THE SOCIAL HEALTH WELFARE SYSTEM AND THE LONG TERM CARE: LOCAL MODELS

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Abstract

The analysis focuses on recent revisions, in Italy, of social welfare systems in relation to Western demographic transformations. The focus of the study is dedicated to the exploration of services in the field of forms of care and assistance, in the more general area of chronic long-term illnesses in which to combine health care with social work projects in the most direct forms taking charge. Furthermore, the work also analyzes the role that the so-called "do-it-yourself welfare", or informal care work, represents in the context of institutional welfare.

Keywords: social work, services of welcare of health, social services, do-it-yourself welfare, institutional welfare

Résumé

L'analyse se concentre sur les révisions récentes, en Italie, des systèmes de protection sociale en relation avec les transformations démographiques occidentales. L'étude faire l'exploration de services dans le domaine des soins et de l'assistance, dans le domaine plus général des maladies chroniques, dans lesquelles il est possible d'associer les soins de santé aux projets de travail social les plus directs. En outre, le travail analyse également le rôle que le soi-disant «bien-être», ou travail de soins informel, représente dans le contexte du bien-être institutionnel.

Mots-clés: travail social, services des soins, service sociaux, bien-être, bien-être institutionnel

Rezumat

Analiza se concentrează asupra revizuirilor recente, în Italia, a sistemelor de protecție socială în raport cu transformările demografice occidentale. Accentul studiului este dedicat explorării formelor serviciilor de îngrijire și asistență, în domeniul mai general al bolilor cronice, al îngrijirii pe termen lung, în care întâlnim combinarea asistenței medicale cu intervenţiile de asistență socială. În plus, lucrarea analizează rolul pe care îl reprezintă așa-numita ”bunăstare individuală” sau ”îngrijire informală” în contextul bunăstării instituționale.

Cuvinte cheie : asistenţă socială, servicii de îngrijire a sănătăţii, servicii sociale, bunăstare individuală, bunăstare instituțională

1. Introduction

According to the definition provided by the *Organization for Economic Cooperation and Development* with Long Term Care means: "the set of

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services required by an individual whose functional, physical and cognitive abilities are reduced, and which consequently is in a position not independent for an extended period of time in carrying out the activities”[1]. The issue of long term care is necessarily linked to that of disability and non self-sufficiency, but it is important to underline that not all disabled people are not self-sufficient, just as not all non self-sufficient are elderly. In this regard, it is necessary to make a clarification: the ISTAT (Italian Statistic Institute) surveys in this regard do not examine children under the age of 6 and patients with psychiatric disorders.

That said, in this work, we will specifically consider the non self-sufficiency deriving from progressive aging.

The aging population is the demographic aspect that distinguishes our country in the international context. According to the latest ISTAT forecast (2017a), the percentage of individuals aged 65 and over, which already stands at 22 percent, will grow by more than 10 percentage points by 2050, coming to form 34 percent of our population. Will continue to grow the so-called old age index, which is the percentage ratio between the elderly population (65 and older) and the younger population (0-14 years) (ISTAT Annual Report 2017a, 96).

The growth of the index is continuous, as is evident from the data reported in Table below, and it is expected that it will increase from the current value of 165.2 to 283 percent in 2050, indicating that there will be almost three seniors over sixty-five for each young up to 14 years. The decrease in the birth rate also continues, showing that the average number of births is decreasing (in a year per thousand inhabitants).

This progressive aging of the population results in a new structure of the Italian population and its needs, with consequences that affect most of the sectors of society and with new balances to be found among the various population groups (NNA – Network Non Autosufficienza 2017, 33). One of the most important effects of aging is the growth in the health and social care needs of individuals in conditions of fragility, with about 2.5 million non self-sufficient people present in Italy (ISTAT 2014).

The increase in the complexity of the social and health assistance needs of the population makes it necessary, with regard to the provision of social and health services,

> to shift from a performance type of logic (more appropriate to the response to acute health needs, which require a ”here and now” type of assistance in

[1] http://venus.unive.it/share/fileadmin/Eventi/CNR/Brugiavini_CNR_n.pdf

hospital settings) towards a logic of "taking charge" of the individual, to be implemented at a territorial level through the implementation of a system based on Primary Care (Osservatorio nazionale sulla salute nelle regioni italiane 2017, 347).

There are three main forms of support available: public assistance services for long-term care (LTC), the direct contribution of families (family care-givers) and the work of family cares (the so-called caregivers) (NNA 2017, 33). Public spending on LTC services is accompanied by the always priority of families. From a multi-purpose survey promoted by ISTAT in 2011, the presence in Italy of at least 3,329,000 caregivers emerged that, in the family context, take care of elderly, sick, disabled and compensate the services formal, together with about 830,000 family assistants hired directly by the elderly and families (Pasquinelli 2013, 41-55)[2].

Table 1. Index calculated on the population residing in Italy

	Old age index	**Birth index x 1.000 inahbitants**
Year	1° gennaio	1°gennaio-31 dicembre
2010	144,0	9,3
2011	144,5	9,1
2012	148,6	9,0
2013	151,4	8,5
2014	154,1	8,3
2015	157,7	8,0
2016	161,4	7,8
2017	165,2	-

Data source: Istat 2017a

[2] What is seen in recent years is an increasingly reduced availability of public financial resources for the satisfaction of a social demand that appears, instead, rapidly growing (Ascoli and Ranci 2003).

2. The articulation of the public offering network for Long Term Care

In Italy, continuous public assistance assumes three main forms characterized by different access criteria and sources of funding: services provided by the National Health Service on a regional basis, monetary services provided by INPS and social assistance services provided by regions and local authorities (Rebba 2010, 116). Social and health interventions are planned and regulated by the Regions, while, at the local level, the Local Health Authorities and the Municipalities are responsible for the provision and financing of health and social interventions. The services can be purchased by other providers, public or private, accredited by the Region. In particular, it is the Municipalities that often resort to the outsourcing of social welfare services by turning to private non-profit providers. The services provided by the National Health Service and by the regions and local authorities include residential, semi-residential and home-based services. In fact, these are territorial services, which are provided by local health authorities, public producers and private producers (Fosti and Notarnicola 2014, 98).

2.1. *Types of Services with public ownership for LTC: Home care: ADI and SAD*

The health and social services for the disabled, the elderly and non self-sufficient people, are distinguished, according to the place of intervention, in home and residential (Mauri and Pozzi 2007, 4). In the recent past, the progressive expansion of the local network of public-owned services has concentrated, in most of the country, mostly on two poles. On the one hand, integrated home care (ADI), with nursing-nursing responses, which generally provides few interventions by accident, through a mainly performance approach and for limited periods of time. On the other, the residential structures, focused on people in conditions that are much more critical than in the past and that therefore require increasingly demanding assistance. The other actor in the field, that is the municipal social service, has long experienced a reduction in his home care (SAD), whose extension is nowadays very limited (NNA 2017, 19).

The Municipal Social Service is a service relatively continuous over time that concerns interventions aimed at individuals or families who, in particular situations or due to an incomplete self-sufficiency, are not able to satisfy personal and domestic needs. This service is the responsibility of the Municipalities through the professional figures of the social worker who detects

the need and draws up the intervention project, and the assistance operator, who, at home, realizes assistance and sanitary protection interventions for the person (get out of bed, cleaning of the person, help with eating, etc.), housekeeping, social secretarial and other interventions.

In many cases, as already mentioned, the services are managed by non-profit individuals and social cooperatives. "Overall, the SAD registers an inadequate supply both in quantitative terms (...) and in qualitative terms (...) and this is also evidenced by the strong increase in the last years of the demand for home care offered by non-specialized operators (caregivers) with expenses charged to families" (Rebba 2010, 119). In most of the municipalities this service is not free, but provides for an economic sharing by the user based on his socio-economic situation.

Unlike SAD, the ADI is mainly characterized by health services, then medical, nursing and rehabilitation, and/or social assistance, related to personal care, coordinated with each other in a personalized assistance program and provided at the domicile of the assisted by various professional figures within the District as provided for by national legislation, including National Collective Agreements for General Medicine, and by acts approved by the Regions on social-health assistance[3]. The ADI is managed by the ASL which provides the patient with nursing services (eg withdrawal, mobilization, administration of therapies) rehabilitation, medical (eg specialist visits, diagnostic-instrumental examinations) therapeutic (eg oxygen therapy, enteral nutrition). On the other hand, social welfare services (personal hygiene and the home environment, surveillance for drug therapies, home meals activation and transport) are provided by the municipal social services in agreement with the District (Mauri and Pozzi 2007, 5).

The signaling to the District of the problem of assistance can be made by the person concerned, by the general practitioner or hospital, by the social services of the municipality or by the family members. At a later time, the requests are collected and analyzed according to the user's needs, the intervention objectives are defined and, in the most complex cases, the intervention of the Multidisciplinary Evaluation Unit is requested.

In general, the taking charge of the person reported is just following an analysis of the situation and verification of the existence of the need presented through this Unit that defines the single program of care intervention (type, quantity and frequency of social and health interventions) to be provided home.

[3] https:/www.altroconsumo.it/salute/diritti-in salute/speciali/assistenza-domiciliare/servizi#

3. Residential and semi-residential assistance

According to the definition of the Ministry of health, with "residential and semi-residential assistance" we mean "The integrated complex of health, social and health care interventions, procedures and activities provided to non self-sufficient and non-home-care workers, within suitable 'nuclei accredited' for the specific function". Residential and semi-residential cares are increasingly important due to the progressive aging of the population and the consequent presence of chronic-degenerative diseases. Admissions can be definitive or temporary[4]. This type of assistance includes medical, nursing, rehabilitation and hotel services, based on the specific needs of users. The insertion of an assisted person is defined by the Multidimensional Evaluation Unit (or Geriatric, in the case of the elderly) of their Health District. The client can be called to share, partially or totally, the costs of the service, on the basis of criteria defined by the local health authority.

3.1. *Residential services*

The residential care activity is aimed at non self-sufficient or partially non self-sufficient people and is provided in residential structures with different levels of specialization. On paper, the RSA, are aimed at providing temporary healthcare (about three months) of temporarily self-sufficient individuals discharged from the hospital. In reality, 24 percent of the elderly in RSA are self-sufficient, the health services are not always preponderant on the entire treatment provided and the length of hospital stay is normally more extensive than that expected, if not even definitive (ISTAT 2002). The social and health residential facilities have the aim of allowing people who cannot be assisted at home (due to the difficulties of the family or the high level of care they need) to continue living as much as possible as if they were in own home.

The welfare services are based on the integration of health services with the social ones and involve several stakeolders present in the territory, such as voluntary associations, families and individuals. In addition to health care, other services relating to personal care, hygiene and nutrition are provided.

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[4] http://www.salute.gov.it/portale/temi/p2_5.jsp?lingua=italiano&area=sistemaInformativo&menu=residenziale

3.2. *Semi-residential services*

Semi-residential care activity takes place in a day center, an alternative structure to hospitalization that has as its objective the support to families who take care of a person in need every day. The primary objective of these structures is to favor the recovery or maintenance of the residual abilities of the patient so that he can continue his stay in the family. The activities that are carried out within day care centers are social-assistance, recreational and socializing. The insertion of a person in these Centers, as well as the definition of the nature and frequency of the services is preliminary to the evaluation of a specific Unit, which also defines the assistance program.

According to the 6th Report 2017/2018 on the assistance to non self-sufficient elderly people in Italy, edited by NNA (2018, 19),

> the territorial welfare, in summary, has come increasingly articulated mainly between an ADI mainly performance and a residency for those in particularly serious conditions (...). The overall network of services, as configured, is obviously incomplete. The set of responses present in the territories, in fact, leaves a large gap between these two supply units: there are no other types of interventions able to fill it and thus satisfy the many needs that do not match existing services. The need to further articulate the methods of responses available are increasingly recognized and in many local areas, reflections, experiments and innovations are under way in this direction, while in others some interventions are already in place.

4. Private home care

The phenomenon of private home care has taken on a very important role in Italy. This is due to some elements that characterize the welfare system of our country:

> To a background characterized by relatively low institutionalization rates, low diffusion of public home services and by caring loads which are mainly concentrated on the family unit, the transformations that have affected contemporary family, with the growing aging of the population that leads to a greater need for welfare labor, the lowering of fertility rates, the nuclearization and the embrittlement of informal support networks (Pozzi and Mauri 2007, 5).

The 2017 data published by the Leone Moressa Foundation, based on the statistical sources of ISTAT, INPS and Domina (National Association of Household Families), show how, in a market, always growing, domestic workers, caregivers represent a category destined to increase. Consider that

since 2007, the total number has grown by 42 percent, with a slight decrease in 2015, but this is due to administrative and regulatory measures. The areas of origin are mostly belonging to Eastern Europe followed by Italy and the Philippines.

5. Conclusions

In Italy, to date, the ADI is guaranteed by 100 percent of the local health agencies, even within the deep geographical, political and economic differences, the inter-regional regulatory fragmentation and the succession of numerous reforms, which led to a different declination of the ADI at the local level according to multiple models. The result is a variegated panorama, whose organizational nuances differ to such an extent that the description becomes difficult, inducing numerous reflections on the real efficiency of the system and its potential for development. Within the multiplicity of models, there is a first macro-differentiation:

> on the one hand, there are the Regions and the ASLs in which the Municipalities have delegated to the ASLs also the social-assistance activity or, as often happens in our sample, there are structured junctions between the two bodies at the level of programming, assessment of the need and activation of the service; on the other, there are the regions in which ASL and Municipalities move independently, responding in a separate way to the health and social needs of the assisted, even when, as in most cases, the assessment of the care need is carried out together with the social worker (who can be in charge of the Municipality or the Local Health Authority), a figure always envisaged also in cases of taking charge at the time of hospital discharge (Vetrano and Vaccaro 2017, 22).

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