, 33*.

Braun,D., Bullinger,A.-B., & Walti,S. (2002). The influence of federalism on fiscal policy making. *European Journal of Political Research., 41*(1), 115-145.

Campbell AL., & Morgan KJ (2005). Federalism and the Politics Of Old-Age Care in Germany and the United States. *Comparative Political Studies, 38*(8), 1-28.

Cicoletti,D. (2008). Il percorso assistenziale. In: Il governo delle politiche regionali, (Gori C.eds). Le riforme regionali per i Non Autosufficienti, Carocci, Roma.

Connor W (1972). Nation-Building or Nation Destroying? *World Politics., 24*(3 April), 319-355.

Costa-Font J (2010). Devolution, Diversity and Welfare Reform: Long-term Care in the 'Latin Rim' . *Social Policy & Administration, Vol.44, No.4, August 2010, pp.481-494., 44*(4), 481-494.

Coyte C, Goodwin N, & Laporte A (2008). How can the settings used to provide care to older people be balanced? Policy brief, WHO Regional Office for Europe and European Observatory on Health Systems and Policies, WHO European Ministerial Conference on Health Systems, 25-27 June, Tallinn, Estonia.

Esping Andersen G (1999). *Social Foundations of Postindustrial Economies*. Oxford: Oxford University Press.

Esping Andersen G (2002). A child centred social investment strategy . In Esping Andersen G (Ed.), *Why we need a new welfare state*. Oxford: Oxford University Press.

European Commission (2007). Special Eurobaromer 283. Health and long term care in the European Union.

Fabroni,R. (2009). in La disabilitá in Italia: il quadro della statistica ufficiale, (Solipaca A eds) ISTAT collana Argomenti.

France G (2009). Nation-building e servizio sanitario nazionale. In Balduzzi R (Ed.), Trent'anni di Servizio Sanitario Nazionale, un confronto interdisciplinare. (pp.205-222). Bologna: Il Mulino.

Gabriele S, Pollastri C, & Raitano M (2009). Assessing Determinants of the Increase of Italian Households Vulnerability. *Rivista di Politica Economica, Monitoring Italy 2009, Measuring the Progress of Italian Society, (Brandolini A, Giovannini E, Malgarini M, Piga G eds).*

Giorgi G Ranci Ortigosa P (2008). Il governo delle politiche regionali, in Gori C.(, a cura di), Le riforme regionali per i Non Autosufficienti, Carocci, Roma.

Gori C, & Casanova G (2010). I servizi domiciliari. In Network per la Non Autosufficienza (Ed.), L'assistenza agli anziani non autosufficienti in Italia. (pp.35-52).: Maggioli Editore.

ISTAT (2006). Condizioni di salute e ricorso ai servizi sanitari, Roma, Istat.

ISTAT (2007). L'assistenza residenziale e socio-assistenziale in Italia, Roma, Istat.

ISTAT (2008). L'assistenza residenziale e socio-assistenziale in Italia, Roma, Istat.

ISTAT (2010). L'assistenza residenziale e socio-assistenziale in Italia, Roma, Istat.

ISTAT (2011a). Conti della protezione sociale.: available at http://www.istat.it/dati/dataset/20110517_00/.

ISTAT (2011b). Geo demo, available at http://demo.istat.it/index.html .

Kraus M, Riedel M, Mot E, Willemè P, Röhrling G, & Czypionka T (2010). A typology of systems of Long-Term Care in Europe .: Results of Work Package 1 of the ANCIEN Project, Final Report, Institute for Advanced Studies (IHS), Vienna, August.

Lamura, & Principi (2010). I trasferimenti monetari. In Network per la Non Autosufficienza (Ed.), L'assistenza agli anziani non autosufficienti in Italia. Rapporto 2009.

Marano A (2011). I tagli all'assistenza in Italia. Motivazioni e conseguenze. *La rivista delle politiche sociali.In press.*

Ministero del Lavoro e delle Politiche Sociali (2011). Rapporto 2010 sulla non autosufficienza in Italia.

Ministero dell'Economia e Finanze (2009). Relazione sul Federalismo Fiscale, Relazione del governo alle camere in ottemperanza alla disposizione dell'art. 2, comma 6, della legge 5 Maggio 2009, N. 42, June 30th, 2010.

Ministero per lo Sviluppo Economico (2010). Obiettivi Servizio Quadro Strategico Nazionale 2007-2013. Aggiornamento indicatori, Roma, october, available at http://www.dps.mef.gov.it/obiettivi_servizio/dati.asp .

Obinger H, Castles FG, & Leibfried S (2005). Introduction. Federalism and the welfare state. In Obinger H, Castles FG, & Leibfried S (Eds.), Federalism and the Welfare State: New World and European Experiences. Cambridge: Cambridge University Press.

Paci M (2007). *Nuovi lavori, nuovo welfare.* Bologna: Il Mulino.

Pesaresi F, & Brizioli E (2010). I servizi residenziali. In Network per la Non Autosufficienza (Ed.), L'assistenza agli anziani non autosufficienti in Italia. (pp.53-68).: Maggioli Editore.

Political Economy Committee (2006). Age-related public expenditure projections for the EU25 Member States up to 2050. Brussels: European Union.

Quattrini S, Melchiorre G, Balducci M, Spazzafumo C, & Lamura L (2006). Services for Supporting Family Carers of Older Dependent People in Europe: Characteristics, Coverage and Usage. The National Survey Report for Italy.

Ragioneria Generale (2011). Le tendenze di medio-lungo periodo del sistema pensionistico e socio-sanitario - Le previsioni elaborate con i modelli della RGS aggiornati al 2010. **Rapporto n. 11, Roma**.

Rebba,V. (2009). Long-term care in Italy. Presentation iHEA 2009 Beijing, July 14th 2009.

Robine J, & Michel J (2004). Looking forward to a general theory of population ageing. *Journal of Gerentology*, *59*(6).

Seshamani M, & Gray A (2004). Ageing and Health Care Expenditure: The Red Herring Argument Revisited. *Health Economics, 13*.

Solipaca,A. (2009). La disabilitá in Italia: il quadro della statistica ufficiale, ISTAT collana Argomenti.

Swank D (2001). Political institutions and welfare state restructuring: The impact of institutions on social policy change in developed democracies. In Pierson P (Ed.), The new politics of the welfare state. (pp.197-237). Oxford: Oxford University Press.

Taylor-Gooby P (2004a). New Risks and Social Change". In Taylor-Gooby P (Ed.), *New Risks, new welfare* Oxford: Oxford University Press.

Taylor-Gooby P (2004b). *New Risks, New Welfare: the Transformation of the European Welfare State.* Oxford: Oxford University Press.

Tediosi F, Gabriele S, & Longo F (2009). 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.*

Telford H (2003). The Federal Spending Power in Canada: Nation-Building or Nation-Destroying? *The Journal of Federalism*, *33*(1).

Tsebelis G. (1995). Decision Making in Political Systems: Veto Players in Presidentialism, Parliamentarism, Multicameralism and Multipartysm. *British Journal of Political Science.*, *25*(3, July), 289-325.

[1] In the literature different scenarios have been envisaged (Political Economy Committee, 2006; Robine J & Michel J, 2004; Seshamani M & Gray A, 2004).

[2] In fact people often "underestimate their own risk of needing long-term care and try to avoid pondering the unpleasant subjects of aging, decline, and dependency" (Campbell AL. & Morgan KJ, 2005).

[3](Swank D, 2001) for instance, in a quantitative analyses, finds a negative association between decentralization of policy making authority (including federalism) and social welfare effort.

[4] Often exercised through bicameralism and a constitutional court. On the concept of veto players see (Tsebelis G., 1995).

[5] As otherwise they had in any case to bear some burden for supporting elderly people with chronic illness.

[6] (Braun, Bullinger & Walti, 2002), considering the more general issue of the relation between federalism and fiscal policy making, underline that the distribution of taxing and spending powers and the patterns of intergovernmental relations are crucial.

[7] For an analysis of social vulnerability perception trend in Italy - based on consumer confidence - and of some features and determinants of this trend see (Gabriele S, Pollastri C & Raitano M, 2009).

[8] 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 (ISTAT, 2006). The National Institute of Statistics does not define the persons in need of LTC, it only defines disable people. Anyway, ISTAT definition has a statistical interest, but is not a legal definition, linked to any entitlement. 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.

[9] A second attempt to adopt a constitutional federal reform, aiming also to reinforce the executive, was rejected through a constitutional referendum in 2006.

[10] The Regions transfer resources to the Municipalities, that also use there own resources. The municipality's resources are strongly inhomogeneous.

[11] Nevertheless, at the same time the NSP Fund allocated to Regions decreased (€500 million in 2009).

[12] It is important to observe that, with the law 122/2010, aimed to the financial stabilisation, also the SSN funding for 2011 was reduced (-€1,500 millions) and the transfers to Regions, Provinces an Municipality were cut down as well (for a total amount of €6,300 millions for 2011 and €8,500 millions for 2012 and 2013).

[13] The switch from hospital to community care was a target also for the previous Governments, that had already imposed a target for the number of acute beds per residents.

[14] According to the Government this was due to the shift of the responsibilities on social policies to the Regions and this kind of benefits has been questioned as being a form of generic income support .

[15] Although it is to be noticed that the general framework for the Fondi sanitari integrativi had been outlined during the previous legislature.

[16] A previous attempt to implement fiscal federalism in Italy was made with the decree 56/2000 - which remained essentially unapplied - aiming to implement an automatic mechanism to equalise the resources among Regions, intended to progressively replace the criterion of the "historical expenditure".

[17] The LES, standard costs, and requirements will be set with reference to homogeneous macro sectors (health, social care, etc.), regardless of the level of Government supplying the services.

[18] Adjusted to account for determinants of health care use such as age for instance.

[19] The governance of the SSN results from a long process of negotiations between the central Government and the Regions, a major effort to increase Regions accountability and improve available data and information on health expenditure, and, also, more recently, on the services supplied (Tediosi F, Gabriele S & Longo F, 2009).

[20] The Conferenza Unificata has been established by the delegated decree 281/97. It includes the so called Permanent Conference for the relations among the Central State, the Regions and the Autonomous Provinces (Conferenza Stato Regioni) and the Conference for the relations State-cities (Conferenza Stato.Città) and should foster cooperation between State and local autonomies.

[21] A recognition of the LES in social care and other fields has to be carried out. Also a recognition of interventions needed for an infrastructural equalization is required, and more generally, as required by the Constitution, the Central Government should use additional resources and carry out special interventions to promote the economic development and remove the economic and social unbalances.

[22] The standard requirement is determined also taking into account a system of indicators aimed to value the services adequacy and consent to improve them.

[23] It seems that only the cut to Regions resources ex decree-law 78/2010 could be excluded when calculating the financing of the standard requirements which will substitute central transfers.

[24] CGIL, CISL and UIL.

[25] An example is the experimental credit card for the poor, managed by charitable private body.

[26] On Nation-Building e Nation Destroying see (Connor W, 1972; France G, 2009; Telford H, 2003).