AN ANALYSIS OF THE INTEGRATION STATUS OF HOME HEALTH AND SOCIAL CARE SERVICES, WITH A FOCUS ON INFORMATION SYSTEMS, MULTIDIMENSIONAL ASSESSMENT SYSTEMS, AND INTERNATIONAL BEST PRACTICES, INCLUDING SOCIAL PRESCRIBING

OUTPUT 3

OECD
BETTER POLICIES FOR BETTER LIVES

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Ministero della Salute

ProMIS

OECD Directorate for Employment, Labour and Social Affairs &
OECD Trento Centre for Local Development

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Executive summary

Why is it important to develop an integrated care system aimed at dependent individuals? Which governance framework can facilitate co-ordination among various governmental levels and between the public and Third Sector in Italy? Additionally, what territorial challenges hinder the co-ordination among diverse caregiving roles, and what bottlenecks arise? What actions are necessary to develop informative systems and integrated service models bridging healthcare and social domains? What practices stand out as significant and innovative on the global stage?

This report aims to provide answers to these questions and address the primary issues raised by population ageing and the rise of chronic illnesses. It is a broad and pressing topic, at the forefront of concerns for policymakers, users, and those working in healthcare and social settings across many OECD countries.

The underlying premise of this report and the broader project it is a part of is that the complexity of the needs of individuals in need of home care – along with the challenges faced by caregivers – demand a coordinated, holistic, person-centred approach capable of overcoming traditional divides between the healthcare and social sectors.

The main objective of this report is therefore to shed light on the challenges and opportunities associated with the integration of home health and social care services for dependent individuals. It aims to achieve this through a careful and detailed exploration of the key dynamics within the sector, identifying best practices both in Italy and abroad, while also questioning major innovations and potential areas for improvement. Particular attention is given to the regional and local dimension, given the ongoing decentralisation of the healthcare and social system in Italy for over two decades. It does so by paying special attention to providing policymakers with the necessary elements to design and reform integrated care systems, focusing on individual-centred approaches and making them sustainable in the long term.

To achieve this goal, which is neither easy nor immediate, the project team has adopted a multidisciplinary approach. This involves combining a thorough review of existing policies and practices with a detailed analysis of national and international databases. The study also makes use of new and unpublished data collected through a survey conducted by the OECD targeting Italian regions and autonomous provinces between February and March 2024. This wealth of information has enabled a fresh perspective on a field whose fragmentation has long hindered both research and impact assessments.

Furthermore, through an analysis of experiences gained in other countries, efforts were made to identify the best strategies and key lessons that, with the necessary adjustments, could be applied to the Italian context.

Given the complexity of the subject, the analysis was structured around four macro-areas: governance, workforce, data and information systems, and service delivery. Each of these areas represents an essential piece in the mosaic of practices, policies, and services that make up the universe of "integrated care". The integration of care, or integrated assistance, is a healthcare policy objective aimed at promoting patient-centred, value-based, and resilient healthcare systems. This goal has gained traction in recent years with the increasing prevalence of chronic diseases and their growing burden on societies. Examining these macro-areas has allowed for a detailed understanding of the challenges, needs, and opportunities to effectively improve the system. For the sake of analysis and presentation simplicity, each area has been discussed separately with a dedicated chapter. However, collectively, they form a single system which is deeply interconnected and interlinked.

The study highlights that, in Italy, efforts are underway to develop a multilevel and participatory governance model for integrated care, involving local administrations and the Third Sector to reduce service fragmentation and improve programming and co-ordination.

On the professional front, legal and training barriers hinder multidisciplinary collaboration among healthcare, social healthcare, and social services personnel in the formal sector, which is also facing a growing labour shortage. Simultaneously, the need to strengthen recognition and protections for family caregivers and personal/family assistants persists, as – despite the prevalence of undeclared work – they continue to shoulder the majority of caregiving responsibilities.

The challenge of integrating healthcare and social information systems remains critical: despite progress in digitalisation, sectoral and territorial discrepancies persist, along with limitations in interoperability, hindering effective data management and coordinated care.

The regions and autonomous provinces themselves generally view integration in service delivery as inadequate. However, initiatives like social prescribing emerge as innovative models to enhance integration and equity in service access, addressing social and healthcare needs holistically.

Lastly, the report introduces a preliminary dashboard proposal comprising 34 indicators across the four analytical dimensions. This tool is deemed valuable for estimating, with an acceptable level of approximation, the level of integration attained in the 18 participating regions and autonomous provinces, as well as the gap from an optimal level.

Summary

The definition of an integrated care model

In Italy, over the past few decades, the demographic transition driven by declining fertility rates and increased life expectancy has had significant epidemiological and social repercussions. There has been significant growth in the prevalence of chronic conditions among the population, which often require long-term care and ongoing support. This situation has heightened the need for establishing an integrated care system for dependent individuals.

In Italian discourse, the concept of integration between the healthcare system and social services has long been considered the linchpin for new policies capable of reorganising existing services, addressing the fragmentation and lack of co-ordination that characterise them. The increased awareness of the influence of social factors on health has led to the identification of integrated social healthcare as the tool to implement a renewed approach to assistance, capable of addressing the multidimensional and complex needs of dependent individuals.

Internationally, multiple definitions and models of 'integrated care' are observed. The World Health Organization (WHO) defines it as "an approach to strengthen people-centred health systems through the promotion of the comprehensive delivery of quality services across the life-course, designed according to the multidimensional needs of the population and delivered by a multidisciplinary team." Models of public health management and chronic care have been developed in various countries to increase the quality of care services and improve the well-being of the population.

The evidence supporting the positive impact of these integrated care initiatives on improving service access and user satisfaction is becoming increasingly robust. Moreover, some experiences demonstrate how integrated care allows for the improvement of intervention appropriateness, reduction in hospital admissions, and preservation of individual autonomy, thus ensuring overall well-being.

Analysing the state of integrated social healthcare in Italy requires the use of a comprehensive model informed by approaches developed internationally but specifically tailored to the national context. Building on proposals developed as part of the SELFIE project[1] and by the Social and Healthcare Integration Observatory [2], an evaluation model across three territorial levels (macro/national, meso/regional, and micro/local) is proposed, which includes four key dimensions for integration (governance, workforce, information systems, and service delivery).

This framework represents the conceptual basis for an investigation carried out in the first quarter of 2024 on the models and practices of social and healthcare integration used in the Italian regions and autonomous provinces, the results of which are presented below. Supporting the national reforms

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[1] The SELFIE project, an acronym for "Sustainable intEgrated care modeLs for multi-morbidity: delivery, FInancing and performancE," was funded by the EU under the Horizon 2020 framework program. For more information: https://cordis.europa.eu/project/id/634288.

[2] For more information: https://www.oiss.it/.

undertaken by Italy in this context, these findings are accompanied by descriptions of relevant examples of international best practices.

Multilevel and participatory governance: a rapidly evolving dimension

The governance of social and healthcare interventions at home, such as supporting activities of daily living, plays a crucial role in reorganising the current system towards greater integration. It encompasses the planning and financing of services, thereby shaping their nature, quantity, and delivery methods. Service integration can be achieved through a coordinated and participatory governance model involving various levels of government.

In Italy, the governance of home social and healthcare services for dependent individuals is highly decentralised, spanning various levels of government: national, regional or autonomous province, and local (multilevel governance). Like in most OECD countries, regions and local authorities in Italy have increasingly played a prominent role in service governance since the 1970s. Furthermore, due to its ability to understand and respond to the complex needs of the dependent population, in recent years, the participation of civil society in general – and the Third Sector in particular – in service governance has taken on a crucial role (participatory governance).

In recent years, Italy has also seen the launch of several initiatives aimed at improving the governance of home care services.
At the national level, the establishment of the *Interministerial Committee for Policies in Favour of the Elderly* (law 33/2023) was recently established, while a push towards social healthcare integration at the governance level is also evident in the National Plan for Dependency 2022–2024. Simultaneously, there is a growing use of tools to organise and co-ordinate health and social activities at the territorial level. These include Territorial Activity Programmes on a regional basis, Area Plans for social areas, and Programme Agreements to connect various levels of government. Following the 2017 reform of the Third Sector Code, the Third Sector has increasingly become central to shared administration initiatives with the public sector through co-planning and co-design.

Nearly all the regions and autonomous provinces responding to the OECD questionnaire (17 out of 18) report having their own governance tools to enhance the integration of care services. Specifically, 12 regions have promoted social healthcare integration through targeted investments and projects, and 7 have initiated co-programming experiences with the Third Sector, which serves as a social and economic system that complements public institutions and the market, interacting with both in the interest of communities.

Despite these initiatives, more than half of the respondents (11 out of 18) indicate that the current level of integration between the two types of home care in Italy – Integrated Home Care (Assistenza Domiciliare Integrata [ADI]) and the Home Assistance Service (Servizio di Assistenza Domiciliare [SAD])[3] – remains largely insufficient. Challenges cited include difficulties integrating planned intervention models, coordinating the delivery of nursing services (ADI) and social inclusion support services (SAD), and fostering inter-professional collaboration.

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[3] the Integrated Home Care Service (ADI) and the Home Care Service (SAD) are both services to help elderly, disabled or mentally or physically frail individuals. Despite this commonality, they meet distinct needs. ADI consists mainly of healthcare services delivered in the home by medical or nursing staff. Although the name itself emphasises integration, the services provided in the home are purely health-related and short term. SAD, on the other hand, involves the provision of services of a social nature, i.e., forms of support in the performance of activities of daily living in the home environment related activities, such as personal and household hygiene, provided by social workers and other professionals in the social and health sector.

Several international examples of successful social healthcare service integration at the governance level can serve as inspiration for the Italian experience. Eleven OECD countries (Austria, Colombia, Korea, Estonia, Finland, Japan, Norway, the Netherlands, the United Kingdom, the United States and Sweden) have established a single ministry for health and social policies at the national level. Others, such as Denmark, Finland, France, Norway, and Sweden, have created interdepartmental bodies to enhance the governance of health and social services. They have also introduced co-ordination mechanisms between the national government, regions, and municipalities for improved planning and management of services. A noteworthy experience is that of the autonomous community of Catalonia in Spain, which plans to establish an agency as a new body for the integrated management of the budget dedicated to health and social care services and the related information systems.

Workforce integration: obstacles in the formal and informal sectors

Achieving full integration of social healthcare requires enhanced co-ordination among the professionals directly involved in caregiving activities. On one hand, it calls for greater interpenetration between the functions and skills of social health care professionals within the formal sector. On the other hand, it underscores the growing need to fully recognise the roles of family caregivers and personal assistants in the informal sector. These individuals play a vital role in connecting existing services with the needs of dependent individuals and constitute a significant portion of the caregiving workforce in Italy.

In Italy, various obstacles hinder professional-level social healthcare integration. Legally, the principles of protecting worker professionalism and dignity restrict the expansion of contractually defined duties. In terms of training, the prevailing approach in tertiary education and continuous professional development is confined to specific sectors, offering limited emphasis on multidisciplinary collaboration. Additional barriers stem from the shortage of workforce in both the healthcare and social sectors, limiting the potential pool for integrated training initiatives.

The OECD survey reveals that most regions and autonomous provinces allow a variety of professionals to request and participate in assessments (these two phases involve up to 8 and 11 actors, respectively, in some areas). Furthermore, almost all responding regions and autonomous provinces (16) provide opportunities for collaboration among the professionals involved in assessments.

However, professional integration diminishes during the service delivery phase. This is evident not only from the high number of respondents who consider the integration level between ADI and SAD to be insufficient but also from the low number of regions (6) that use a case manager to promote an integrated care approach.

Internationally, there are several initiatives aimed at enhancing the role of healthcare professionals in identifying and addressing population needs. In Austria, for example, a pilot project focuses on community nurses as key supporters of elderly individuals and their families within local communities. This initiative is bolstered by robust monitoring conducted by a scientific partner, which will provide evidence on the impact of multidisciplinary interventions on the well-being of dependent individuals. In light of the increasing recognition of family caregivers' rights at the national level, almost all Italian regions and autonomous provinces have implemented measures to support this vital role. Prevalent forms include monetary disbursements, training courses, information desks, and psychological support.

Most Italian regions and autonomous provinces also have their own legislation that provides for and/or defines the role of personal or family assistants. Given the high prevalence of irregular work (between 52% and 76% of personal/family assistants work irregularly, according to different estimates) and the challenges in monitoring the quality of care provided, some regions have implemented measures to promote the regular employment of assistants. These measures include tax incentives, financial contributions, and the establishment of regional registries. Such initiatives could be reinforced by recently introduced national policies aimed at promoting and standardising the training of personal/family assistants and their regular employment.

Despite these promising developments, the vast majority of responding regions and autonomous provinces (14) indicate that they do not have data on the number of family caregivers, and despite the presence of statistical reports, on personal/family assistants active in their territory. This reveals a potential limitation on their ability to develop appropriate policies for these professional roles.

The adoption of policies to support family caregivers is crucial to ensure the well-being of these essential figures in the care of dependent individuals and to improve the quality of life for all involved parties. Several good practices in this area are observed internationally. In the United Kingdom, for example, caregivers have the right to request an assessment of their well-being and the creation of a personal care plan. Sweden has also established methods to assess caregiver well-being and support their role in caring for dependent individuals, aimed at improving the quality of life for both parties. In Australia, the establishment of the Carer Gateway provides family caregivers with an extensive array of relief services and accessible training, even during emergencies.

Information systems: the challenge of interoperability

The availability of data in the healthcare and social sectors is fundamental for effectively designing and monitoring public policies in these areas. In particular, a key tool for full integration between the healthcare and social sectors is provided by the interoperability of their respective information systems. Efficient management of healthcare and social data can enable professionals in the healthcare, social healthcare, and social services sector to plan interventions in a fully informed manner. Moreover, the presence of interoperable information systems can enhance the equity of the care system, the quality of interventions, and patients' participation in intervention planning. In Italy, achieving this goal faces a significant hurdle due to the gap between the level of digitalisation in social and healthcare information systems.

Within the social sector, the Unified Information System of Social Services (SIUSS), introduced nationwide in 2017, is an information resource with great potential for collecting data on social benefits. It presents itself as a valuable tool for policymaker, aiding the planning, monitoring, and evaluation of social policies.

However, its effectiveness is hampered by limited data transmission from municipalities, many of which have yet to embrace digital solutions, resulting in a fragmented information landscape. At the regional and local levels, the OECD survey also reveals the presence of an innovative digital resource for managing and storing social service information: the Computerised Social Record (CSI). This tool is already operational or on the verge of activation in 15 of the 18 responding regions and autonomous provinces. However, CSI implementation is fragmented at the territorial level, even within individual regions. Major obstacles to its full implementation include the lack of appropriate technical and IT tools and privacy issues.

In the healthcare sector, the digitalisation of information systems appears more advanced and less fragmented, and several tools have been introduced since the 1990s. Among these, the Home Care Monitoring Information System (SIAD) allows the collection of data on social healthcare interventions provided by the national health service in the home care setting. The *Electronic Health Record* (Fascicolo Sanitario Elettronico, Electronic Health Record [FSE]), established in 2015, also allows professionals and patients to easily access health data. Among the regions surveyed, nine indicated that issues related to privacy, resistance from healthcare workers, and a lack of specific training hinder the complete implementation of the FSE at the regional level. The enhancement of FSE usage will be encouraged nationwide by the Steering Committee of the New Health Information System (Cabina di Regia del Nuovo Sistema Informativo Sanitario [New Health Information System]), which establishes strategic objectives and new functionalities for the FSE.

The shortcomings exposed in the digitisation of the health and social care information systems are accompanied by a limited level of interoperability, found at both the national and regional levels. The survey indicates that only in three regions is an integrated information system for ADI and SAD currently being prepared. Even at this juncture, the main obstacles encountered are related to privacy and the lack of adequate technical-information tools. Some recent national initiatives aimed at promoting data interoperability, particularly the establishment of the National Digital Data Platform (PDND), may encourage the emergence of new regional and local experiences in the social healthcare sector as well.

Internationally, several good practices of integrating healthcare and social information systems are observed, for example in Finland, England (United Kingdom), and Catalonia (Spain). In Finland, the Kanta system represents a model of excellence for the centralised and secure management of data collected from public and private services, capable of improving the efficiency of the care system and promoting patient empowerment. In the United Kingdom, the Federated Data Platform (FDP) fosters collaboration among hospitals, healthcare facilities, and social healthcare services. It grants access to family caregivers, optimises healthcare resource management, and safeguards patient privacy. In Catalonia, the integration of healthcare and social information systems is promoted by government initiatives aimed at improving interoperability, ensuring effective use of data for policy planning, and enhancing the quality of the integrated care system for people with disabilities.

Service delivery and social prescribing: towards new home care intervention models

The co-ordination of intervention methods of care for dependent individuals represents the final pillar of social and healthcare integration described in this report. As mentioned earlier, Italy envisages two different home care services based on cultural models and the nature of services offered: ADI, falling under the jurisdiction of the national health service, and SAD, a social service under the jurisdiction of municipalities.

Due to these differences, as previously outlined, the majority of regions believe that the level of integration between these two service models can be significantly improved. This assessment is supported by available evidence; for instance, only 7% of elderly ADI beneficiaries also receive SAD.

Recent national initiatives, such as the introduction of new dimensional assessment tools for dependency (Legislative Decree 29/2024) and disability (delegated law 227/2021), the single access point (PUA) as a unified gateway to healthcare and social services, and the individual care plan (Progetto di Assistenza Individuale [PAI]) as a privileged tool for planning interventions for individuals, may incentivise co-ordination between the existing service models.

Internationally, good practices are observed in integrated service delivery and multidimensional assessment systems for the needs of dependent individuals, as well as integrated intervention planning. For example, in the Basque Country, Spain, local integrated care service ecosystems are being initiated, which involve defining individual care plans for dependent individuals by a team of professionals, including a case manager.

An innovative tool for integrating health and social care and improving equity in the care system is social prescribing. This concept embraces a variety of approaches to address the social needs of patients in a more holistic manner, removing the economic, geographic, interpersonal, or psychological barriers that individuals may encounter in developing new skills, participating in meaningful activities, and connecting with their communities.

The services provided within the social prescribing network are numerous and diverse in nature, ranging from services that address basic material and legal needs (e.g. food, housing, transportation), to lifestyle interventions to improve health behaviours (e.g. exercise, diet, smoking cessation), to programmes for the development of vocational skills (e.g. education, vocational training) or social activities (e.g. volunteering, arts and crafts, nature activities, community engagement).

This approach is spreading internationally, albeit with highly differentiated practices. In England, social prescribing is already a key component of the approach to personalised care for all ages and populations. In Spain, social prescribing can be prescribed to any patient of any age. In the United States, attention is focused on basic needs (food and housing), given significant socioeconomic inequalities and a weaker public social safety net. In the Netherlands, Sweden, and Wales, social prescriptions have often focused on combating social isolation and promoting overall well-being.

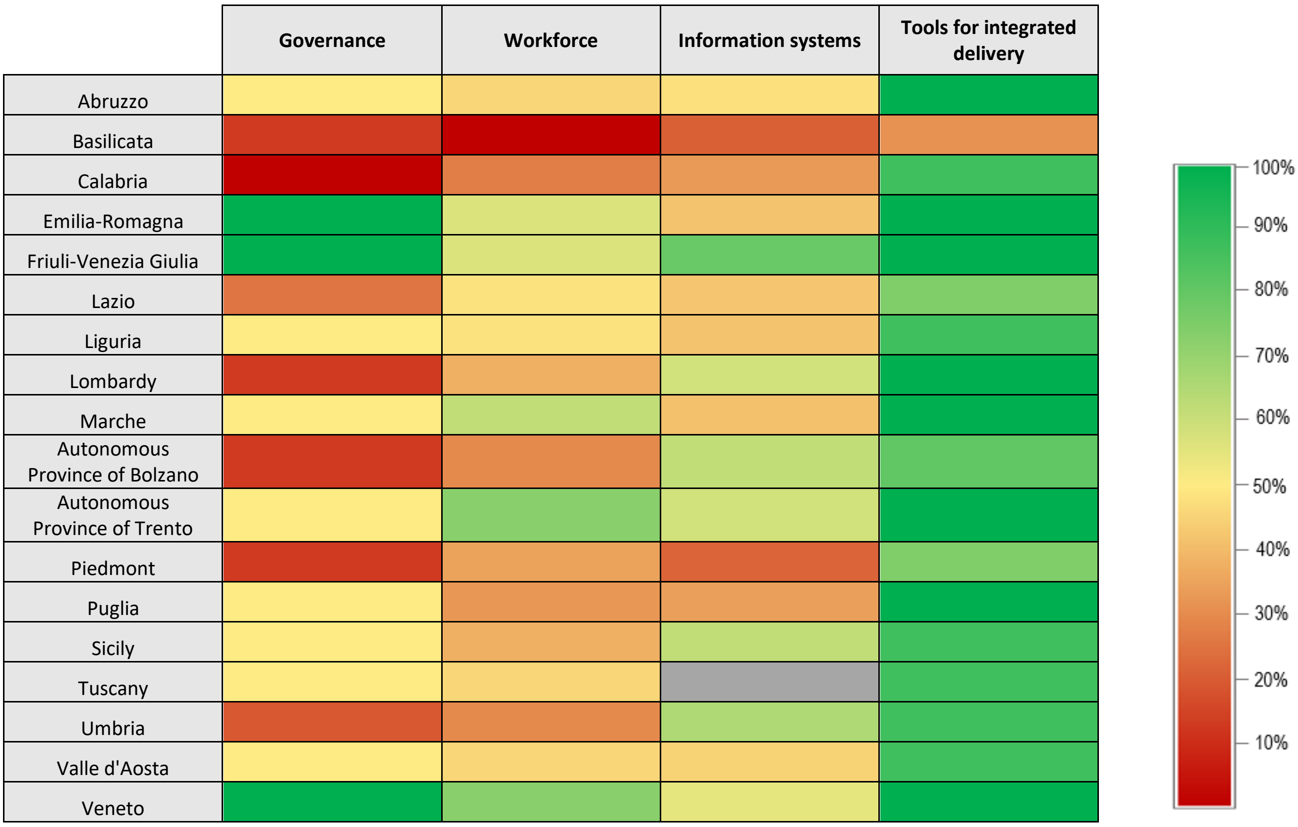
In this context, the role of the link worker is of particular importance. This professional can be identified as someone capable of connecting the most vulnerable patients with community resources and building a trusting relationship with the patient, working in collaboration with the healthcare and social assistance system. In some countries where this role already exists, such as Portugal and Spain, this professional is able to encourage collaboration between primary care, public health, social services, and the community, significantly contributing to the creation of a truly integrated and person-centred care system.

The distance from a model of integrated home health and social care interventions

The preliminary dashboard below, based on a set of 34 indicators divided into the four dimensions of analysis, allows for an estimation, with an acceptable level of approximation, of the level of integration achieved in the 18 regions and autonomous provinces that participated in the survey, and how far they are from a model of integrated home-based social healthcare interventions. This model corresponds to the availability of the entire set of functional tools for integration related to the four dimensions examined: governance, workforce, data and information systems, and integrated social and healthcare service delivery.

Dark red indicates a marked discrepancy from the model, while the progressive shift to green indicates a closer approach to the adoption of an increasingly advanced and comprehensive model of integrated social and healthcare services.

The preliminary dashboard can be used to identify the four pilot sites for the project "Towards Integrated Person-Centred Social Healthcare in Italy".


Governance
Workforce
Information systems
Tools for integrated delivery
Abruzzo
Basilicata
Calabria
Emilia-Romagna
Friuli-Venezia Giulia
Lazio
Liguria
Lombardy
Marche
Autonomous Province of Bolzano
Autonomous Province of Trento
Piedmont
Puglia
Sicily
Tuscany
Umbria
Valle d'Aosta
Veneto
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%

Defining a model of integrated health and social care interventions

The analysis of the state of integration of home health and social services for the dependent population in Italy requires a clear definition of care integration and dependency. However, defining such concepts is not a simple task, and the literature has often focused on finding adequate definitions and building models of integrated social healthcare interventions.

This chapter will focus on discussing existing definitions of integrated care and dependency in order to propose a model for integrated social healthcare interventions.

The concept of integrated care is complex and multidimensional

As chronic diseases affect an increasing proportion of the population and have become a public health priority, various theoretical models have been developed to conceptualise the system's support for the population's health needs, such as *population health management* and *chronic care management.*

The integration of social care interventions is essential for maintaining and improving the health status of the population

Both the *population health management model* and the *chronic care management model* take a holistic approach to people's health, addressing issues related to the physical and mental health of the population, improving the well-being of the workforce, and reducing the cost of care (NHS, 2024) (Deloitte centre for health solutions, 2019) (Capelli, Quattrini, Abate, Casalgrandi, & Cacciapuoti, 2016). These approaches involve community engagement and co-ordination with the social care sector to maintain or improve people's well-being, distinguishing themselves from a care system focused solely on the health sector.

To achieve the set objectives, population health management and chronic care management models require the integration of care – within the healthcare system and between the healthcare and social sectors — to be successful. Although the concepts are strongly interconnected, integrated care — or care integration — is a flexible model that can be focused and tailored to a target population group. Furthermore, care integration can involve all dimensions of the healthcare and social care systems or target a specific dimension of integration, such as governance, financing systems, or the workforce.

There are various definitions of integrated care and modes of integration

Care integration, or integrated care, is a health policy goal aimed at promoting patient-centred, value-based, and resilient health systems, which has gained momentum in recent years with the increasing prevalence of chronic diseases and their growing impact on societies. The integration of social and healthcare services for dependent individuals is a complex issue which is currently central to many OECD countries and EU policies (Box .1).

Box .1. The European Strategy for Assistance

The European Care Strategy, presented in September 2022, implements the European Pillar of Social Rights, particularly Principle 18 on long-term care.

This strategy highlights the need for a strategic and integrated approach to care, recognising that person-centred and independent-living-friendly approaches are often lacking. This situation is exacerbated by insufficient integration between long-term care and healthcare, or between informal care, home care, community care, and residential care.

Putting people at the centre means offering a choice of services in line with people's needs and improving the transition from institutional care to home and community care services. Long-term care services that are well integrated with healthcare and provide good care solutions improve quality of life and health outcomes and can promote cost-effectiveness while also helping reduce the burden on hospitals and other healthcare facilities.

Regarding Principle 18 on long-term care, the Commission recommends that member states develop national action plans to make health care more available, accessible and of better quality for all. Such plans should:

- Ensure that long-term care is timely, comprehensive, and affordable, allowing people with long-term care needs to maintain a dignified standard of living.
- Increase the supply and mix of long-term care services (home care, community care, and residential care), bridge territorial gaps in access to long-term care, introduce accessible digital solutions in service delivery, and ensure that long-term care services and facilities are accessible to people with disabilities.
- Ensure high-quality criteria and standards for long-term care providers.
- Support informal care, (often provided by women and relatives) through training, counselling, and psychological and financial support.
- Mobilise adequate and sustainable funding for long-term care, including EU funds.

Through the Technical Support Instrument "Towards Person-Centred Integrated Care", the Commission helps member states design and implement reforms aimed at strengthening co-ordination between health, social care and long-term care, as well as integrating different levels of care delivery, placing the individual at the centre of services to ensure better access and quality of care at every stage of life.

Source: European Commission https://ec.europa.eu/commission/presscorner/detail/en/ip_22_5169

Despite the widespread use of the term in public debate and literature, there is no single definition of integrated care. Depending on context and associated policy goals, integrated care can have different meanings for different stakeholders and is therefore "polymorphous in nature". (Nolte & Pitchforth, 2014).

Integrated care refers to the transition process towards patient-centred, interconnected, aligned, and collaborative care that addresses the patient as a whole person, rather than focusing solely on their illness (WHO Regional Office for Europe, 2016).

The concept of integrated care has its roots in the debate around the value of healthcare systems and the recognition that access to healthcare is only one of the determinants of health, alongside socioeconomic and environmental factors. In this sense, integrated care can best be defined by what it is not and what it is intended to replace i.e. fragmented, service-based care that focuses on treating illness rather than promoting health.

A literature review identified more than 150 different definitions of integrated care (Armitage, Suter, Oelke, & Adair, 2009). This variety hinders the comparability of integrated care initiatives across countries and expected outcomes. Terms such as integrated care, care co-ordination, continuing care, care pathway, and continuous care are used interchangeably. However, these definitions reflect different perspectives, including those of patients, service providers, and policy makers. Box 2 gives some definitions of integrated care.

Box 2. Definitions of integrated care in literature

WHO defines integrated health service provision as an approach aimed at strengthening person-centred health systems by promoting the comprehensive delivery of quality services across a person's life. These services should be designed according to the multidimensional needs of the population and the individual, and delivered by a coordinated multidisciplinary team of practitioners working across different care settings and levels. It should be managed effectively to ensure optimal outcomes and appropriate use of resources based on the best available evidence. Feedback cycles for ongoing performance improvement should be in place, along with efforts to address the upstream causes of poor health and promote well-being through cross-sectoral and multi-sectoral actions. (WHO Regional Office for Europe, 2016).

Integrated health services have also been defined as health services that are managed and delivered to ensure people receive a continuum of care, spanning health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation, and palliative care services. This is coordinated across various levels and locations of care both within and outside the healthcare sector, tailored to their needs across their lifespan (Contandriopoulos, 2004).

Definitions of integrated care also encompass the various dimensions of care integration. In this context, care integration can be defined as a cohesive set of methods and models across the financial, administrative, organisational, service delivery, and clinical level, aimed at fostering connectivity, alignment, and collaboration within and between care and support sectors. The objective of these methods and models is to enhance the quality of care and life, consumer satisfaction, and system efficiency for individuals, across multiple services, providers, and contexts. When the outcome of these multiple efforts to promote integration leads to benefits for individuals, the result can be termed "integrated care". (Kodner & Spreeuwenberg, 2002)

Source: OECD Secretariat, 2024

A substantial body of literature explores the various meanings and mechanisms of care integration. In particular, multiple possible dimensions of integration are discussed:

- *Horizontal* or *vertical integration*. The first consolidates services among organisations operating within the same phase of the delivery process (e.g. hospital mergers for acute patient care). The second brings together organisations at different service levels (e.g. primary and secondary care). [4]

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[4] In Finland, for example, health and social care reform aims to bring primary care, community care, primary mental health care, social work, outpatient rehabilitation care, and some other specialised care services under the same management.

- *The breadth of integration*, ranging from integration for certain individuals, specific diseases, or population groups, to the entire population.
- *The care timeline* , as integration may target specific care episodes (e.g. post-surgical follow-up), stages in a person's life cycle (e.g. neonatal care), or to a lifelong approach (e.g. for chronic conditions such as diabetes or mental health).
- *The intensity of integration*, which may vary from linkage (operating through separate organisations, each retaining their own responsibilities for service delivery, funding and eligibility criteria, and operating rules), and co-ordination (involving additional organisations and explicit processes, such as shared information and joint case management to co-ordinate care across sectors), to full integration (the integrated organisation/system takes responsibility for all services, resources, and funding, which may be managed by a single organisation or through contractual arrangements between different organisations).
- *The level of governance* at which care integration occurs determines whether integration involves macro, meso, or micro levels of care delivery. The macro level corresponds to national-level integration (e.g. integrating governance of healthcare and social services under a single ministry or institution). The meso level corresponds to regional-level integration (e.g. integrating multidimensional needs assessment using a common assessment tool at the regional/provincial/state level). The micro level corresponds to local-level integration (e.g. adopting an integrated system for accessing healthcare and social care services at the local level, such as the "single access point" in Italy, or implementing local-level social prescribing initiatives).

Evidence on the impact of integrating interventions is mixed

Early models of integrated care focused primarily on single disease management with case management approaches. However, evidence on the effectiveness of these models has been mixed: while there has been an improvement in patient satisfaction, limited effects on outcomes have been observed, particularly in terms of appropriate service utilisation and intervention costs (Stokes, Checkland, & Kristensen, 2016) (Baxter, et al., 2018).

More recently, integrated care has evolved towards population-based models focused on chronic disease management and prevention-based approaches (Alderwick, Ham, & Buck, Population health systems: Going beyond integrated care, 2015). This approach has seen considerable success, particularly at Kaiser Permanente in the United States, (Pines, Selevan, George, & McClellan, 2015) sparking a movement towards *Accountable Care Organizations* (ACOs) (Alderwick, Shortell, Briggs, & Fisher, 2018). However, it is unclear whether the results of ACOs can be transferred to other OECD countries (McWilliams, Hatfield, Chernew, Landon, & Schwartz, 2016). *Gesundes Kinzigtal* in Germany is the most well-known example in Europe, but studying its application in other healthcare systems has proven difficult due to its unique context and lack of internationally comparable data. (Busse & Stahl, 2014).

The expected impact of intervention integration includes better access to services, increased satisfaction for patients and healthcare workers, more appropriate care, improved prevention, reduced avoidable hospital admissions, prolonged independent living, delayed institutional care admission, improved health status and quality of life, and greater cost-effectiveness. (Nolte & Pitchforth, 2014) (Curry & Ham, 2010). Furthermore, some studies have shown that integrated care reduces adverse drug events, diagnostic errors, diagnostic delays, and complications arising from poor care transitions, (Slawomirski, Auraaen, & Klazinga, 2017) while also helping individuals become partners in health co-production (Moreira, 2018) and addressing waste in service provision (OECD, 2017).

Despite extensive literature, evidence on the effectiveness of intervention integration remains limited. This is partly due to the difficulty in interpreting and generalising intervention impact results due to high context variability, and to the ambiguity of the term "integrated care".

However, some studies highlight factors facilitating integrated care:

- Lessons learned from the last 15 OECD reviews on quality of care have highlighted key factors for improving integrated care, such as the need to strengthen the governance model, adequately develop information systems, have a prepared and trained workforce, and optimise the use of financial incentives (OECD, 2017).
- WHO has developed a conceptual framework, while also sharing examples of best practice in the design and implementation of integrated care (WHO Regional Office for Europe, 2016).
- The *European Health Systems Assessment* series *on Integrated Care* provided a descriptive overview of integrated care initiatives in European countries (European Commission, 2017).
- The EU INTEGRATE project(*Benchmarking Integrated Care for better Management of Chronic and Age-related Conditions in Europe*) has provided evidence on best practices for the clinical delivery of integrated care enabled by healthcare data systems and financing (Borgermans & Devroey, 2017).

An analysis of the state of the integration of health and social care interventions is instrumental in defining an integration model

Integrated care is a complex concept. Conceptual frameworks have been developed both internationally and in Italy to guide the design, implementation and evaluation of the degree of care integration (Valentijn, Schepman, Opheij, & Bruijnzeels, 2013) (Leijten, et al., 2018) (Osservatorio cronicità, 2022).

For example, the SELFIE project (*Sustainable intEgrated care modeLs for multi-morbidity: delivery, FInancing and performancE*) has developed an integrated care framework for people with chronic conditions (Leijten, et al., 2018). This framework was developed between 2015 and 2016 by a group of researchers with diverse expertise, ranging from medicine and public health to health policy, health economics, sociology, and anthropology. It includes 6 dimensions of care integration (service delivery, leadership and governance, workforce, financing, medical technologies and products, information, and research), and three levels of care integration: macro, meso, micro, as shown in Figure 1.

Figure 1. The SELFIE framework

F.R.M. Leijten et al. / Health Policy 122 (2018) 12–22

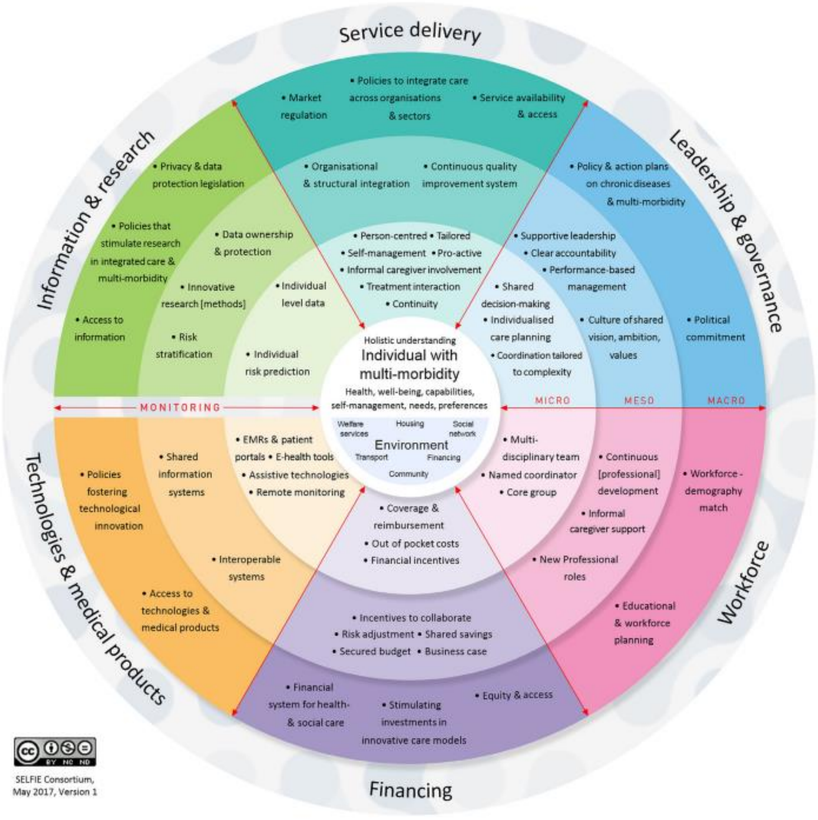

Fig. 1. The SELFIE Framework for Integrated Care for Multi-Morbidity.

Source: (Leijten, et al., 2018)

The Observatory on Social and Health Integration (OISS*)* has developed an integrated care matrix that includes 5 spheres of integration (institutional, programmatic, managerial, professional, community), on three levels: state, regional, local (Figure 2) (Osservatorio cronicità, 2022).

Figure 2. The spheres of health and social care integration in Italy

Health and social care integration matrix developed by the Observatory on Social and Health Integration

Approccio Sistemico Multilivello	Integrazione Sociosanitaria				
	Istituzionale	Programmatoria	Gestionale	Professionale	Comunitaria
Livello Statale					
Livello Regionale					
Livello Locale					

Source: (Osservatorio cronicità, 2022)

The two matrices share a number of features. The three levels of governance in the SELFIE framework (macro, meso, micro) conceptually overlap with the three levels of governance in the OISS matrix, where the macro level corresponds to the national/state level, the meso level corresponds to the regions/autonomous provinces, and the micro level corresponds to the local/community integration of services in the OISS matrix. In addition, the five types of integration proposed by the OISS matrix show a number of conceptual overlaps with the six integration dimensions of the SELFIE framework. Below, each table shows the overlaps between the five types of integration proposed by the OISS matrix and the six integration dimensions of the SELFIE framework for each level of integration (macro/national, meso/regional, micro/local) (Table 1, Table 2,Table 3).

Table 1. Dimensions of integration at the macro/national level

Overlay of integration dimension at the macro/national level between the SELFIE framework and the OISS matrix

SELFIE framework ↓	Matrix OISS →	Institutional	Programmatic	Management	Professional	Community
Leadership and governance		Policy and action plans on chronic diseases and multi-morbidity, political commitment, definition of services to be provided to dependent persons (Essential Levels of Care - Livelli Essenziali di Assistenza [LEA])	Policy and action plans on chronic diseases and multi-morbidity or other national tools for planning health and social services, including through collaboration with regions/provinces and the local level			Planning health and social care services in collaboration with community stakeholders
Workforce				Workforce planning and training	Staff planning and training, definition of new professional figures to promote care integration	
Service delivery		Service availability and "co-design", definition of access criteria		Service management and planning with shared resources for service delivery	Workforce planning to ensure sufficient resources are available for service delivery	Planning of health and social care services in collaboration with community stakeholders
Information and research				Management of privacy regulations, information access and information sharing policies at different levels (macro, meso, micro).		
Technologies and medical products		Policies that promote technological innovation with the potential to improve the integration of health and social care		Policies that promote technological innovation with the potential to improve the integration of health and social care		

SELFIE framework ↓	Matrix OISS →	Institutional	Programmatic	Management	Professional	Community
Financing		Financial system for health and social care, definition of criteria for access to health and social services		Sharing of financial resources between the health and social care sectors		

Source: OECD based on (Osservatorio cronicità, 2022) and (Leijten, et al., 2018).

Table 2. Dimensions of integration at the meso/regional or autonomous province level

Overlay of integration dimensions at the meso/regional or autonomous province level between the SELFIE framework and the OISS matrix

SELFIE framework ↓	OISS matrix →	Institutional	Programmatic	Management	Professional	Community
Leadership and governance			Accountability and supportive leadership, service availability planning (Territorial Activity Plan and Area Plan)			Planning health and social care services in collaboration with community stakeholders
Workforce				Defining new roles for care integration and staff training	Defining new roles for care integration and staff training	
Service delivery		Organisational and structural integration	Planning for the availability of services (Territorial Activity Plan and Area Plan)		Organisational and structural integration	Planning health and social care services in collaboration with community stakeholders
Information and research		Shared data ownership and production			Supporting the workforce in the use of new information systems	
Technologies and medical products		Shared information systems			Supporting the workforce in the use of new technologies	
Financing			Financial incentives for collaboration and funding guarantee	financing guarantee	Financial incentives for collaboration and funding guarantee	

Source: OECD based on (Osservatorio cronicità, 2022) and (Leijten, et al., 2018).

Table 3. Dimensions of integration at the micro/local level

Overlay of the integration dimensions at the micro/local level between the SELFIE framework and the OISS matrix

SELFIE framework ↓	OISS matrix →	Institutional	Programmatic	Management	Professional	Community
Leadership and governance		"Co-planning" of services with local communities and the Third Sector.	Planning of local services through the "Territorial Activity Plan" and "Area Plan".			
Workforce				Workforce planning,	Multidisciplinary	Appointed

SELFIE framework ↓	OISS matrix →	Institutional	Programmatic	Management	Professional	Community
				recruitment, and training for integrated care	teams, care coordinator, and dependency case manager	coordinator or social prescription practices
Service delivery		"Co-design" of services with local communities and the Third Sector		Person-centred care and "single access points".	Person-centred care and "single access points".	"Co-design" of services with local communities and the Third Sector
Information and research				Integration of care through shared information systems	Integration of care through shared information systems and training professionals in the use of integrated information systems	Integrated data and information systems facilitate community-wide integration.
Technologies and medical products					Co-ordination of care through the use of integrated information systems, remote monitoring, and teleconsultation	
Financing			Financial incentives for collaboration and funding guarantee		Financial incentives for collaboration and funding guarantee	

Source: OECD based on (Osservatorio cronicità, 2022) and (Leijten, et al., 2018).

This report focuses on four key spheres of integration common to both the OISS and SELFIE frameworks and relevant to the Italian context, Table 4:

1. Governance
2. Workforce
3. Data and information systems
4. Service delivery

For each of the four key dimensions, this report analyses existing national and regional legislation and initiatives to improve integration at different levels. The report also summarises international practices aimed at improving the integration of governance, workforce, data and information systems, and service delivery, if deemed relevant to the Italian context. In addition, the report includes an analysis of existing international social prescribing practices aimed at improving the degree of integration of social and healthcare services.

Table 4. OECD matrix of health and social care integration in Italy

OECD matrix of health and social care integration in Italy	Governance	Workforce	Data and information systems	Service delivery
Macro/national level	Policy and action plans or other national planning tools for health and social welfare services, including in collaboration with the regions/provinces and the local	Staff planning and training, definition of new Professional Roles to promote integration of care, setting standards at	managing privacy regulations, information access and sharing policies at different levels (macro, meso,	Service availability and "co-scheduling", definition of access criteria

	level, political commitment, definition of services to be provided to dependent persons (Essential Levels of Care - LEAs and Essential Levels of Social Benefits - LEPS)	the national level (e.g. minimum levels of social and health care staffing)	micro), and policies for defining the architecture and technical operation of nationally important information systems	
	Planning health and social care services in collaboration with community stakeholders Monitor LEAs and LEPS			Service management and planning with shared resources for service delivery
				Planning health and social welfare services in collaboration with institutional actors and stakeholders at various levels
Meso/regional or autonomous province level	Accountability and supportive leadership, service availability planning (Territorial Activity Plan and Area Plan)	Defining new roles for care integration and staff training	Shared data ownership and production	Planning for the availability of services (Territorial Activity Plan and Area Plan)
	Planning health and social welfare services in collaboration with community stakeholders		Supporting the workforce in the use of new information systems	Planning health and social welfare services in collaboration with community stakeholders
Micro/local level	"Co-planning" of services with local communities and the Third Sector	Planning, recruitment, integrated care staff training Multidisciplinary teams, care coordinator & case manager for dependency Appointed coordinator or social prescribing practices	Integration of care through shared information systems	"Co-design" of services with local communities and the Third Sector
	Planning of local services through the "Territorial Activity Plan" and the "Area Plan" and implementation of LEAs and LEPS		Training professionals in the use of integrated information systems	Person-centred care and "single access points"
			Co-ordination of care through remote monitoring and tele-consultations	

Source: OECD.

Defining disability and functional limitations is helpful in delineating the scope of dependency

The project "Verso un'assistenza integrata incentrata sulla persona in Italia" ("Toward Person-Centred Integrated Care in Italy") aims to integrate health and care services provided at home to dependent individuals. However, there is no internationally agreed definition of dependency. Some concepts that overlap with the concept of dependency are limitations in activities of daily living (ADLs), instrumental activities of daily living (IADLs), and disability. The latter was defined by the United Nations Convention on the Rights of Persons with Disabilities (CRPD) as a broad concept encompassing several dimensions. According to the CRPD, a person with a disability is a person with long-term physical, mental, intellectual, or sensory limitations that may limit their full and active participation in society. Disability is therefore defined as a social construct, resulting from the interaction between individuals with disabilities and their environment. Although this report does not aim to propose an internationally agreed definition of dependency, the next section reviews the standards and methodologies used in the literature to identify individuals with limitations in daily activities due to physical, mental, and/or social constraints.

Multiple definitions and tools for measuring disability and dependency are used internationally.

In recent decades, several models have been developed to define and measure disabilities, multi-morbidities, and functional limitations. The WHO, Eurostat, and the Washington Group of Disability Statistics have designed classifications, frameworks, and scales to define and measure these concepts in an internationally comparable way.

The literature on disability and functional limitations has often identified people with disabilities or functional limitations as those with at least one limitation in ADLs/IADLs, or based on existing frameworks such as Cutler's framework, the V-J framework, and the FE-BRIT-SE framework. Several tools have also been developed to measure disability and functional limitations based on limitations in ADLs and IADLs (Azad, 2020).

Table 5 reports more details on the classifications, frameworks and measurement systems currently available internationally to define and measure disability and functional limitations.

Table 5. Examples of classifications, frameworks, and systems for measuring disability and functional limitations

WHO	The International Classification of Functioning, Disability and Health (ICF) is an international standard developed by the WHO to measure and classify disability, functional limitations and health status, taking into account all elements of human functioning. It includes body functions (e.g. neuromusculoskeletal and movement-related functions, mental functions), activities and participation (e.g. learning, self-care, relationships), environmental factors (e.g. services, systems and policies, support and relationships), and body structures (e.g. nervous system structures, skin and related systems). It was endorsed by all 191 WHO member states during the World Health Assembly on 22 May 2001 as the international standard for describing and measuring health and disability.
WHO and the World Bank	The Model Disability Survey (MDS) collects information on all dimensions of disability (health conditions, activity limitations, participation restrictions, and environmental factors that facilitate or hinder full participation) to understand how disability manifests in daily life and determine the most appropriate policy and intervention responses. The MDS conceptualises disability based on the International Classification of Functioning, Disability and Health (ICF).
WHO	The WHO Disability Assessment Schedule 2.0 (WHODAS 2.0) is a disability assessment tool linked to the ICF definition of disability. WHODAS 2.0 covers six domains of operation: (i) cognition, (ii) mobility, (iii) self-care, (iv) interaction with other people, (v) life activities, including work and leisure, and (vi) community participation. The Italian version of the WHODAS 2.0 guide is available here.
Washington group on Disability Statistics[5]	The "Short Set on Functioning" was developed in 2006 for inclusion in population censuses and non-health/disability-focused surveys. The Short Set consists of six questions that measure difficulties in the following areas: vision, hearing, mobility, cognition, self-care, and communication. The Short Set is already widely used in censuses and surveys in more than seventy-five countries. The Short Set is designed to assess functional limitations in individuals aged 5 and above. However, it is not advised for measuring disability in younger children, as it may lead to underestimation by omitting questions pertaining to crucial aspects of child development.

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[5] The Washington Group for Disability Statistics was formed as a result of the International Seminar on the Measurement of Disability held in 2001 in New York, as a citizen group of the United Nations Statistical Commission. The group aims to develop internationally comparable measures of disability.

The Washington Group on Disability Statistics	The WG-Extended Set, developed in 2010, aimed to broaden insights into disability and facilitate its assessment in surveys by allowing for the inclusion of additional questions. The tool incorporates the Short Set alongside additional questions for certain domains. Moreover, it explores new areas such as upper body functioning, anxiety and depression, and pain and fatigue. It also begins to explore the relationship between functioning and the environment through the inclusion of questions regarding the use of aids and personal aids. In total, the module investigates 11 domains, encompassing just over 30 questions.
The Washington Group on Disability Statistics	The Child Functioning Module, designed in collaboration with UNICEF, measures disability in children. Two questionnaires were prepared: one for the 2-4 age range and the other for the 5-17 age range. A total of 13 areas of functioning were analysed (vision, hearing, walking, communication, self-care, dexterity, learning/remembering, concentration, playing, behaviour control, accepting change, friendships, anxiety/depression).
Eurostat - European Disability Measurement Project (EDM)	The Global Activity Limitations Indicator (GALI) classifies the level of limitation experienced by individuals who respond to the question "For at least the past 6 months, to what extent have you been limited due to a health problem in the activities you usually do?" Only limitations directly caused by or related to one or more health problems of various kinds are considered. Indicators based on this concept can be used to assess overall health status, disability and related inequalities, and health care needs at the population level. Minimum European Health Module (MEHM). The MEHM includes questions related to self-perceived health, chronic morbidity, and activity limitations. To measure limitations and disability in children, there exists a version of GALI where proxy responders can conduct the assessment of limitations.
Eurostat - EDM	Eurostat has partnered with member states to encourage the consistent gathering of harmonised data, following the recommendations of the EDM project. This collaboration has led, among other initiatives, to the establishment of the health status module. This includes the MEHM, questions on the presence of chronic diseases and conditions, and sensory, motor and cognitive functional limitations, as well as including some questions from the WG Extended Set. Furthermore, it investigates challenges in carrying out personal care activities, utilising both the ADL tool and IADL.
(Gu, Gomez-Redondo, & Dupre, 2014)	The FE-BRIT-SE framework was constructed as an extension of existing disability assessment frameworks (e.g. Cutler's framework and the V-J framework). The name FE-BRIT-SE comes from the inclusion of individual characteristics as (F)ixed attributes, which include genetic factors, personality, age, past life experiences and external factors related to the (E)nvironment; habits and individual (B)ehaviours, resources ((R)eFontes), (I)nterventions, and (T)echnology; and the (S)ocioeconomic and (E)cological consequences of disability (the (S)ocioeconomic and (E)cological consequences of disability trends.

Source: OECD Secretariat, 2024.

Definitions and assessments of disability and dependency in Italy

In Italy, the 2022-2024 National Plan for Dependency (PNNA) considers non-self-sufficient:

1. The elderly (≥65 years) with low or high care needs
2. Individuals with severe or very severe disabilities, including those classified as legally disabled or disabled under Italian law

With the exception of the definitions legal disability or disability (shown in Table 1 of the Inception report[6]), the assessment of care needs (low or high) and disability (severe or very severe) is delegated to the regional level, through the use of multidimensional assessment tools.

Almost all of the regions that responded to the OECD questionnaire (15 out of 18) reported having a regional classification system for assessing care needs, categorised as either 'high' or 'low', and for disability, categorised as either 'severe' or 'very severe' (OECD Questionnaire, 2024). These definitions, where provided by the regions, are reported atTable 6. While most PA-regions base the definition of levels of need on scales applied through multidimensional assessment tools[7], some PA-regions refer to national

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[6] https://www.oecd.org/health/towards-person-centered-integrated-care-in-Italy.htm

[7] The chapter on service delivery provides a description of regional assessment tools for disability and dependency in Italy.

or regional legislation for defining levels of care. National legislation also identified the levels of ADI based on the coefficients of care intensity (CIA) through DPCM 12/01/2017 Art. 22.

In recent years, Italy has undertaken a reform initiative aimed at standardising the definitions of disability and aligning assessment systems with the principles outlined in the CRPD (OECD, 2023). This is crucial because the definitions and measurement of dependency, disability, and functional capacity greatly influence the estimation of the target population for interventions and their associated needs. For instance, the Istituto Superiore di Sanità (ISS) relies on measuring limitations in ADLs and IADLs to identify older people with disabilities or frailty. The ISS estimates that in 2023 13% of people aged 65 and above had at least one limitation in ADLs and 17% of people aged 65 and above had at least two limitations in IADLs (ISTAT, 2023). The Institute of Statistics (ISTAT) has adopted the Global Indicator of Activity Limitations designed by Eurostat to collect data on people with functional limitations. ISTAT estimates that in 2021, 21.4% of the population presented limitations, 5% of which were severe, and 16.4% of which could be classified as not serious (ISTAT, 2023).

Table 6. Regional definitions of the level of need of the dependent elderly

Region	Low level of care	High level of care	Severe disability	Very severe disability
Abruzzo	Partial impairment of functional abilities in daily living activities assessed using the SVAmDI scale	Complete loss of functional abilities in daily living activities, necessitating continuous support, evaluated using the SVaMA scale	Individuals with a disability requiring support to overcome health, social, and employment barriers for the purpose of fostering their inclusion. (Article 3, Paragraph 3, Law No. 104/92)	A person in a state of dependency due to a very severe disability, requiring continuous and permanent personal assistance, particularly in cases of vital dependence (Art. [missing information]). 3 paragraph 2 (a), (b), (c), (d), (e), (f), (g), (h) and (i), Interministerial Decree of 26/09/2016)
Basilicata	There is no regional definition of low/high level of care	There is no regional definition of low/high level of care		
Emilia-Romagna	The assessment is conducted according to the multidimensional assessment tool BINA	The assessment is conducted according to the multidimensional assessment tool BINA	When single or multiple impairments significantly reduce age-appropriate personal autonomy to the extent that continuous, comprehensive assistance becomes necessary in both the individual's personal sphere and their social interactions, the situation takes on a grave significance	The definition of very severe disability now refers to a list of conditions endorsed by the Ministry of Labour and Social Policies as part of the National FNA Fund. This list expands upon the previous classification of very severe disability, initially formulated at the regional level through DGR 2068/04. This revised classification now includes scenarios of total dependency resulting from brain injury, myelopathy, or degenerative neurological diseases

Region	Low level of care	High level of care	Severe disability	Very severe disability
Friuli-Venezia Giulia	Individuals with low care needs are defined in profile C. These individuals typically have mild (or occasionally, moderate) healthcare requirements alongside moderate social and healthcare needs. They may be susceptible to potential functional decline, necessitating prompt intervention. This profile includes individuals in need of treatment, including rehabilitation, aimed at restoring or preserving residual capacities, and also at controlling disease progression and preventing exacerbation of chronic conditions. It also includes individuals with medium-to-low cognitive impairments and/or mild behavioural issues that do not fall under the previous profiles	Individuals with high care needs are classified under the complex A profile. These individuals, due to acute or chronic degenerative diseases, present complex needs of utmost social and healthcare significance, and require intensive treatment crucial for supporting vital functions. In particular, individuals experiencing total impairment in performing basic ADLs, who mainly require specialised multi-day clinical monitoring and intensive therapeutic interventions to support vital functions for the fulfilment of their clinical care needs, are categorised within this profile	Individuals with severe disabilities are classified within profile III (high-intensity support). This profile includes individuals with high support needs in one of the following Q-VAD domains: functional supports, problem behaviours, and health. Concurrently, these individuals display moderate support needs in at least one of the remaining domains. Overall, these situations are characterised by high complexity	Individuals with severe disabilities are defined within profile IV (very high-intensity support). This includes individuals in a state of profound disability, with exceptionally high support needs or complete dependence in ADLs, and affected by health issues necessitating 24/7 assistance and monitoring. These conditions frequently entail restricted capacity for interpersonal engagement and a pronounced requirement for cognitive support, often accompanied by severe impairment of consciousness
Lazio	Individuals eligible for attendance allowance as outlined in Law No. 18 of February 11, 1980, or otherwise identified as dependent or disabled according to Annex 3 of Prime Minister's Decree No. 159 of 2013	Dependent elderly individuals (aged over 65) with high care needs and/or individuals with very severe disabilities, as defined in Article 1, Paragraph 168 of Law No. 234/2021 and by current legislation and detailed in the Dependency Plan, as well as by Article 3, of the Ministerial Decree of September 26, 2016	If the impairment, whether single or multiple, has diminished age-appropriate personal autonomy to the extent that continuous, comprehensive assistance intervention becomes necessary in both the individual's personal sphere and their social interactions	The definition of very severe disability is based on Art. 3, of the Ministerial Decree of September 26, 2016, and by the Prime Ministerial Decree of November 21, 2019
Liguria	Evaluation using the AGED form: A partial non-self-sufficiency score ranging from 10 to 16 indicates elderly individuals with chronicised outcomes of senile pathologies	Evaluation using the AGED form: A total dependency score exceeding 16 indicates elderly individuals with chronicised outcomes from multiple pathologies	Individuals with 100% legal disability and recipients of the attendance allowance	Individuals with severe disabilities requiring continuous 24-hour social and healthcare assistance to facilitate their stay at home
Lombardy	There is no regional definition of low/high level of care	There is no regional definition of low/high level of care	Definition based on Art. 3 of DPCM 159/2013 column "severe disability" column	Definition based on art. 3 of the Ministerial Decree of 2016: "Individuals receiving the attendance allowance or otherwise defined as non-self-sufficient in accordance with Annex 3 of DPCM 159/2013 and for whom at least one of the conditions in letters a)-i) has occurred"

Region	Low level of care	High level of care	Severe disability	Very severe disability
Marche	The care need (low/high) is defined through a unique regional information system (Sistema Informatico Rete del Territorio, or Territory Network Information System [SIRTE]). It is defined based on a score that highlights the individual's level of care and defines its setting	The care need (low/high) is defined through a unique regional information system (SIRTE). It is defined based on a score that highlights the individual's level of care and defines its setting	Disability is defined as severe when the individual requires permanent, continuous, comprehensive assistance in both the personal sphere and their social interactions (Article 3 paragraph 3, Law 104/1992)	An individual with a very severe disability is defined as one who requires continuous 24-hour care, sometimes provided by more than one person at the same time, the interruption of which, even for a very short period, can lead to serious complications or even death. The decision between "severe" and "very severe" is determined by completing a regional form provided by the UMEA for dependent young adults with psycho-physical disabilities
Autonomous Province of Bolzano	For the provision of benefits under the law on dependency, the following levels of assistance are provided, based on the outcome of the assessments: - 1st level of assistance, when a need for care and assistance of 60 hours per month up to a maximum of 120 hours per month is recognised - 2nd level of assistance, when a need for care and assistance exceeding 120 hours per month up to a maximum of 180 hours per month is recognised - 3rd level of assistance, when a need for care and assistance exceeding 180 hours per month up to a maximum of 240 hours per month is recognised - 4th level of assistance, when a need for care and assistance exceeding 240 hours per month is recognised	For the provision of benefits under the law on dependency, the following levels of assistance are provided, based on the outcome of the assessments: - 1st level of assistance, when a need for care and assistance of 60 hours per month up to a maximum of 120 hours per month is recognised - 2nd level of assistance, when a need for care and assistance exceeding 120 hours per month up to a maximum of 180 hours per month is recognised - 3rd level of assistance, when a need for care and assistance exceeding 180 hours per month up to a maximum of 240 hours per month is recognised - 4th level of assistance, when a need for care and assistance exceeding 240 hours per month is recognised		
Autonomous Province of Trento	The assessment is conducted according to the SVaMA multidimensional assessment tool	The assessment is conducted according to the SVaMA multidimensional assessment tool	The assessment is conducted according to the ICF-CY scale (International Classification of Functioning, Disability and Health - Children and Youth Version	The assessment is conducted according to the ICF-CY scale (International Classification of Functioning, Disability and Health - Children and Youth Version

Region	Low level of care	High level of care	Severe disability	Very severe disability
Puglia	Dependent elderly individuals (> 65 years old) with low care needs and/or individuals with severe disabilities are understood as beneficiaries of the attendance allowance, as established by Law No. 18 of February 11, 1980, or otherwise identified as dependent or disabled according to Annex 3 of Prime Minister's Decree No. 159 of 2013, consistently with the requirements defined by the regions with reference to the assessment criteria of the multidimensional evaluation unit (UVM) Committees and the models for the provision of regional benefits	Dependent elderly individuals (> 65 years old) with high care needs and/or individuals with severe disabilities, as provided for by Article 1, paragraph 168 of Law No. 234/2021 (also known as 2022 Budget Law), by current legislation, and as detailed by Article 21, paragraph 6, letter c of the Dependency Plan, by Legislative Decree No. 147 of September 15, 2017, as well as by Article 3 of the Ministerial Decree of the Ministry of Labour and Social Policies of September 26, 2016	Based on Law No 104/1992 and Regional Law No. 10/1987, severe disabilities are those involving a stabilised and progressive physical, psychological, or sensory impairment, as determined by the health authorities (Medical Committees referred to in Article 1 of L. Law No. 295/1990), which causes learning, relationship, or work integration difficulties leading to a process of social disadvantage or marginalisation. Regione Puglia has established UVMs through Regional Law No. 19/2006 (Article 59) and regulated them through Regulation No. 4/2007 (Article 3) and subsequent amendments. These are organised professional teams that operate within each social healthcare district and territorial area and are considered an essential level of care (known as LIVEAS). These units are responsible for defining the social and healthcare needs of individuals and their family units (described in specific Multidimensional Assessment Forms known as SVaMA and SVAmDI) and for defining the PAI, indicating the nature of the need, the complexity and intensity of the intervention, its duration, the monitoring stages for Integrated Care Pathway, costs, and the case manager. Regione Puglia has further detailed the organisation and functioning of the UVMs with Regional Council Resolution (DGR) 1984/2008 regarding guidelines on dependency and with DGR 691/2011 concerning access to services and the multidimensional assessment of needs	The most severe disabilities are identified under the Ministerial Decree of September 26, 2016 (Article 3, paragraph 1), certified through the multidimensional evaluation defined by the Integrated Multiprofessional Teams operating in each social healthcare district, as regulated by Article 3 of Regional Regulation No. 4/2007 and subsequent amendments, and by DGR 691/2011 concerning access to services and the multidimensional assessment of needs

Region	Low level of care	High level of care	Severe disability	Very severe disability
Sicily	The assessment is conducted according to the SVaMA multidimensional assessment tool	The assessment is conducted according to the SVaMA multidimensional assessment tool	Individuals with severe disabilities are those identified as dependent disabled persons under Article 3, paragraph 3 of Law 104/1992. Regione Sicilia has issued the decree of June 29, 2011 – G.U.R.S. No. 30 of 14.07.2011 – "Adoption of the SVAmDI multidimensional evaluation form as a tool for assessing individuals with disabilities"	
Tuscany	There is no regional definition of low/high level of care	There is no regional definition of low/high level of care		
Umbria	The assessment is conducted according to the SVaMA and ICF multidimensional assessment tool	The assessment is conducted according to the SVaMA and ICF multidimensional assessment tool	The assessment is conducted according to the SVaMA and ICF multidimensional assessment tool	The assessment is conducted according to the SVaMA and ICF multidimensional assessment tool
Valle D'Aosta	There is a definition of low/high need, but no details on that definition were provided	There is a definition of low/high need, but no details on that definition were provided	The definition of severe disability refers to Article 3 paragraph 3 of Law 104/92: "When single or multiple impairments significantly reduce age-appropriate personal autonomy to the extent that permanent, continuous, and comprehensive assistance becomes necessary in both the individual's personal sphere and their social interactions, the situation takes on a grave significance. Situations recognised as serious determine priorities in public service programmes and interventions"	

Veneto	The assessment is conducted according to the SVaMA multidimensional assessment tool. A low level of need corresponds to a score greater than or equal to 10 and a basic level of care intensity (1-3 visits per month)	The assessment is conducted according to the SVaMA multidimensional assessment tool. A low level of need corresponds to a score greater than or equal to 25 with autonomy profiles of 14 and 15, indicating not only high assistance needs but also healthcare needs (e.g. presence of stomas and ventilator assistance) and at least 4 home visits per month	The assessment is conducted according to the SVAmDI multidimensional assessment tool. A SvaMDi score of less than 9; need for permanent, continuous and comprehensive care interventions in the individual or social sphere. Intensity that partially disrupts (severely) the person's daily life (causing significant impairment in functioning). Individuals with all types of dementia accompanied by severe behavioural disturbances or with greater care needs - individuals with psychiatric and intellectual disabilities aged between 3 and 64 years who have been recognised as having severe disability status and individuals with physical and motor disabilities aged between 18 and 64 years who have been recognised as having severe disability status.	The need for assistance arises from the inability to perform ADLs without continuous 24-hour support. A modified synoptic table of the SVaMA form with a score greater than or equal to 54. The presence of the condition of most severe disability, as defined by Article paragraphs 2 and 3 of the Ministerial Decree of September 26, 2016, is characterised by a loss of autonomy in ADL defined by a Barthel Index score for basic activities equal to or greater than 50 and a degree of mobility impairment on the Barthel Index for Mobility equal to or greater than 15 from the SVaMA with: - Health assessment form, part of nursing care, where point 12 (Respirator/Assisted ventilation) or point 15 (dependence on electro-medical devices) is noted, or the presence of diagnosis code ICPC = A07 (coma) or SVaMA with the presence of diagnosis code ICPC = F83, F84, F94, and F99 (eye) and H86 and H99 (ear), and a score equal to or greater than 50 on the Barthel scale for ADLs. SVaMDi form indicating diagnosis codes ICD-X = H 54 (deafness) and = H 90.3 (bilateral neurosensorial hearing loss) alongside a score of 4 out of 4 on the ICF communication performance scale. Alternatively, SVaMDi with a severity score greater than or equal to 6, coupled with one of the following ICD-X diagnosis codes: - F84.0 - Autistic disorder - F84.1 - Atypical autism - F84.2 - Rett syndrome - F84.3 - Childhood disintegrative disorder - F84.5 - Asperger's syndrome - F84.9 - DPS-NAS or SVaMDi with a severity score greater than or equal to 6, combined with one of the following ICD-X diagnosis codes: - F72 - Severe intellectual disability - F73 - Profound intellectual disability.

Region	Low level of care	High level of care	Severe disability	Very severe disability

Source: OECD Questionnaire, 2024.

Governance

The governance of social healthcare services for dependent individuals plays a key role in defining the type of services that exist, their accessibility, and integration of care.

The multifaceted nature of services for dependent individuals, which include social and health services and very often involve several levels of government, complicates the governance of these services and underscores the importance of a multilevel, participatory governance approach.

Multilevel governance refers to service governance that involves different levels of government in the planning and management of services. Over the past 50 years, OECD countries have progressively adopted or refined governance reforms that delegate more powers to regional and local levels of government. Between the 1970s and 1990s, many OECD countries undertook reforms to strengthen the governmental autonomy of the regional level. After the economic crisis of 2008, a new wave of reforms in multilevel governance emerged (OECD, 2022).

In Italy, especially after the reform of Title V of the Constitution, which enhanced the authority granted to subnational levels of government, autonomous regions and provinces play a pivotal role, working in collaboration with the national government and local entities, in the administration of social and healthcare services.

Another important factor is the participation of society in the governance of social healthcare services, for example through the involvement of the Third Sector in the planning and design of services (participatory governance, or *inclusive governance*). Participatory governance holds intrinsic significance as it provides citizens with the opportunity to influence decision-making processes concerning public services that directly impact them.In addition to this intrinsic value, participatory governance contributes to improving the level of welfare of society (OECD, 2020).

This chapter examines the governance tools in use in Italy at the national, regional, autonomous province, and local levels to enhance the integration of social and healthcare services for dependent individuals. This analysis is then complemented by a description of the reforms and initiatives underway in some OECD countries.

There are multiple initiatives for improving the integration of governance of health and social care services in Italy

In the past few years, Italy has developed initiatives to improve the integration of social and healthcare services for dependent individuals through greater governance integration at different levels.

At the national level, the Inter-Ministerial Committee for Policies on the Elderly Population and the National Dependency Plan serve as macro-level integration tools. They involve multiple ministries and function as instrumental tools for planning integrated social and healthcare services for dependent individuals.

At the regional level, local activity programmes, area plans, and programmes agreements represent integrated planning tools for social and health care services. By requiring co-ordination and integration of governance between the regional/autonomous province level and the local level, these tools contribute to the integration of multilevel governance of these services.

Finally, the Third Sector Code offers a model of 'shared' administration between the Third Sector and public social and health care service providers, providing for co-programming and co-design activities for care services.

The Inter-ministerial Committee on Policies for the Elderly Population

At the national level, Article 2 of Law No. 33 of March 23, 2023, "Delegations to the Government on Policies for the Elderly" establishes the Inter-ministerial Committee on Policies for the Elderly (CIPA). The committee is chaired by the Prime Minister and the Ministers of Labor and Social Policies, Health, Equal Opportunity and Family, Disability, Regional Affairs, and Economy and Finance, or their delegates. It is assigned the task of promoting the integration of national policies for older people, particularly for the frail and dependent elderly population. CIPA is mandated to adopt a "National Plan for Active Ageing, Social Inclusion and Preventing Frailty in the Elderly Population" and a "National Plan for the Care and Treatment of Frailty and Dependency in the Elderly Population". These plans are to be adopted every three years and updated annually. It is also expected that regional and local plans will be developed on the basis of these national plans (Parlamento italiano, 2023).

The National Dependency Plan

The 2022-2024 National Dependency Plan (PNNA) stands as a national initiative dedicated to enhancing the integration of governance across home-based social and healthcare assistance services for dependent individuals. The 2019-2021 National Dependency Plan introduced a national definition of very severe disability and emphasised the need to introduce an unambiguous national definition of 'dependent population', along with a system for identifying beneficiaries of benefits and services for dependent people. The 2022-2024 PNNA subsequently established guidelines for defining the dependent population at the national level and outlined a programming framework of measures to enhance social and healthcare assistance for non-self-sufficient individuals. (Ministero del Lavoro e delle Politiche Sociali, 2022). The inception report ""Towards an Integrated Person-Centred Social and Healthcare Assistance in Italy" provides further information on the 2022-2024 PNNA.

Territorial Activity Programmes, Area Plans, and Programme Agreements

The integration of the planning and governance processes of social and healthcare services at the regional/autonomous province level is facilitated by the availability of tools such as the Territorial Activity Programme (PAT), the Area Plan (PdZ), and programme agreements, which are operational in certain Italian regions and autonomous provinces (Table 7). While these tools are initially formulated through the establishment of guidelines at the regional or autonomous province level, their implementation subsequently necessitates action at the local level, specifically within municipalities, health districts, and Social Territorial Areas.

Specifically, the Territorial Activity Programme (PAT) serves as the mechanism through which the health district plans and oversees local health activities, with the goal of integrating them into the social and economic fabric of the area. On the other hand, the Area Plan (PdZ) serves as the programmatic instrument for territorial social services, focusing on enhancing prevention, care, protection, and social inclusion. By jointly developing the PAT and the PdZ to align the social and healthcare provisions in both frameworks, regions can effectively enhance the integration of governance across local social and healthcare services. Furthermore, programme agreements serve as tools for fostering inter-institutional co-ordination, aimed at supporting and promoting the integration of social and healthcare services.

Co-planning and co-designing with the Third Sector

As anticipated, participatory governance is gaining increasing international attention. Italy has recently embarked on a reform process that involves the Third Sector in the planning and design of social and healthcare services for various target populations, including dependent individuals.

This reform proposes a unified definition of Third Sector entities, delineates their role, and outlines their relationships with public entities. Legislative Decree No 117 of 3 April 2006, known as the Third Sector Code, summarises the changes introduced by the reform. Article 5 of Title II of the legislative decree stipulates that certain activities conducted by Third Sector organisations should be carried out in collaboration with social and healthcare services and competent public entities at the territorial level. Additionally, Article 55 of Title VII of the code mandates the active involvement of Third Sector organisations in the planning and organisation of public services in sectors of general interest.

This involvement is facilitated through co-planning, co-design and accreditation processes in accordance with the principles of Law No. 241 of August 7, 1990, and specific rules governing these procedures.

- Co-planning aims to identify needs, interventions, implementation modalities, and available resources from the public administration.
- Co-design focuses on defining and implementing specific projects to address identified needs.
- Accreditation formalises Third Sector organisations as partners of the public administration, which in turn defines their intervention objectives, duration, essential characteristics and selection criteria in a transparent, impartial and participatory manner. This collaboration aims to promote subsidiarity, co-operation, effectiveness, efficiency, and uniformity in service delivery.

For further information, please refer to Box 3.

Box 3. Accreditation and shared administration in the Third Sector for home care in Italy

Accreditation and shared governance serve as pivotal tools for fostering public-private partnerships in the planning, design, and provision of social and healthcare home care services in Italy. These mechanisms are anchored in the constitutional principle of horizontal subsidiarity (Article 118, paragraph 4 of the Italian Constitution), advocating for collaborative action among individuals and social entities across various realms of public intervention. Specifically, they underscore the obligation for public institutions — be it the State, regions, or municipalities — to ensure the active involvement of the Third Sector in the planning and design of public policies pertaining to the care of dependent individuals, thus promoting a more participatory and supportive society, (note: A. Pioggia, La cura nella Costituzione. Prospettive per una amministrazione della cura (*Care in the Constitution: Perspectives for an Administration of Care*) in G. Arena, M. Bombardelli (ed.), L'amministrazione condivisa (*Shared Administration*), 2022

Accreditation

Accreditation, governed by regional legislation, is the process through which regional and local social and healthcare services acknowledge that a Third Sector entity meets predefined quality and operational standards for delivering social and healthcare services, including those related to home care. This process is essential to ensure that the services offered meet quality, safety and effectiveness criteria, all while respecting the rights and needs of users, and is preliminary and necessary for affiliation with an institution.

The accreditation process involves several stages:

- Application Submission: Interested Third Sector organisations submit accreditation applications to the relevant regional or local authorities, certifying that it meets the required standards.
- Assessment: Subsequently, an evaluation phase ensues, which includes site visits, interviews, and document reviews to assess whether the established criteria are being met.
- Recognition: If the outcome of the assessment is positive, the organisation is officially accredited and included in a list of authorised providers. Once a contractual agreement is reached with public institutions, it can deliver services on behalf of the public healthcare system under a convention regime.

Shared administration

Shared administration, on the other hand, is a participatory mode of exercising the public function of planning and designing services, including social and healthcare services, between public institutions and Third Sector entities. It entails diverse collaborative activities between the two actors to better identify community needs and requirements (co-planning) and consequently design more efficient and effective social and healthcare services (co-design).

The functioning of shared administration can be summarised as follows (Article 55 of Legislative Decree 117/2017):

- Co-planning: Public institutions involve Third Sector entities in identifying the needs to be addressed, necessary interventions, and in seeking the modalities and resources for their implementation.
- Co-design: Public institutions engage the Third Sector in defining and/or implementing specific service projects or interventions aimed at addressing the needs identified in the preceding phase.

These two shared administration tools promote the integrated and participatory exercise of the public function of planning and designing social and healthcare services, thereby enhancing public institutions' ability to better understand and respond to the complex and growing care needs of dependent individuals.

In both cases, the principle of subsidiarity plays a fundamental role, as it promotes a vision of participatory and collaborative welfare, where the state recognises and values the role of Third Sector organisations as essential partners in both the planning and delivery of social and healthcare services, contributing to a more inclusive system of local assistance. This approach not only improves the accessibility and quality of services offered but also strengthens the connection between social and healthcare services and the communities they serve, promoting a community welfare model.

Examples of existing tools in Italian regions and autonomous provinces for improving the integration of governance of health and social care services

57% of the regions and autonomous provinces that responded to the OECD questionnaire consider the level of integration between ADI services and SAD services to be significantly improvable. Among the reasons cited, the lack of shared governance between the healthcare and social sectors appears as a significant issue hindering the integrated delivery of care (OECD Questionnaire, 2024).

Almost all of the regions and autonomous provinces that responded to the OECD questionnaire (17 out of 18) reported the existence of governance tools to improve the integration of healthcare, social healthcare, and social services at home (OECD Questionnaire, 2024). Sixteen regions confirmed the existence of territorial governance tools such as the Territorial Activity Plan, inter-institutional agreements, and integrated planning between health districts and Social Territorial Areas (ATS). Twelve regions reported the existence of funding for projects on social and healthcare integration, or other projects with a significant impact on social and healthcare integration, and seven regions reported the existence of co-planning tools as defined by Decree no. 72/2021. Table 7 summarises the existing territorial governance tools in the regions that responded to the OECD questionnaire.

Confirming the importance of integrated governance, the regions that indicated a sufficient, more than sufficient, or adequate level of integration between ADI and SAD emphasised that integration tools at the territorial governance level have been instrumental in achieving better service integration. In Abruzzo, for example, the 2017-2021 District Social Plans and the Local Plan for Dependency were identified as the tools that played a central role in improving integration, in contrast to operational integration of services that struggles to be implemented.

Examples of territorial governance integration can be found in the Marche region, the Veneto region, and the Autonomous Province of Trento.

In 2015, the Regione Marche established the Social and Health Operational Unit (Unità Operativa Sociale e Sanitaria, UOSeS) with DGR 110. This functional unit is situated at the level of the Health District/Social Territorial Area and is tasked with territorial planning responsibilities. It is composed of the District Director, the ATS Coordinators, the operators of the Coordination Office for District Activities, and the Area Planning Office. Operations are ensured by a secretariat, with a healthcare and administrative operator designated by the District Director, and a social and administrative operator from the ATS or the municipalities, designated by the Area Coordinator in charge.

In the Veneto region, the Municipal Administration Service Centre (IPaB) and ULSS have drafted a programme agreement to regulate the home care system, in order to strengthen the ADI system for dependent individuals. The initiative includes organising periodic training events between ULSS, facilities, and municipalities to address specific social and healthcare issues.

Another example of governance integration is provided by the Spazio Argento project, sponsored by the Autonomous Province of Trento. The Spazio Argento Office is the local specialised reference point in elderly welfare, contributing to the definition of dedicated territorial social and healthcare planning, thus avoiding overlaps of interventions and fragmentation. Additionally, it oversees administrative relations with Public Companies for personal services (Apsp), the Provincial Company for Health Services (Apss), and private service providers. Spazio Argento's organisational model (Provincial Council Resolution no. 1719/2022) is currently being structured and aims to improve the integration of home services for dependent individuals. The model includes three levels of governance: i) A provincial level, whose main function is "monitoring" the functions of Spazio Argento, ii) An intermediate level that includes six Steering Committee made up of social and healthcare representatives from a restricted area that manage integration and monitoring functions, iii) A local level of operational management at each Community/Val d'Adige Territory, where the Spazio Argento Team oversees operational management, communication, social secretariat and integrated care (OECD Questionnaire, 2024).

Examples of co-design and co-programming are currently found in Italy at the regional level in Abruzzo, Friuli-Venezia Giulia, and Liguria, among other regions.

Regione Abruzzo has established a Steering Committee to facilitate dialogue among the various stakeholders involved in drafting the 2022-2024 Regional Dependency Plan, including representatives from ANCI, Social District Areas, District Social Services and the Local Health Authority, UPI, Volunteer Service Centres of Abruzzo, Third Sector Forum, Alliance of Cooperatives, ASP, and others. The co-programming process has involved plenary meetings on specific topics, as well as the collection of contributions and proposals through the abruzzosociale.it website, originating from individual and associated local administrations, other institutional entities, employer and trade unions organisations, the Third Sector, civil society, and individual citizens.

Regione Friuli-Venezia Giulia has activated an experimental project for the community home care of people with dementia, aimed at preventing their institutionalisation and initiating ADI pathways. The project involves the provision of services by healthcare companies, municipal social services, and Third Sector entities, and is therefore an example of co-programming and co-design (OECD Questionnaire, 2024). Additionally, the region has initiated the pilot phase of a model involving Third Sector entities in the integration of social and healthcare services for the care of frail elderly individuals. The pilot aims to develop a model of integrated care for frail elderly individuals, incorporating Third Sector entities into the integration of social and healthcare services. The pilot is being conducted in six territorial areas of the region, through the activation of six Working Groups. These groups include representatives from the health district, the territorial area, and co-designing Third Sector entities (OECD Questionnaire, 2024).

Similarly, Regione Liguria has involved the Third Sector in initiatives to improve the integration of social and healthcare services. The co-programming and co-design mechanism with the Third Sector has been activated within the "Meglio a Casa" (Better at Home) protected discharge project. This initiative provides temporary home care assistance to frail, non-self-sufficient individuals being discharged from hospitals in the region by hiring a family assistant free of charge for 30 days (OECD Questionnaire, 2024).

Table 7. Territorial governance tools for the integration of home-based health and social care services

Region	Territorial governance tools
Abruzzo	Area-level governance tools (e.g. Territorial Activity Plan, inter-institutional agreements, and integrated planning between health districts and ATS)
	Co-planning tools as defined by Decree no. 72/2021

Region	Territorial governance tools
	Funding for the implementation of social and healthcare integration projects, or other projects that have a significant impact on social and healthcare integration
	District Social Services and Local Health Authority (ASL) Agreements: The 2023-2025 Social District Plans, as outlined in the Regional Social Plan 2022-2024 (DCR. 63/2 of 02/24/2022) and the Regional 2022-2024 Dependency Plan (DGR. 149 of 20/03/2023) promote the network agreements between District Social Services and the Local Health Authority (ASL) for the implementation of SAD and ADI
Basilicata	Governance tools at the territorial level, (e.g. Territorial Activity Plan, inter-institutional agreements and integrated planning between health districts and ATS): “Piano regionale integrato della salute e dei servizi alla persona e alla comunità 2012-2015 Ammalarsi meno. curarsi meglio” ("*2012-2015 Integrated Regional Plan for Health and Services for Individuals and the Community: Get Sick Less, Get Better Care*",) approved by DCR No. 317 of 07/24/2012
Calabria	Funding for the implementation of social and healthcare integration projects, or other projects that have a significant impact on social and healthcare integration
Emilia-Romagna	Area-level governance tools (e.g. Territorial Activity Plan, inter-institutional agreements, and integrated planning between health districts and ATS)
	Co-planning tools as defined by Decree no. 72/2021
	Funding for the implementation of social and healthcare integration projects, or other projects that have a significant impact on social and healthcare integration
Friuli-Venezia Giulia	Governance tools at the territorial level, (e.g. Territorial Activity Plan, inter-institutional agreements and integrated planning between health districts and ATS): Management lines Frailty Plan Chronicity Plan Regional Programme for Territorial Assistance FNA Plan Regulation for the Autonomy is Possible Fund D.P. Reg 214/2023
	Co-planning tools as defined by Decree no. 72/2021: • community home experiments • Si Fa Rete • restorative justice.
	Funding for the implementation of social and healthcare integration projects, or other projects that have a significant impact on social and healthcare integration: • Alzheimer's Fund • Autism Funds • Family Policy Fund

Region	Territorial governance tools
	• Funds for countering gender-based violence • National Recovery and Resilience Plan Missions 5 and 6 (working groups on national projects as an important opportunity to consolidate social and healthcare integration).
	Prisma 7 Project
Liguria	Area-level governance tools, (e.g. Territorial Activity Plan, inter-institutional agreements, and integrated planning between health districts and ATS)
	Funding for the implementation of social and healthcare integration projects, or other projects that have a significant impact on social and healthcare integration
Lombardy	Governance tools at the territorial level, (e.g. Territorial Activity Plan, inter-institutional agreements and integrated planning between health districts and ATS): ○ Resolution No. 704 of July 17, 2018, "Single points of contact for assistance and care (SUAC)," Article 5 and Article 7.
Marche	Area-level governance tools, (e.g. Territorial Activity Plan, inter-institutional agreements, and integrated planning between health districts and ATS)
	UOSeS DGRM 110/2015
Autonomous Province of Bolzano	○ Provincial Law No. 13 of April 30, 1991, "Reorganisation of social services in the Province of Bolzano", Article 15/bis. Integration and governance tools are being introduced at the territorial level with the provision for greater involvement of Social Policies.
Autonomous Province of Trento	Governance tools at the territorial level, (e.g. Territorial Activity Plan, inter-institutional agreements and integrated planning between health districts and ATS): ○ "Silver space" organisational model
	Funding for the implementation of social and healthcare integration projects, or other projects that have a significant impact on social and healthcare integration
Sicily	Governance tools at the territorial level, (e.g. Territorial Activity Plan, inter-institutional agreements and integrated planning between health districts and ATS): ○ Memoranda of Understanding ○ PNES ○ Specific Programmes ○ Telemedicine ○ Plan of the social and healthcare actions and services and the Single Accreditation System of social and health care service providers. Approved by decree dated July 31, 2017, G.U.R.S. No. 32 of 04.08.2017
	Co-planning tools as defined by Decree no. 72/2021
	Funding for the implementation of social and healthcare integration projects, or other projects that have a significant impact on social and healthcare integration

Region	Territorial governance tools
Umbria	Governance tools at the territorial level, (e.g. Territorial Activity Plan, inter-institutional agreements and integrated planning between health districts and ATS): ○ Integrated implementation plans between the Social Zone and the Social and Healthcare District
Veneto	Area-level governance tools, (e.g. Territorial Activity Plan, inter-institutional agreements, and integrated planning between health districts and ATS)
	Co-planning tools as defined by Decree no. 72/2021
	Funding for the implementation of social and healthcare integration projects, or other projects that have a significant impact on social and healthcare integration
Valle D'Aosta	Area-level governance tools, (e.g. Territorial Activity Plan, inter-institutional agreements, and integrated planning between health districts and ATS)
	Co-planning tools as defined by Decree no. 72/2021
	Funding for the implementation of social and healthcare integration projects, or other projects that have a significant impact on social and healthcare integration

Source: OECD Questionnaire, 2024

Other OECD countries have implemented initiatives aimed at better integrating the governance of health and social care services

Fragmentation in the governance of social and healthcare services for the dependent population is a common challenge in many OECD countries. Indeed, the governance of these services is often shared between two or more ministries at the national level. In addition, the governance of social and healthcare services is often distributed over several levels of government and is shared between the national/central level and the local level. The fragmentation of governance in social and healthcare services, coupled with the rising demand driven by an ageing population and an increase in chronic diseases, has prompted a growing number of OECD countries – including Finland, Slovenia, Spain, and the United Kingdom – to embark on a process of reforming these services. Other countries, although not undertaking a systemic reform process, have improved the integration of social and health services through targeted policies (OECD, 2023).

Eleven OECD countries (Austria, Colombia, Korea, Estonia, Finland, Japan, Norway, the Netherlands, the United Kingdom, the United States and Sweden) currently have a single ministry or department responsible for health and social policies. Some countries, such as Finland, France, and Spain, have created intergovernmental bodies to streamline communication among the actors involved in the governance of social and healthcare services.

France has established a "funders' conference" charged with discussing and defining measures and funding for services dedicated to the dependent population aged 60+. Finland has provided for the establishment of 21 "welfare service districts", funded by the central government. Districts will be directly responsible for social and health services, currently managed by municipalities.

Spain has implemented initiatives at both the national and local levels to improve the governance of social and healthcare services. The Spanish case is particularly relevant to Italy because of the similar organisation of governance and delivery of social and health care services. In Spain, regions and municipalities play an important role in the governance and delivery of social and healthcare services:

- At the national level, the central government has established a *Territorial Council of the Public System for Autonomy and Dependency Care*. The Council, chaired by the Ministry of Social Policies, brings together representatives from the national government's Ministries of Social Policies, Health, and Economy, as well as representatives from local governments. The Council has the power to make decisions on the governance and delivery of social and healthcare services according to a simple majority voting method. For example, the Territorial Council of the Public System for Autonomy and Dependency Care approved the possibility for local governments to obtain more funding from the central government for the provision of social and healthcare services, provided that social and healthcare services (i) use a unified and homogeneous multidimensional assessment tool established at the national level, (ii) implement individual care plans, and/or (iii) meet the quality standards set by national guidelines, for example regarding the intensity of care services offered to the dependent population (OECD Interview, 2024).
- In Catalonia, an integrated agency for social and health services is being established (OECD Interview, 2024). More information on this initiative can be found at Box 4.
- In the Basque Country, the Osakidetza Local Health Authority has implemented a strategy to facilitate the co-ordination between different levels of governance, while the Basque Country Social and Health Policy Directorate has established a protocol for collaboration between social and health services and other stakeholders.

Other OECD countries, including Denmark, Finland, France, Norway and Sweden, have activated systems for co-ordination and communication among actors involved in service planning and management. For instance, Finland has scheduled meetings on a regular basis between the central government (the Ministry of Health and Social Policies, the Ministry of the Interior, and the Ministry of Finance) and representatives of 'welfare service districts.' In France, on the other hand, there are 'public exercises for inter-municipal cooperation' (EPCI). There are also financial incentives for French municipalities to participate in EPCIs.

Box 4. The integrated agency for social and health care services in Catalonia (Spain)

In Spain, the regional government of Catalonia is currently planning to establish an integrated social and healthcare agency, a body for the integrated governance of social and healthcare services in home and residential settings for dependent persons. The establishment of the agency is currently being discussed and awaiting approval in Parliament. If approved and operational, the integrated agency for social and health services in Catalonia would currently stand as a unique international model due to its structure and objectives.

Under the project, the management of the agency's activities will be shared between the health department and the Catalonia Department of Social Policy. Agency staff will consist of personnel from both departments, as well as personnel from municipalities to ensure adequate territorial representation. The management of the agency will alternate between the regional health department and the social services department, with each department taking turns in leading for a period of 3 years.

The current plan, if approved, will cause part of the funds pertaining to each of the two departments to be allocated to the agency in order to establish an integrated fund to finance social and healthcare services.

This configuration of the agency would enable the integrated management of the budget dedicated to social and healthcare services, an improvement in the integration of data and information services between the social and health sectors, as well as integrated delivery of care services. In fact, the agency aims to improve communication between social and health care staff, adopt multidimensional assessment tools, and encourage the establishment of integrated care plans for people with complex needs.

Source: OECD Interview, 2024.

Workforce

The integration between the social and health sectors represents a fundamental objective for improving the quality and efficiency of home care services offered to dependent individuals. The goal pursued by national regulations, although challenging and only partially achieved, is the integration of skills and human resources from the social and health sectors to provide holistic care, considering all the needs of the assisted person, both medical and related to their daily life and psychosocial well-being. (Gramigna, Poli, Accorinti, & Giovannetti, 2022)

This integration manifests itself along different stages of the care chain – from activation to assessment, and up to service delivery – requiring coordinated and multidisciplinary commitment from all involved actors.

- Activation: At this early stage, integration can be hindered by the lack of effective communication between social and health services. Information sharing is crucial to identify the individual's needs and activate appropriate services.
- Assessment: At this stage, the integration of social and health care on the professional level is crucial for the establishment of an individualised care plan. Collaboration between professionals from both fields enables a holistic assessment of the individual's needs, considering medical, social, and psychological aspects.
- Service delivery: Here, integration takes the form of the implementation of coordinated interventions and joint monitoring of the care plan. In particular, the presence of professional figures tasked with promoting an integrated approach to caring for the individual, which simultaneously considers medical, psychological, and social aspects, can play a key role in facilitating this process, acting as a bridge between different services and professionals.

Personnel working in integrated social and healthcare home assistance play a crucial role, as they must be able to address a wide range of needs. This implies the necessity for a broad variety of skills, from the ability to provide basic medical care and assisting with daily activities, to recognising and managing the social and psychological needs of the assisted individual. Therefore, it is essential that staff are properly trained and supported in developing and updating their skills.

However, various obstacles to social and healthcare integration can arise at the professional level, related to the duties of personnel and their skills. These include contractual obstacles (for example, if applicable contracts specify rigidly defined job scopes that are difficult to adapt), training barriers (if existing training pathways do not cultivate interdisciplinary skills), labour shortages (resulting in reduced availability of personnel capable of delivering integrated services), as well as, more generally, a lack of co-ordination between the formal and informal sectors.

The analysis presented in this chapter primarily aims to investigate three questions: at which stages of the care pathway (activation, assessment, service delivery) and to what extent does integration occur between the social and health sectors at the professional level? What are the main obstacles – contractual barriers, compartmentalisation of training, labour shortages, inadequate co-ordination between the formal and informal sectors – to this integration, how do they manifest, and with what intensity? What role does the informal sector (family caregivers and personal/family assistants) play, and what support is provided to them by regions and autonomous provinces?

Formal sector

An assessment of the levels of health and social care integration along the care pathway

This section analyses the different stages of the care pathway, finding elements of integration in both the activation and the conduct of multidimensional assessment aimed at promoting a bio-psycho-social approach in responding to the care needs of dependent individuals. In particular, there is a significant number, which varies between different regions and autonomous provinces, of professional categories with the power both to request the assessment (up to 8 actors) and to participate in carrying out the assessment itself (up to 11 actors), fostering a multidisciplinary approach to taking care of the dependent individual. In contrast, there is less integration in service delivery, as evidenced by, among other aspects, the limited institutionalisation of the figure of the case manager - the professional responsible for the coordinated management of the interventions envisaged in the individualized care plan (PAI) - among Italian regions and autonomous provinces.

Activation

The OECD survey[8] reveals that the authority to initiate the request for a multidimensional assessment is given to a plurality of actors in all 17 responding regions and autonomous provinces,[9] ranging from a minimum of 2 (Piedmont) to a maximum of 8 (Friuli-Venezia Giulia) types of actors. As illustrated in Table 8, the actors most frequently in charge of initiating the request are general practitioners (16, with the exception of Valle d'Aosta alone), followed by free-choice paediatricians, dependent persons and their family members, and social workers (each with 14 occurrences), and medical specialists (11). Home nursing service and community nursing follow with 9 and 7 occurrences, respectively. In 7 regions, other figures also play a role, including caregivers (Emilia-Romagna), other health professionals (Friuli-Venezia Giulia), the single point of access (Lazio), other social and health services, including private contracted (Marche), and the support administrator (Veneto). In addition to Piedmont, which gives this power only to general practitioners and dependent persons and their family members, other regions where the power to initiate the request is given to no more than 4 types of actors are Emilia-Romagna and Veneto (4), Lazio, Puglia, and Valle D'Aosta (3).[10]

Table 8. There is great variability among Italian regions and autonomous provinces in the number of actors entitled to initiate the request for a multidimensional assessment

Categories of personnel and other actors with authority to initiate the request for multidimensional assessment in Italian regions and autonomous provinces

Region	MMG	M5	PLS	Fam	AS	IdC	SID	Other	Total
Abruzzo	-	-	-	-	-	-	-		7
Calabria	-	-	-	-	-		-	-	7
Emilia-Romagna	-	-			-			-	4
Friuli-Venezia Giulia	-	-	-	-	-	-	-	-	8
Lazio	-		-					-	3
Liguria	-		-	-	-	-			5

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[8] The question reads: "Who has the authority to initiate the request for a multidimensional assessment? Select all possible answers."

[9] Basilicata did not answer this question.

[10] In contrast, 6 administrations selected 7 actors (Abruzzo, Calabria, Lombardy, Marche, P.A. of Bolzano and P.A. of Trento), and 3 administrations selected 5 (Liguria, Sicily and Umbria).

Lombardy	-	-	-	-	-	-	-		7
Marche	-	-	-	-	-		-	-	7
Autonomous Province of Bolzano	-	-	-	-	-	-	-		7
Autonomous Province of Trento	-	-	-	-	-	-	-		7
Piedmont	-			-					2
Puglia	-		-	-					3
Sicily	-	-	-	-	-				5
Tuscany	-	-	-	-	-	-	-	-	8
Umbria	-		-	-	-		-		5
AostaValley		-		-	-				3
Veneto	-		-		-			-	4
Total	16	11	14	14	14	7	9	7	

Notes: GP: General Practitioner; MS: Medical Specialist; FCP: Free-Choice Paediatrician; Fam: Family; SW: Social Worker; CN: Community nurse; HNS: Home nursing service.
Source: Questionnaire administered to Italian regions and autonomous provinces in February and March 2024.

Multidimensional assessment

The survey[11] highlights that in all 17 responding [12]regions and autonomous provinces, a variety of categories of formal sector professionals are involved in conducting the multidimensional assessment, both for evaluations concerning the elderly population and those concerning people with disabilities.

As highlighted in Table 9, the regions that involve the highest number of professional figures, out of a total of 11 categories considered, both as members of the core assessment team and as additional members, are Veneto (10 and 11, depending on whether the assessment concerns the elderly or the disabled population, respectively), Abruzzo (9 and 10), and Marche (9 and 8). In contrast, the Autonomous Province of Bolzano involves the least number of professional categories (3 and 2), just above Lazio (4 and 5), Liguria and Lombardy (5 and 4).

The survey reveals that the differences in the composition of the core assessment teams, depending on whether the evaluations concern the elderly or disabled population, range from a minimum of 0 to a maximum of 3 across all 16 observed [13] regions and autonomous provinces, with the sole exception of Valle D'Aosta, where these differences amount to 7. [14] Overall, the deviations tend to break even, indicating a similar level of multi-disciplinarity among assessments targeting the elderly and disabled population.[15]

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[11] The question reads: "Which professionals are responsible for conducting a multidimensional assessment? Select all possible answers. If necessary, distinguish according to the target population."

[12] Basilicata did not answer this question.

[13] Basilicata did not answer this question.

[14] A case worthy of further exploration is provided by some regions that have identified certain categories of professionals both as components of minimum assessment teams and as additional members.

[15] There are 4 regions where the composition remains unchanged: Abruzzo, Lombardy, Puglia and Umbria. Only 1 deviation is observed in 6 regions and autonomous provinces: Calabria, Friuli-Venezia Giulia, Autonomous Province of Bolzano, Autonomous Province of Trento, Sicily, and Tuscany. 2 deviations are observed in 3 regions: Emilia-Romagna, Lazio, and Veneto. In addition, 3 deviations are observed in 3 regions: Liguria, Marche, Piedmont.

The survey also indicates that social workers, followed by general practitioners and nurses, are the predominant professionals conducting multidimensional assessments, whether they target the elderly population or focus on disability.[16]

The professional category by far the least represented in the assessments is that of social and healthcare workers, who are involved in the core assessment team only by the Autonomous Province of Bolzano, regardless of the population being evaluated. Friuli-Venezia Giulia includes them in both assessments, while Veneto includes them only when the assessments concern the disabled population.

Another category that plays a minor role is that of educators, who are involved as additional members for assessments concerning the elderly population only in Abruzzo and Veneto. For the disabled population, they are involved in Emilia-Romagna, Liguria, Valle D’Aosta, and Veneto.[17]

Table 9. There is significant variability among the Italian regions and autonomous provinces in the number of categories of professionals involved in the multidimensional assessment, with minor differences between the assessments concerning the elderly population and those concerning the disabled population.

Core Assessment Team (and Additional Members) for Evaluating the Elderly Population in Italian Regions and Autonomous Provinces

Region	SW:	HCA	Nur	GP	Ger	Edu	Phys	Psych	Neu	Psy	MS:	Tot	UNI
Abruzzo	-		-	-		-	-	-	-	-	--	5 (6)	9
Calabria	-		-	-	-		--	--	--			7 (3)	7
Emilia-Romagna	-		-	-	-							2 (2)	4
Friuli-Venezia Giulia	-	-	-	-							-	3 (2)	5
Lazio	-		-	-							-	4	4
Liguria	-		-	-	-				-			4 (1)	5
Lombardy	-		-	-	-		-					3 (2)	5
Marche	-		-	-	-		-	-	-	-	--	4 (6)	9
Autonomous Province of Bolzano		-	-	-								3	3

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[16] Only the Autonomous Province of Bolzano does not involve social workers in any assessment. The only regions that do not involve nurses in assessments involving the elderly population are Umbria and Puglia, but the latter incorporates them as additional components to the minimum assessment unit. Similarly, the only regions that do not involve nurses in evaluations involving the population with disabilities are Puglia, Valle d'Aosta, and Emilia-Romagna, but the latter provides for their inclusion as additional members. Emilia-Romagna and Valle d'Aosta are also the only two regions that do not involve general practitioners in the assessment of the elderly population, but both integrate them as additional members. These two regions, along with the Autonomous Province of Bolzano, are also the only ones not to involve general practitioners in the evaluation of the population with disabilities, except for their integration as additional members in Valle d'Aosta alone.

[17] Categories such as physiatrists, psychiatrists, neurologists, and psychologists are predominantly involved as additional members, while only in a few regions do they participate in the evaluation as part of the minimum core team. This tendency is particularly pronounced in assessments involving the elderly population. In an apparently counterintuitive manner, geriatricians belong to the minimum core team in a greater number of regions for evaluations related to the disabled population. However, this prevalence is reversed when considering only additional members and the total number of professionals involved in evaluations of the elderly population. Other specialist doctors are structurally included in evaluation teams in approximately one in two regions or autonomous provinces, and they are integrated in several cases.

Autonomous Province of Trento	-		-	-	-			-	-		-	4 (3)	7
Piedmont	-		-	-	-		-				-	6	6
Puglia	-		-	-	-		-		-	-	--	3 (6)	8
Sicily	-		-	-	-		-	-	-		-	4 (4)	8
Tuscany	-		-	-	-		-		-			2 (4)	6
Umbria	-			-	-		-		-	-	-	3 (4)	7
Valle D'Aosta	-		-	-	-			-	-	-		3 (4)	7
Veneto	--		--	--	--	-	-	-	-	-	--	5 (10)	10
Total	16 (1)	1 (1)	15 (2)	15 (3)	6 (9)	0 (2)	3 (8)	1 (7)	1 (11)	0 (6)	8 (6)		

Notes: SW: Social Worker; HCA: Social healthcare assistant; Nur: Nurses; GP: General Practitioners; Ger: Geriatrician; Edu: Educator; Phys: Physiatrist; Psych: Psychiatrist; Neu: Neurologist; Psy: Psychologist; MS: Medical Specialist; Tot: total number of professionals involved, as part of the minimum core and as additional members (in brackets); Uni: total number of professionals involved. -: involvement in the core team; -: involvement as an additional member.
Source: Questionnaire administered to Italian regions and autonomous provinces in February and March 2024.

Minimum core (and additional members) for the assessment of the disabled population in Italian regions and autonomous provinces

Region	AS	HCA	Nur	GP	Ger	Edu	Phys	Psych	Neu	Psy	MS	Tot	
Abruzzo	-		-	-	-	-	-	-	-	-	--	5 (6)	10
Calabria	-		-	-	-		-	-	-		-̲	8	8
Emilia-Romagna	--		--			--	-̲-	-	-	-		3 (7)	7
FVG	-	-	-	-	-̲						-	4 (2)	6
Lazio	-		-	-	-̲						--	4 (1)	5
Liguria	-		-	-	-	-				-̲		4	4
Lombardy	-		-	-			-					3 (1)	4
Marche	-		-	-	-̲		-̲	-	-		--	5 (3)	8
Autonomous Province of Bolzano		-	-	-								2	2
Autonomous Province of Trento	-		-	-	-̲			-	-		-	5 (2)	7
Piedmont	-		-	-	-		-̲		-̲		-	6	6
Puglia	-		-	-	-		-		-	-	--	3 (6)	8
Sicily	-		-	-	-		-	-	-		--	5 (3)	8
Tuscany	-		--	-	-	-	-	-	-	-	-	1 (9)	10
Umbria	-		-	-			-	-	-	-	-	4 (4)	8
AostaValley	-			--	-̲	-	-	-̲-	-̲	-̲	-̲-	7 (3)	8
Veneto	--	-	--	--	-̲-	--	-	-	-	-̲-	-̲-	7 (11)	11
	16 (2)	1 (2)	12 (4)	13 (3)	9 (3)	4 (4)	5 (7)	2 (9)	3 (9)	3 (6)	8 (9)		

Notes: SW: Social Worker; HCA: Social healthcare assistant; Nur: Nurses; GP: General Practitioners; Ger: Geriatrician; Edu: Educator; Phys: Physiatrist; Psych: Psychiatrist; Neu: Neurologist; Psy: Psychologist; MS: Medical Specialist; Tot: total number of professionals involved, as part of the core team and as additional members; Uni: total number of professionals involved. -: involvement in the core team; -: involvement as an additional member; -̲: positive deviation from the assessment of the elderly population; -: negative deviation from the assessment of the elderly population.
Source: Questionnaire administered to Italian regions and autonomous provinces in February and March 2024.

The survey [18] indicates that in 16 regions and autonomous provinces that responded – i.e. all except Basilicata and the Autonomous Province of Bolzano – there are opportunities for professionals to collaborate during the multidimensional assessment process, where the evaluation is conducted by

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[18] The question reads: "If the assessment is carried out by different professionals at different times, are there opportunities for collaboration between professionals in the multidimensional assessment process?"

different professionals at different times. As highlighted in Table 10, these moments of collaboration occur frequently (9 occurrences) in the form of integrated teams within the framework of multidimensional assessment units (UVM). This is the case in Friuli-Venezia Giulia, Lazio, Liguria, the Autonomous Province of Trento, Puglia, Tuscany, Umbria, Valle D'Aosta, and Veneto. In 4 cases (Lazio, Puglia, Tuscany, and Valle D'Aosta), the respondents clarify that formal meetings of the UVM occur after the collection of information (in the form of direct assessment of the patient) by one or more competent professionals (for example, Tuscany reports a "first evaluative, instructive, mono-professional phase"). However, it is reasonable to assume that this also occurs in other regions that have not specified this step. In Veneto, UVM meetings take place via videoconference. Abruzzo, Calabria, Lombardy, Marche and Sicily resort to in-person or telephone meetings, while Piedmont devolves organisational arrangements to the local level. However, it is plausible that patterns vary significantly from territory to territory in other regions as well.

Table 10. In almost all regions and autonomous provinces, there are opportunities for collaboration between professionals in the multidimensional assessment process

Opportunities for professional collaboration in the multidimensional assessment process, in cases where assessments are conducted by different professionals at different times in Italian regions and autonomous provinces

Region	Yes	No	If yes, please detail the modes of collaboration here
Abruzzo	-		Thematic meetings at Single Point of Access and Districts
Basilicata		-	
Calabria	-		In-person/telephone consultation
Emilia-Romagna	-		At the regional level, specific methods of collaboration have not been defined, although the region's orientation is to promote flexible and simplified approaches.
FVG	-		During the multidimensional assessment unit, various care settings are provided for.
Lazio	-		The multidimensional assessment is structured in two phases: the direct assessment of the individual, during which one or more professionals competent for the specific need gather information, and the evaluation of the collected information, which is carried out collectively by the formally convened UVMD.
Liguria	-		During the integrated team meeting, the PAI is drafted through collaborative discussion.
Lombardy	-		In-person and remote meetings, email phone contacts: organisation is left to the territories
Marche	-		Face-to-face and by telephone
Autonomous Province of Bolzano		-	
Autonomous Province of Trento	-		As part of the UVM team
Piedmont	-		Defined at the local level
Puglia	-		The assessment is not conducted at separate times, a UVM is organised with the different professionals for comparison following their assessments
Sicily	-		Before closing the SVaMA file, the UVM physician meets with or hears from specialists
Tuscany	-		After an initial evaluative and instructive phase conducted by a single profession, a team meeting is scheduled, including the involvement of the individual, to define the PAI for the elderly and the Profilo di Funzionamento (Function Profile) and Progetto di Vita (Life Project) for people with disabilities
Umbria	-		This process takes place within the UVMD.
Valle D'Aosta	-		Meetings for information exchange/sharing, information gathering through specific forms. UVMD Commission for the elderly and UVMDI Commission for individuals with disabilities
Veneto	-		Any asynchronous evaluations are discussed in the UVMD through video conferencing. Preliminary multidisciplinary meetings to share relevant documentation and define and discuss the case.

Source: Questionnaire administered to Italian regions and autonomous provinces in February and March 2024.

Provision

The survey[19] indicates that the role of a case manager exists only in 6 out of 16 responding regions and autonomous provinces, as illustrated in the Table 11.[20] This role is central in managing the understanding and response to the needs of dependent individuals for their care, which is further emphasised by DM 77 of 2022. This role is assumed by a variety of professionals, among which the most prevalent is the nurse (Calabria, Friuli-Venezia Giulia where this role is not formalised, Autonomous Province of Trento which mentions the figure of the nurse case manager, and Veneto which has territorial and family or community nurses), followed by the social worker (Friuli-Venezia Giulia, where the role is also not formalised, Autonomous Province of Trento, Piedmont, and in some cases, Veneto). Assigning this role to general practitioners and paediatricians (Piedmont) and educators (Autonomous Province of Trento) is less common. Only Abruzzo seems to have established a dedicated figure, the case manager, recognised by some local health authorities (ASLs) through acts of reorganisation of territorial assistance.

The limited use of the case manager role, which can be carried out by various professional figures in different Italian regions and autonomous provinces, may be interpreted as a signal of less integration in the most decisive phase of the care pathway i.e. the provision of care services.

Table 11. The role of case manager exists in a minority of regions and autonomous provinces

Presence of the role of case manager in Italian regions and autonomous provinces

Region	Yes	No	If so, specify which type of professionals perform this role – for example, general practitioners, community nurses
Abruzzo	-		Case manager
Basilicata		-	
Calabria	-		Nurse
Friuli-Venezia Giulia	-		The role is not formalised, but is typically filled by a nurse or social worker
Lazio		-	
Liguria		-	
Lombardy		-	
Marche		-	
Autonomous Province of Bolzano		-	
Autonomous Province of Trento	-		Social worker, nurse case manager, educator
Piedmont		-	M
Puglia	-		GP/FCP/social worker, as appropriate
Sicily		-	
Tuscany		-	
Umbria		-	
Valle D'Aosta		-	
Veneto	-		Case referrer identified at the multidimensional assessment unit. Generally, it is the general practitioner (GP) or the community nurse (CN), including the family or community nurse. In some borderline cases, the case worker/case manager may be the social worker
Total	6	10	

Source: Questionnaire administered to Italian regions and autonomous provinces in February and March 2024.

More generally, when asked about the quality of social and healthcare integration in home care, the vast majority of responding regions and autonomous provinces (11 out of 18) consider it to be largely improvable or at least mediocre. This includes the level of integration between ADI and SAD, the two types of home care currently available in Italy.

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[19] The question reads: "Does the role of operator exist in the Autonomous Region/Province?"

[20] Emilia-Romagna did not answer this question.

There are numerous reasons for the difficulties in integrating the intervention models envisaged and coordinating the provision of predominantly nursing care services and support interventions for the social inclusion of dependent individuals, as identified by the responding regions and autonomous provinces in the survey. In particular, the historic divide between the healthcare nature of ADI and the social nature of SAD is highlighted, which could be addressed by the provision of a new unified model of home care (Autonomous Province of Bolzano/Bozen) Additionally, some regions emphasise the challenges of coordinating between the two types of services and incentivising inter-professional collaboration, which also stem from the divide between the organisation and nature of the services offered by ADI and SAD (Puglia, Lombardy, Valle D'Aosta). In general terms, from the analysis of the provided responses, it is evident that the lack of integration between the healthcare and social sectors is recognised as particularly critical in this final phase of the care continuum.

In the context of strategies aimed at promoting social and healthcare integration in home care by addressing functions, organisational methods, and workforce competencies, the Austrian initiative to introduce community nursing represents a precedent of clear interest for Italy. Here, with DM 77/2022, the legislature has initiated a process to define the role of the community nurse. This process has seen initial experimentation in some territories to date, but systemic implementation still requires several steps, including a more precise formulation of the concept itself, the requirements, tasks, and operational methods related to the new figure of the community nurse. The innovative model introduced in Austria as a pilot project, as outlined in the Box 5, aims to improve accessibility and quality of care for the most vulnerable groups, emphasising a holistic and proactive approach to individual and collective health and well-being. The evaluation of the pilot's impact, currently underway, will provide Italian policymakers with valuable insights into the effectiveness of this figure as a solution to promote dehospitalisation, geographical proximity in service delivery, expansion of skills among care personnel, and better connection with the services and institutional networks involved.

Box 5. Health and social care integration and the innovative role of community nurses in the Austrian context

As chronic diseases affect an increasing proportion of the population and have become a public health priority, various theoretical models have been developed to conceptualise the system's support for the population's health needs, such as population health management and chronic care management. This model responds to the growing need to adapt systems of care to the changing needs of an ageing population and individuals with complex health conditions. It also aims to help reduce inequalities in access to care by promoting care based on proximity and continuity. This approach is manifested in the promotion of individual and family interests, as well as the creation and strengthening of support networks within communities to improve access to health and welfare services.

The SELFIE project has developed an integrated care framework for people with chronic conditions. This framework was developed between 2015 and 2016 by a group of researchers with diverse expertise, ranging from medicine and public health to health policy, health economics, sociology, and anthropology. It includes 6 dimensions of care integration (service delivery, leadership and governance, workforce, financing, medical technologies and products, information and research), and three levels of care integration: macro, meso, micro, as shown in Figure 1. During the period between October and December 2021, local governments and social welfare organisations had the opportunity to apply for funding to start community nursing projects, which were selected through an evaluation process that took into account both content and proposed cost-effectiveness. The essence of these projects lies in enhancing the health literacy of vulnerable communities and their families, aiming to significantly improve quality of life by increasing autonomy and awareness in health-related decision-making.

Centrality is given to addressing care gaps present within communities, promoting holistic wellness and increasing health knowledge and expertise among the population. Aiming to deploy at least 150 community nurses by 2024, the project aspires to strengthen support for the elderly and their families, improve health care delivery at the local level, and optimise care and treatment systems on a regional scale.

Activities under the project encompass a wide range of interventions, such as preventive home visits, counselling, assessments of care conditions, and co-ordination of additional services, with the ultimate goal of encouraging people to remain in their home environment for as long as possible. This results in care characterised by a deep attention to individual needs, emphasising the importance of an integrated and personalised health care approach.

The Institute for Applied Research on Ageing and the Department of Nursing and Health Care Sciences at the Fachhochschule Kärnten are responsible for evaluating the impact and effectiveness of community nursing. They aim to scrutinise the various dimensions of the initiative through a multidisciplinary and inclusive approach, assessing its social & healthcare, economic, and technological outcomes. The evaluation methodology involves a participatory design, which encourages the active involvement of various stakeholders in order to arrive at a holistic understanding of the project's impact.

The Austrian initiative of community nurses constitutes a significant example of how the redefinition of roles and the adoption of new care models can effectively contribute to the integration between health and social services, guiding care systems towards a greater focus on patient and community-centred care.

Source: Community Nursing in Österreich | CN-Österreich (cn-oesterreich.at).

Barriers to workforce co-ordination and integration

Contractual barriers

Although the topic of social and healthcare integration has been the subject of numerous academic studies and debates, there is a lack of literature on the legal and contractual barriers that can hinder integration on the professional level, particularly in the area of home care for dependent individuals. This calls for further analysis of the contractual dynamics that influence the integration of the functions, skills, and responsibilities of the professionals involved, particularly at the service delivery stage.

The evidence collected suggests that the expansion of duties for healthcare and social sector professionals does not directly stem from the national collective agreements that extensively regulate the sector in Italy. Rather, some limitations may result from national legislative provisions (in particular, from Art. 2103 of the Civil Code, as amended by Law 81/2015) that reflect the tension between the protection of workers' rights and employers' needs. In both the public and private sectors, there is also the mandatory principle of protection of the worker's professionalism, which stipulates that the assignment of different tasks is possible only within the same or a higher level of classification and within the same legal category. For example, in implementation of this principle, the duties of nurses may be limited to providing healthcare services (monitoring patient health, administering medications, and dressing wounds). These national provisions are intended to protect the worker and ultimately only indirectly affect the issue of social and healthcare integration on the professional level.

The rigidity of professional categories within collective agreements reflects the existing separation in the training paths of different professional figures in the healthcare, sochealthcare, and social sectors. In particular, barriers to socio-healthcare integration on a professional level primarily stem from the compartmentalisation of professional training, which discourages the interdisciplinarity necessary to ensure a holistic approach to care. Additionally, it reduces the ability of professionals to collaborate with each other in taking care of dependent individuals. (Rossi, 2018)

However, social and healthcare integration does not necessarily entail an extension of traditional work activities. Instead, it can materialise as an increase in the level of interaction and collaboration among professionals from various fields of the healthcare and social sectors, both in the assessment phase of the needs of dependent individuals and in the provision of services. In this case, the barrier to integration appears to be organisational and institutional in nature. Collaboration among professionals implies a revision of organisational models, especially in public administrations. Contractually, the obligation of professionals to collaborate stems from the principle of good administration. Therefore, for inter-professional collaboration to be effective, there needs to be an improvement in the organisation between healthcare and social administrations, which can also be achieved through the establishment of regulatory protocols or the provision of a case manager to co-ordinate the activities of the different professional figures involved.

In conclusion, the implementation of professional social and healthcare integration in practice is not only hindered by contractual barriers, but rather by the lack of integration in training and organisational aspects. Faced with these challenges, there is a clear need to promote policies that facilitate the integration of skills among professionals in the healthcare and social sectors, aimed at overcoming the current regulatory, contractual, and organisational obstacles that limit inter-professional collaboration. Additionally, it is important to encourage national, regional, and local integrated training interventions focused on interdisciplinary and inter-professional collaboration in order to prepare professionals capable of ensuring care models that can effectively and holistically meet the complex needs of non-self-sufficient individuals.

Integrated training at the national level

The need to rethink training pathways for healthcare, social healthcare, and social services personnel has long emerged within the scientific debate, both nationally and internationally (WHO, 1988). Specifically, the debate involves the multidisciplinary and interdisciplinary training of both healthcare and social professionals. Additionally, it affects the relationship between the professional and the assisted person, ultimately impacting the entire system's ability to offer integrated and personalised care services (Vicarelli, 2019). This issue can be addressed on two levels, depending on whether the focus is on personnel already working in the sector or those who are still in training. that of training for knowledge updating (continuous education) and that of tertiary education.

As demonstrated by the lack of active policies promoting integrated training at the national level, the issue of integrated training for healthcare and social personnel has not been directly addressed within national training standards and has only been partially recognised within the training activities proposed by respective national professional orders.

In the healthcare sector, some interventions, tools, and methods for improving and strengthening the training of specialist doctors and general practitioners have been outlined in the 2019-2021 Health Pact.[21] Regarding physician training, however, the focus is mainly on the issue of continuous medical education and professional updating of healthcare professionals rather than on interdisciplinary training (Agenas, National ECM Program 2023-2025).[22] For nurses, on the other hand, the offer of integrated training is more frequent and can also involve the topic of communication with other professionals, the patient, and their family. Despite significant differences between healthcare professions, the need to acquire cross-cutting skills — particularly relational, communication, management, and organisational skills — necessary to work effectively in an interdisciplinary team still finds sporadic recognition in nationally promoted training initiatives (Cocchi, Mazzeo, & Mauro, 2021).

Even in the social sector, the emphasis at the national level is often placed on the continuous training of social professionals rather than on the issue of initial multidisciplinary training (Consiglio Nazionale dell'Ordine degli Asisstenti sociali, 2023). Regarding the figure of the social worker, there is often a prevalent identity approach to the profession that discourages interdisciplinary collaboration with other professional figures and consequently reduces social workers' ability to acquire the knowledge and skills necessary to operate within the social healthcare system. (Fazzi, 2022).

However, it is observed that the issue of interdisciplinary training also concerns tertiary education. By providing a series of training obligations and determining membership in professional categories, university education plays a crucial role in promoting multidisciplinary and interdisciplinary training in the healthcare and social sectors.

Regarding the medical profession, university education is still largely based on the compartmentalisation of medical disciplines and does not encourage physicians to consider the social context in which the patient's health and illness occur and to adopt the paradigm of complexity (Rete Italiana per l'Insegnamento della Salute Globale, 2015). (Lusardi & Tomelleri, 2017)Contamination with social service elements, approaches, and tools is only partially present in specialised pathways, such as occupational medicine and hygiene and prevention. The issue of preventing the onset of diseases is indeed the strongest vector for integration with the social sector, although it is still poorly addressed in other specialist medical pathways.

As for the tertiary education of social workers and other professionals in the social sector, only in some university courses is particular attention paid to interdisciplinary training as a requirement for acquiring a holistic view of the concrete situations that must be addressed within the service system. Both due to the interdisciplinary nature of the theoretical teachings provided and the lack of hours and places for practical

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[21] For more information:
https://ape.agenas.it/documenti/Normativa/Accordo_Stato-Regioni_del_2_febbraio_2017_in_materia_di_ECM.pdf

[22] For more information:
https://farmaciavirtuale.it/wp-content/uploads/2024/01/4353-Programma-nazionale-Ecm-2023-2025.pdf

internship activities, Italy is still far from implementing the Global Standards for Social Work Education and Training. (International Federation of Social Workers, 2020).

Integrated training at regional and provincial levels

To complement what was illustrated at the national level, the survey[23] reveals that there are 9 regions and autonomous provinces – or half of the respondents – offering integrated training activities among healthcare and social professionals in the formal sector. i.e. training that embraces methods and tools from both healthcare and social training, ensuring the acquisition of cross-cutting skills and promoting inter-professional collaboration. In the case of 5 regions (Friuli-Venezia Giulia, Lazio, Liguria, Marche and Puglia) these activities are accompanied by other training activities for operators of public services, volunteers, and the Third Sector, while in 4 cases (Emilia-Romagna, Autonomous Province of Trento, Tuscany, and Veneto), they represent the entirety of the training offered. Lombardy and the Autonomous Province of Bolzano, on the other hand, only offer training activities for public service, voluntary, and Third Sector workers. Table 12 provides an overview of the training offered as a tool contemplated by the regions and autonomous provinces to facilitate the integration of health, social and healthcare services in the home.

Among the 8 regions offering integrated training activities, 3 (Friuli-Venezia Giulia, Lazio and Veneto) provide some additional information. Friuli-Venezia Giulia mentions the Volunteer Service Centre and the Si Fa Rete Project, while Lazio indicates that integrated training among healthcare and social professionals is primarily aimed at operators of the single access point (PUA) and is organised by the PUA itself using regional funding. If the outcome of the assessment is positive, the organisation is officially accredited and included in a list of authorised providers. Once a contractual agreement is reached with public institutions, it can deliver services on behalf of the public healthcare system under a convention regime. Any further insights will allow for a deeper understanding of current practices (access and delivery methods, target audience, frequency, and content of the training).

The survey also reveals that training-based strategies play a secondary role among the solutions considered by the Italian regions and autonomous provinces to facilitate the integration of home healthcare, social healthcare, and social services. Instead, there is a strong prevalence of governance tools at the territorial level (14 occurrences) and funding for the implementation of projects aimed at socio-healthcare integration or having a significant impact on it (12). All regions offering integrated training programmes combine them with at least two other tools, up to a maximum of 6 detected in Veneto, followed by Emilia-Romagna and Friuli-Venezia Giulia with 5.

Table 12. One in two autonomous regions and provinces offers integrated training

Tools contemplated by regions and autonomous provinces to facilitate the integration of home healthcare, social healthcare, and social services.

Region	Gov.	Co-prog.	Fin.	Train.	Int. Train.	Audit	Other	Total
Abruzzo	-	-	-				-	4
Basilicata	-							1
Calabria			-					1
Emilia-Romagna	-	-	-	-	-			5
FVG	-	-	-		-		-	5
Latium	-		-		-	-		4
Liguria	-		-		-			3
Lombardy	-			-				2
Marche	-		-		-		-	4

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[23] The question reads: "How does the regional and Autonomous Province context facilitate the integration of social, healthcare, and public health services in the home?" Select all possible answers."

Autonomous Province of Bolzano				-			-	2
Autonomous Province of Trento	-		-	-	-			4
Puglia	-		-		-			3
Sicily	-	-	-					3
Tuscany	-	-			-			3
Umbria	-							1
Veneto	-	-	-	-	-	-		6
Valle D'Aosta	-	-	-				-	4
Total	15	7	12	5	9	2	5	

Notes: Gov: governance tools at the territorial level (such as the Territorial Activity Plan, inter-institutional agreements, and integrated planning between health districts and ATS); Co-progr: co-planning tools as defined by Decree no. 72/2021; Finance: funding for the implementation of social and healthcare integration projects, or other projects that have a significant impact on social and healthcare integration; Train.: training activities for public service, voluntary and Third Sector workers; int. train. integrated training activities among health and social professionals; Audit: multi-professional audit systems
Source: Questionnaire administered to Italian regions and autonomous provinces in February and March 2024.

Staff shortage

Social and healthcare integration can be conceived both as a solution to the staffing shortage problem that is affecting this as well as so many other sectors of the economy, and as a strategic goal threatened by this trend. On the one hand, integrating services makes it possible to optimise the use of available resources, enabling staff to perform a wider range of functions. This can help mitigate the effects of staff shortages by making the system more flexible and responsive to the needs of the people served. On the other hand, effective integration of services requires a high level of expertise, training and co-ordination, which can be difficult to achieve with staff shortages. Furthermore, expanding job responsibilities can increase the workload and stress among workers, potentially negatively impacting the quality of care. This dynamic makes an analysis of challenges to the sustainability of skills and personnel particularly useful (Box 6).

Box 6. Challenges for the sustainability of skills and personnel in the long-term care sector

Data from the 6th Long Term Care Observatory Report in Italy sheds light on multiple challenges that the long-term care (LTC) sector is facing, with a focus on the sustainability of skills and personnel. These challenges, which relate to the attractiveness of the sector, staff turnover, retention, and incentive and compensation models, intersect in complex ways, directly affecting the quality of care provided to users and the future sustainability of LTC service delivery organisations.

The low attractiveness of the LTC sector, combined with high staff turnover, emerges as a central problem. These trends translate into difficulty finding and retaining qualified professionals. Data indicates that LTC service providers suffer from an average 10% shortage of healthcare staff, and a 7% shortage of care staff, with higher peaks among providers in the social and healthcare supply chain. This situation is further exacerbated by a negative perception of staff well-being, with significantly low average well-being values indicating a dissonance between workers' expectations and what the industry is currently able to offer.

Despite attempts to mitigate the difficulties associated with staff recruitment and retention through economic incentive models and investment in training, these efforts still do not seem sufficient to counter negative trends. Organisations struggle to create an attractive and sustainable work environment, which is reflected in widespread dissatisfaction and high staff mobility.

The need to invest in new skills and define new professional roles is cited as a priority to address the multidimensional challenges presented by LTC users. The focus on skills such as case management, which are essential for personalised and integrated care management, underscores the importance of developing a more holistic, user-centred approach.

To address these issues, it is essential to adopt strategies aimed at creating a work environment that values and supports professionals in the field. This may include:

Improving working conditions through fair compensation, clear career growth paths, and investment in staff welfare and continuing education.

Developing new professional roles that better meet the complex needs of LTC users by encouraging specialisation and skill upgrading.

Promoting the attractiveness of the sector by enhancing LTC work in social and professional terms and creating a positive organisational climate to reduce turnover and incentivise retention.

Source: (Fosti, Notarnicola, & Perobelli, 2024).

When asked about the challenges affecting ADI (A.2.4)[24] and SAD (A.2.5)[25], as well as the critical issues hindering the integration of health, social and healthcare services in the home (A.2.6)[26], several survey respondents raised the issue of staff shortages. More specifically, the regions and autonomous provinces indicating staff shortage issues are, respectively, 8 (FVG, Lazio, Liguria, Lombardy, Marche, Umbria, Valle D’Aosta, Veneto), 6 (Abruzzo, Calabria, Friuli-Venezia Giulia, Liguria, Autonomous Province of Bolzano, Valle D’Aosta), and 4 (Abruzzo, Calabria, Marche, and Veneto). If we consider the intersections between these groups, there are a total of 11 regions and autonomous provinces that, although not explicitly prompted on this aspect, raise the issue of staff shortage.

The issue is evoked with variable formulations from case to case, making it unclear whether the staff shortage is due to a generalised lack of resources to remunerate them, difficulty in sourcing specialised individuals in the labour market, or a combination of these factors. The fact that most regions and autonomous provinces use generic expressions like "staff shortage", and that these are often accompanied by broader references to the lack of financial resources and the low intensity and coverage of services, suggests that the first hypothesis is prevalent. However, explicit references to difficulties in sourcing specialised individuals are not lacking, albeit sporadic (for example, in Lombardy and Valle D’Aosta).

The potential absence of dedicated educational or professional development paths for personnel tasked with providing integrated services could exacerbate the problem. Limiting the analysis to existing staff, 4 regions (Liguria, Lombardy, Puglia and Veneto) raise critical issues related to the absence of integrated training and a low propensity for collaboration within integrated teams.

Informal sector

Doctors, nurses, and other social and healthcare professionals play an essential role in ensuring qualified health and social interventions and in closely monitoring patients' conditions. However, the contribution of

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[24] The question reads: "What are the challenges/critical issues facing ADI in your Region/Autonomous Province today?"

[25] The question reads: "What are the challenges/critical issues facing SAD in your Region/Autonomous Province today?"

[26] The question reads: "Are there any critical issues that hinder the integration of social, healthcare, and public health services in the home?"

the informal sector (family caregivers and personal assistants) is equally indispensable, as they provide ongoing, individualised support that is critical to the patients' daily well-being. This part of the chapter explores how effective collaboration between these two sectors can significantly improve patient quality of life by facilitating a smooth and coordinated transition between formal and informal care.

Regional and autonomous province initiatives to support family caregivers

Family caregivers represent a large proportion of the Italian population. Based on the results of the European Health Interview Survey of 2019, it appears that in Italy, 13.5% of the population (aged 15 and over) - corresponding to more than 7 million individuals - provide care and assistance to people in need at least once a week, mainly within family settings. The proportion of women engaged in such caregiving activities, at 15.1%, is higher than the percentage of men, which stands at 11.7% (OECD, 2023).

The family caregiver can generally be identified as an individual – often a family member – who is responsible for organising and establishing the necessary care for the person who is in a condition of dependency or disability and, therefore, requires ongoing care.

According to current national legislation (Article 1, paragraph 255, of Law 205/2017), a family caregiver is defined as an individual “who provides assistance and care to their spouse, cohabitant, or a family member up to the second degree of kinship, who is unable to take care of themselves and requires comprehensive, long-term assistance."

Several bills aimed at introducing a comprehensive reform of the legal status of family caregivers are currently under discussion (see the last section of this chapter). In fact, on Oct. 3, 2022, the UN Committee on the Rights of Persons with Disabilities condemned Italy for its inadequate legal protection of caregivers (UN Human Rights Treaty Bodies, 2023), noting a violation of the international commitments made with the ratification of the UN CRPD in 2006.

In addition to national legislation, many regions and autonomous provinces have regulatory and/or planning acts that provide for and define the role of the family caregiver. Of all the regions and autonomous provinces, only Basilicata and Umbria do not have legislation on the subject (Table 13). According to Pesaresi (Il manuale dei caregivers familiari, 2021) some regions (e.g. Abruzzo, Campania and Puglia) have passed their regional law on family caregivers inspired in structure and content by that of Emilia-Romagna, the first region to legislate on the subject in 2014.

Table 13. In most regions and autonomous provinces there is legislation that provides for and defines the figure of the family caregiver

Existence of regional/provincial legislation that provides for and defines the figure of the family caregiver

Region	Regional/ provincial regulations	Details
Abruzzo	Yes	Standards for the recognition and support of family caregivers (individuals who voluntarily provide care and assistance) Regional Law No. 43/2016
Basilicata	No	
Calabria	Yes	Regional Law No. 6/2024 "Standards for the recognition and support of family caregivers"
Campania*	Yes	Regional Law No. 33/2017 "Regulations for the recognition of family caregivers"
Emilia-Romagna	Yes	Standards for the recognition and support of family caregivers (individuals who voluntarily provide care and assistance) (Regional Law No. 2 of 3/28/2014)
Lazio	Yes	DGR 239/2023 "Programming of interventions for the enhancement of the caregiving and assistance role of family caregivers" and DGR 341/2021

FVG	Yes	Regional Law No. 8/2023 "Provisions for the recognition, enhancement and support of family caregivers"
Liguria	Yes	DGR 167/2024 approving "Integrated planning guidelines and outline plan of interventions to be implemented through the family caregiver care fund for the year 2023"
Lombardy	Yes	Regional Law No. 23 of 2022 "Family Caregivers"
Marche	Yes	dgr 39/2022, Law 205/2017, DGR 1028/2021
Molise*	Yes	DGR 310/2017 "Guidelines for the recognition and support of family caregivers. Measures"
Autonomous Province of Bolzano	Yes	Definition of "primary carer" in Article 4 of the Resolution of September 27, 2022, no. 694 "Criteria for recognising the state of dependency and providing care allowance"
Autonomous Province of Trento	Yes	Provincial Law No. 15/2012
Piedmont	Yes	DGR. 6-7450 approving "Criteria and methods for the use of resources from the Fund to support the caregiving and assistance role of family caregivers for the year 2021"
Puglia	Yes	Regional Law No. 3/2020 "Regulations for the support of family caregivers"
Sardinia*	Yes	Regional Law No. 12/2023 "Recognition, enhancement and support of family caregivers"
Sicily	Yes	DGR 360/2022 "Fund programming to support the care and assistance role of family caregivers for years 2018-2021"
Tuscany	Yes	GRD. 126/2024 "Guidelines for the use of the fund to support the care and assistance role of family caregivers" and G.R.D. 717/2022 and Bill No. 2 of 12/02/2024
Umbria	No	
Veneto	Yes	Operational (non-defining) rules: Regional Law No. 20 (2) Veneto Regional Council Resolution No. 295 of 16/03/2021; Veneto Regional Council Resolution No. 157 of 2023; Veneto Regional Council Resolution No. 682 of 2022
Valle d'Aosta	Yes	Regional Law No. 20/2022 "Provisions on the Guarantor of the Rights of Individuals with Disabilities," which also defines the role of the family caregiver

Notes: *Is there any regional legislation that provides for and defines the figure of the family caregiver?*
(*) The region did not respond to the questionnaire and the information comes from research conducted by OECD.
Source: OECD Questionnaire 2024, 'Towards person-centred integrated social and healthcare in Italy' and (Pesaresi F. , 2021)

Legal recognition of the caregiving role played by family members is essential for accessing public support for informal caregiving activities. This recognition is crucial for enhancing the overall well-being of caregivers, including their psychological well-being.

Public intervention in this area is particularly important given that a large proportion of caregivers find themselves in the position of having to provide care because they are driven by regulatory and social pressures or out of sheer necessity. Furthermore, informal caregiving activities often negatively impact the ability of informal caregivers to participate in the labour market and affect their mental health (OECD, 2022),highlighting the need for public support measures.

Currently, national legislation includes various measures to protect family caregivers in order to support their role in assisting dependent individuals (see OECD (Verso un’assistenza sociosanitaria integrata incentrata sulla persona in italia, 2023) for more information). Specifically, employees are eligible for extraordinary leave to assist family members who need care due to dependency or severe disability (Article 42 of Legislative Decree 152/2001. In addition, for the first time the Budget Law of 2018 established an Ad Hoc Fund for financing interventions to support family caregivers, which was confirmed by subsequent provisions until 2023 and was allocated annually among regions and autonomous provinces.

In addition to national arrangements, regions and autonomous provinces can also implement additional forms of support to strengthen the role of family caregivers. Among the regions and autonomous provinces that participated in the OECD questionnaire, almost all of them (except Basilicata and Calabria) adopted at least one (Figure 3).

The support measures offered to caregivers vary significantly from one Italian region to another, both in terms of beneficiary population and in their nature and mode of delivery. This highlights how public intervention in favour of informal caregivers varies greatly depending on location.[27]

According to analyses of responses to the OECD questionnaire, monetary disbursements are the most common mode of assistance, adopted by 13 of the 18 regions participating in the questionnaire (Figure 3). The other most common forms of support are relief interventions[28] (11 regions and autonomous provinces), training courses (10 regions and autonomous provinces) information desks (10), psychological support (8), and financial incentives (4). No region or autonomous province provides leave, whether paid or unpaid, (Figure 3

Monetary disbursements – the support measure most heavily promoted by Italy's autonomous regions and provinces – support the demand for services while compensating for the loss of income that family caregivers experience by providing ongoing care. However, due to the nature and discipline of such economic support measures, it is difficult for regions to verify how the beneficiaries use the sums disbursed. This is a critical issue that affects not only the regional measures but also the attendance allowance provided by the state (Law 18/1980). According to the OECD, poor monitoring of the intended use of these sums has fuelled the black market.

Figure 3) other than that provided by national legislation. Other forms of support are reported from three regions.[29]

Monetary disbursements – the support measure most heavily promoted by Italy's autonomous regions and provinces – support the demand for services while compensating for the loss of income that family caregivers experience by providing ongoing care. However, due to the nature and discipline of such economic support measures, it is difficult for regions to verify how the beneficiaries use the sums disbursed. This is a critical issue that affects not only the regional measures but also the attendance allowance provided by the state (Law 18/1980). According to the OECD (Who Cares? Attracting and Retaining Care Workers for the Elderly, 2020), poor monitoring of the intended use of these sums has fuelled the black market.

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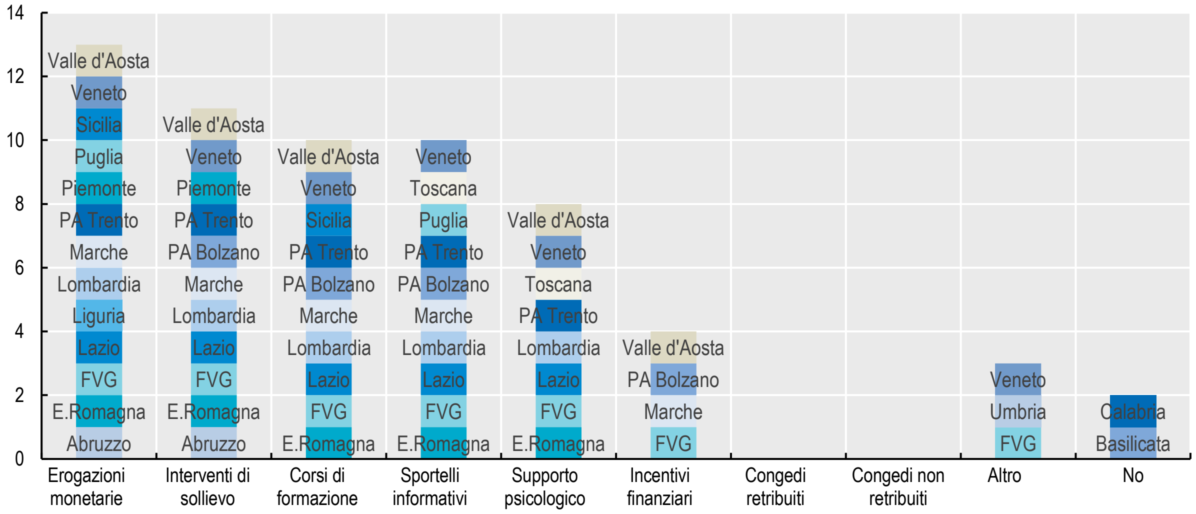
[27] Regarding monetary disbursements, for example, in Abruzzo (under Regional Law. 43/2016) resources are provided to the family caregiver caring for children with nationally recognised rare diseases. In Liguria, as part of the interventions for taking care of an individual with very severe disabilities, the caregiver's work is recognised through an economic contribution. In Valle d'Aosta, family caregiver financial aid is provided for people with very severe disabilities or amyotrophic lateral sclerosis (Article 21bis of Regional Law 23/10).

[28] Respite interventions offer caregivers a break from their usual care activities.

[29] For example, in Friuli Venezia Giulia, basic care is offered through social or socio-medical workers, support and respite interventions, home-based care, and specialist visits of the assisted person.

Figure 3. Most regions and autonomous provinces have implemented support measures to assist family caregivers in their caregiving activities.

Regional forms of support to assist family caregivers in their caregiving activities by number of regions-autonomous provinces



Notes: In addition to the forms of support provided at the national level, are there other forms of regional support to assist family caregivers in their caregiving activities? Select all possible answers.
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'

Academic research at the European level shows that informal caregivers often wish to receive more in-depth training in order to provide better care (COFACE, 2017). For example, caregivers may lack in-depth knowledge about the illnesses of the person being cared for or find it difficult to provide individualised care. Additionally, family caregivers need information about their rights and the rights of those in their care in order to effectively navigate health and social care systems.

Two-thirds of the regions and autonomous provinces that responded to the OECD questionnaire (with the exception of Basilicata, Calabria, Liguria, Piemonte, Puglia, and Umbria) report the existence of training sessions where family caregivers can receive information on the issues related to the people they care for, as well as the rights of both the care recipient and the family caregiver.

Among the various regional experiences, some stand out for implementing measures that support the role of family caregivers in their caregiving activities or interventions that support their training and/or psychological well-being.

Abruzzo has implemented a training programme for family caregivers through a 300-hour educational course (from the 2014/2020 ESF Notice "Abruzzo Carefamily") conducted by the District Social Areas (ADS) in partnership with ASLs, Third Sector entities, and accredited Training Organisations at the regional level.

In Friuli-Venezia Giulia, the SI.CON.TE service has a dual purpose: offering a specialised service to connect supply and demand in the field of domestic work and personal care and providing families with advice on useful tools for balancing work and family life. The implementation of this regional programme takes place through SI.CON.TE desks scattered throughout the area and the Single Family Number. SI.CON.TE also offers training and public events for citizens.

A specific pathway for family caregivers called "CuraInsieme" is active in the Autonomous Province of Trento. The project includes awareness-raising activities, training and mutual self-help groups for people caring for dependent elderly family members.

In Valle D'Aosta, the experimental project Better at Home is nearing completion in the field of dementia and cognitive disorders. This project offers psychological support to family members and caregivers of individuals with these conditions. Given its positive results, the project will be institutionalised.

For several months, regional planning has included a focus on the progressive integration of the Expert Family Member User (UFE) role, following the model piloted in Valle D'Aosta and other regional contexts. This initiative recognises the invaluable insights gained from individuals or family members who have directly experienced the challenges associated with a particular condition. These experts can serve as a 'filter,' providing service navigation and welcoming and informing care recipients and their family with empathy.

In Lazio, some ASLs and certain social territorial areas (ATS) provide listening services for family members and caregivers assisting people with dementia, such as the "AlzheimerAscolto" Desk (Centre for Cognitive Disorders and Dementia, ASL of Rome).

In Tuscany, a "Listening Centre for Family Caregivers" has been established. This centre provides a telephone support service delivered by professional psychologists and psychotherapists. Its aim is to offer listening, psychological support, information, and guidance on available services.

In the Veneto region, there are several Listening Points for family members and caregivers of individuals affected by severe cognitive impairment. These points, established in collaboration between ASLs, municipalities, and volunteer associations, are located within some nursing homes and provide free psychological support services.

Italy could draw inspiration from the good practices of other countries to take further steps in supporting informal caregivers. For example, assessing the needs of informal caregivers is a key aspect of caring for dependent persons, as it allows these caregivers to be effectively recognised and supported. In fact, many caregivers do not identify as such, making it crucial to introduce targeted assessments while caring for the dependent person. Assessing the needs and situation of individual caregivers is the first step towards ensuring that they receive flexible and quality support services.

The assessment of informal caregiver needs is not widely practiced across OECD countries. However, some examples of best practices are discussed in Box 7. In France, caregiver needs are not directly assessed: the assessment of care recipients does not formally consider the caregiver, but in practice, the caregiver's ability to provide care is often taken into account in the planning of the care (OECD, 2022). In Ireland, discussions on an assessment tool for caregivers have been ongoing since 2013. The assessment would focus primarily on the health, well-being, and self-identified support needs of the caregiver (O'sullivan & al., 2017).

Box 7. Family caregiver needs assessment: some international practices

- In England, family caregivers are entitled to an assessment by the *Health and Social Care Trust*. The assessment can take place in parallel with that of the person being cared for. This evaluation explores how caregiving affects the caregiver's physical and mental health, work, leisure and relationships. The assessment can take place in person, by phone, or online, and lasts at least one hour. Social services then develop a 'care plan' based on the assessment, which helps determine the type of support needed (emotional support, help with household chores, and adjustment of equipment at the assisted person's home) (National Health Service , 2020); (National Audit Office (NAO), 2018); (UK government, 2024).
- The Carer Gateway is an Australian government public service that offers caregivers an extensive support network, from counselling and peer support groups, to coaching, respite care services, and online training courses. An assessment is required to access services through Carer Gateway. The planning process helps staff learn more about the caregiver and their role so that they can tailor services to their specific needs. Caregivers in need of immediate assistance do not require an assessment, and emergency respite interventions are available 24 hours a day, seven days a week (OECD, 2022) (Australian Government, 2024).
- In Sweden, caregiver assessment makes it possible to consider caregiver opinions about home care, to create more individualised and flexible forms of support, to work proactively with caregivers to avoid crisis situations for both the caregiver and the person being cared for, and to increase caregiver recognition. Between 2006 and 2008, 'The Carers Outcome Agreement Tool' (COAT) was developed in five Swedish municipalities, focusing on four main areas: helping caregivers provide care; supporting the personal needs of caregivers by exploring support that can improve their quality of life; improving the lives of caregivers by evaluating what can improve their quality of life; getting good-quality support by focusing on what caregivers want from a care service. Evaluations of this programme highlight the significant value of COAT in fostering partnerships between caregivers and providers, recognising the expertise of both parties. COATs urge professionals to devote the necessary time and specific resources for family caregiver support so that COAT becomes a key element of a holistic and lasting strategy for caregivers (Hanson, Magnusson, & Nolan, 2008).

Regional and autonomous province initiatives to support personal/family assistants

A personal/family assistant is a worker who provides care for a dependent person within the home environment. For this reason, the personal/family assistant always works under the direct or indirect supervision of a family member (OECD, 2023).

According to estimates by the DOMINA Observatory on Domestic Work, there are approximately 890,000 personal assistants in Italy, a number that has clearly been on the rise over the past decade (2009-2018). Compared with the number of elderly residents (aged 80+), a higher incidence of personal caregivers is observed in the northern and central regions, compared with those in the south, with the exception of Sardinia (Osservatorio DOMINA sul lavoro domestico, 2023). Similar estimates are reported by the Long-Term Care Observatory (Fosti, Notarnicola, & Perobelli, La sostenibilità del settore Long-Term Care nel medio-lungo periodo, 2024).

The work of family assistants is regulated, at the national level, by the National Collective Bargaining Agreement for Domestic Work, which specifically regulates the basic elements of the employment relationship and economic treatment (Ebilcoba, n.a.). Notwithstanding the absence of a national law that further protects this specific category of workers, regional or provincial legislation that includes provisions that promote regular domestic work for personal assistants is essential to ensure dependent individuals receive safe, high-quality care.

In many Italian regions and autonomous provinces, with the sole exceptions of Abruzzo, Basilicata, Calabria, Campania, the Autonomous Province of Bolzano, and Sicily, there is regional/provincial legislation that provides for and/or defines the figure of the personal/family assistant (Table 14).

The region of Lombardy, through Law 15/2015, defines the family assistant as follows: "The family assistant provides assistance and care for people in conditions of fragility, temporary or partial dependency, or permanent chronicity, in accordance with the requirements and provisions of this law and the current laws on the subject."

Veneto, through Regional Law No. 38/2017, defines family assistant as follows: In Veneto, through Regional Law No. 38/2017, family assistants are defined as follows: "Family assistants are Italian or foreign individuals who possess specific educational and professional qualifications identified by the Regional Council, and who have received adequate training and/or experience. They provide care services for elderly and dependent individuals, and more broadly, for individuals in fragile or dependent conditions, either independently or through an employer. These services are delivered in the home or provided temporarily to support family members or act as substitutes for the family unit in hospital or residential facilities."

In Valle D'Aosta, Regional Government Resolution 142/2008 offers the following definition: "The personal assistant is an operator who cares for non-self-sufficient individuals, whether elderly, disabled, or affected by debilitating conditions. They also support family members, contributing to the autonomy and psycho-physical well-being of the care recipient according to their needs and context." Personal assistants can also act in liaison with the social and health services involved, ensuring a continuity of presence in the person's home and performing direct care activities, particularly in daily routines (e.g. getting up, washing, dressing, preparing and consuming meals, going out) and take care of housekeeping."

In addition to defining the role of personal/family assistant in legislation, some regions have established specific training pathways for this professional figure. This approach establishes appropriate and recognised training for personal and family assistants, clarifying the skills and tasks expected of these professionals, and helps to further enhance and professionalise them.

The Marche region, through Law 118/2009, defines the professional and training profile of the family assistant, setting the standard duration of the training course for the issuance of the attendance certificate at 100 hours, and the minimum training course duration for the issuance of any skill certification at 20 hours.

In Friuli-Venezia Giulia, the role of family assistant was included in the regional repertoire of qualifications through Resolution 825 of 26/05/2023. A 240-hour course is required to receive the family assistant qualification, which can also be obtained through the regional skills certification (DGR no. 2019 of Dec. 15, 2023 "The Regional Skills Certification System – Regional Guidelines for the Identification, Validation and Certification of Skills").

In Valle D'Aosta DGR 142/2008 approved the professional profile and established the minimum training standard for personal assistants, including it in the regional repertoire of professional profiles.

Table 14. In many Italian regions and autonomous provinces, there is regional/provincial legislation that provides for and/or defines the figure of the personal/family assistant

Existence of regional/provincial legislation that provides for and/or defines the figure of the personal/family assistant region

Region	Regional/provincial regulations	Details
Abruzzo	No	
Basilicata	No	
Calabria	No	
Campania*	No	
Emilia-Romagna	Yes	Guidelines for the qualification and regularisation of care work performed by family caregivers under the FRNA - DGR 1206/07
Lazio	Yes	DGR 609/2007 and DGR 223/2016 "Personal care services and social interventions in the Lazio region", which defines and provides measures for the role
FVG	Yes	The role family assistant was included in the regional repertoire of qualifications by Resolution 825 of 26/05/2023; furthermore, DGR no. 2019 of Dec. 15, 2023 "The Regional Competency Certification System - Regional Guidelines for the Identification, Validation and Certification of Competencies" envisions a 240-hour course to obtain the qualification or through the certification of skills
Liguria	Yes	Regional Government Resolution No. 446-2015 "Framework resolution for the integrated social and healthcare system for disabilities"
Lombardy	Yes	Regional Law No. 15/2015
Marche	Yes	Regional Law No. 118/2009
Molise*	Yes	DGR 131/2023 approving the "Regional Plan for Dependency" which provides for but does not define the role of family assistants
Autonomous Province of Bolzano	No	
Autonomous Province of Trento	Yes	Provincial Law No. 15/2012
Piedmont	Yes	Regional Government Resolution 51-8960, which approves the "Guidelines for the Preparation of Independent Living Projects", defines and includes the personal assistant role
Puglia	Yes	Regional Resolution 1040/2023 "Approval of Public Notice for the Care Pact 2023-2024", which includes but does not define the personal assistant role
Sardinia*	Yes	DGR 7-11/2023 provides for but does not define the role
Sicily	No	
Tuscany	Yes	Regional Law No. 82/2009: Accreditation of facilities and services within the integrated social system for individuals, along with Regional Government Resolution 256/2023 approving the Regional Dependency Plan, and Regional Government Resolution 937/2023 "Actions aimed at facilitating the meeting between demand and supply of work for family assistants", which defines and includes the role
Umbria	Yes	Regional Government Resolution 1251/2017 approves the "Guidelines on family care of the elderly in a condition of care dependency or non-self-sufficiency"
Veneto	Yes	Regional Law No. 38/2017 "Rules for supporting families and elderly, disabled, frail, or non-self-sufficient individuals, for the qualification and support of family assistants". Regional Government Deliberation No. 910 of June 28, 2019, "Identification and support of the initial phase of Family Care Centres and the Regional Register of Family Assistants"
Valle d'Aosta	Yes	The Regional Government Resolution 1524/2023, as well as Resolutions 142/2008, 2836/2010, and 366/2014, not only define the profile of the personal assistant but also establish a regional list of personal assistants and their training

Notes: Is there any regional/provincial legislation that provides for and defines the figure of the personal/family assistant?
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'
(*) The region did not respond to the questionnaire and the information comes from research conducted by OECD.

In Italy, despite the recognition of duties, hours, and economic treatment within the national collective agreement for domestic work, the prevalence of irregular work among family assistants is a significant issue. A recent study by Pasquinelli and Pozzoli (Badanti dopo la pandemia: vent'anni di lavoro privato di cura in Italia, 2021) showed that 76% of personal assistants surveyed had worked, either in the past or at the time of the survey, without formal employment. Additionally, according to estimates by Fosti et al. (Il presente e il futuro di long-term care: cantieri aperti, 2022), in 2020 there were over a million caregivers in the country, 60% of whom were working illegally. The DOMINA report estimates that in 2022, 52% of caregivers were working illegally. (Osservatorio DOMINA sul lavoro domestico, 2023).

The presence of tax incentives and economic support to encourage families to formally hire personal or family assistants is one of the tools that could help combat the underground economy. These measures encourage the formalisation of employment relationships in the personal care sector, promoting legality and protecting the rights of both caregivers and care recipients.

At the national level, new provisions have recently been approved to facilitate domestic work for elderly, non-independent individuals. In particular, in addition to the reorganisation of tax benefits, a new universal benefit is being trialled, which involves the provision of an additional monetary allowance aimed at compensating for the caregiving work performed by family assistants who are formally employed (Articles 36 and 37 of Legislative Decree 29/2024).

Table 15 shows that in many Italian regions – except for Basilicata, Calabria, Campania, Friuli-Venezia Giulia, the Autonomous Province of Trento, Puglia, and Veneto – there are tax incentives and/or economic support for formally hiring personal/family assistants. These incentives include additional contributions to care allowances, and various types of bonuses and allowances for formally hiring workers as defined by the law.

In Abruzzo, the regional plan for dependency provides for 'economic contributions to support the at-home care and personal autonomy of dependent, elderly individuals and support for family members participating in care, which can be used to remunerate the caregiving work performed by workers subject to employment contracts in accordance with national sector collective agreements' (Regione Abruzzo, 2022). In Liguria, with Regional Government Deliberation No. 718/2023, the so-called 'caregiver bonus' is attributed primarily to those who have already formally hired a personal assistant with a regular employment contract, or who undertake to produce a regular employment contract within thirty days from the date of acceptance of the application. In Lombardy, one of the requirements to receive the Family Assistant Bonus is to hire a family assistant with an employment contract. In Emilia-Romagna, under the 'Guidelines for the qualification and regularisation of care work performed by family assistants within the FRNA - Regional Government Resolution 1206/07,' the contribution is provided upon certification of the formalisation of the employment relationship with the family assistant. In Veneto, through Regional Law No. 38 of Oct. 17, 2017, economic support interventions are provided to individuals and families based on social security contributions paid to the family caregiver. through Regional Government Resolution 1524/2023, the payment of care allowances is made quarterly upon submission of documentation attesting to the INPS contributory payment in favour of the personal assistant.

Table 15. In numerous regions and autonomous provinces, tax incentives and economic support are available for the formal employment of personal/family assistants

Existence of tax incentives and/or economic support to encourage families to formally employ personal/family assistants

Region	Answer	Details
Abruzzo	Yes	Local Dependency Plan and Regional Law No. 57/2012 on independent living
Basilicata	No	

Calabria	No	
Campania*	No	
Emilia-Romagna	Yes	Additional contribution to care allowance in case of family assistant with a formal employment contract (Guidelines for the qualification and formalisation of care work performed by family assistants under FRNA - DGR 1206/07)
FVG	No	
Lazio	Yes	DGR 544/2010 and 504/2012 providing service vouchers for dependency and Alzheimer's contributions; DGR 239/2013 providing economic support measures for people with other very severe disabilities
Liguria	Yes	Provincial Council Resolution No. 718/2023 approved the fourth public notice to recognise a grant for the employment of personal or family assistants in order to provide dependent persons with the personal assistance they need to remain at home
Lombardy	Yes	The "Family Assistants Bonus" is intended to provide reimbursement for expenses incurred for the family assistant, provided they are registered in one or more territorial registers of family assistants within the territorial areas (Article 7 of Regional Law No. 15/2015) and hired under an employment contract[30]
Marche	Yes	Care allowance and very severe disability allowance, Calls for applications
Molise*	Yes	DGR 131/2023 approving the Regional Plan for Dependency and providing for care and autonomy allowances
Autonomous Province of Bolzano	No	
Autonomous Province of Trento	No	
Piedmont	Yes	DGR 32-6475/2023 and 27-6320/2022 approve the policy document "Support for dependent individuals related to the purchase of home care and assistance services" and establish the Home Care Voucher for elderly individuals and dependent individuals with disabilities
Puglia	No	
Sardinia*	Yes	Regional Law No. 2/2007 providing care allowances for the formal employment of a family caregiver
Sicily	No	
Tuscany	Yes	The regional project "Social Relief Services - Pronto Badante" involves the provision of family booklets as a preliminary step towards the formalisation of the family assistant's contract, as per Regional Law No. 66/2008 and subsequent DGR no. 310/2010, and other executive decrees
Umbria	Yes	Economic contributions for Family Assistance for elderly individuals who depend on care or who are not independent, calls for applications
Veneto	No	
Valle d'Aosta	Yes	Regional Law No. 23/2010, Regional Law No. 19/2023, DGR 1524/2023.

Notes: At the regional level, are there tax incentives and/or economic supports to encourage families to hire a personal/family assistant with a formal contract?
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'
(*) The region did not respond to the questionnaire and the information comes from research conducted by OECD.

A regional public register of personal/family assistants is essential to ensure quality and professionalism in family care. Such a register allows families to easily identify qualified assistants, ensuring transparency and safety. It also contributes to the professionalisation of the sector by ensuring that assistants are properly trained. This tool can also help prevent irregular work, thus improving the quality of care provided and the protection of the rights of family assistants and the dependent individuals they care for. For these

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[30] The entry requirements that are referred to the contract holder are: ISEE equal to or less than €35,000; ISEE less than or equal to €25,000: ceiling of recognisable contribution, not exceeding 60% of the actual expenses incurred for the remuneration of the family assistant, amounting to €2,400; ISEE of more than €25,000 and less than or equal to €35,000: ceiling of recognisable contribution, not exceeding 60% of the actual expenses incurred for the remuneration of the family assistant, amounting to €2,000; Employment contract, regularly registered and valid, signed with a Family Assistant registered in one or more territorial registers present at the Territorial Areas and corresponding to what is indicated in Article 7 of Regional Law 15/2015 for each assistant who should alternate in care. Residence in Lombardy.

reasons, at the regulatory level, it has recently been made mandatory for all regions to establish a special regional register of family assistants (Art. 38, paragraph 3, of Legislative Decree. 29/2024).

Even in the absence of a state requirement, in recent years some regions have established regional public registers of personal/family assistants. Indeed, Table 16 reveals a significant diversity among Italian regions regarding the existence of the register. Regions such as Liguria, Marche, the Autonomous Province of Trento, Sardinia, Sicily, Umbria, Veneto, and Valle D’Aosta have introduced a public registry, which serves as a clear and accessible reference tool for finding family/personal assistants. In other regions, such as Lazio, Lombardy, Puglia and Campania, registers only exist at the local level. Others, such as Abruzzo, Basilicata, Calabria, Emilia-Romagna, Friuli-Venezia Giulia, and the Autonomous Province of Bolzano, do not have such a tool.

Table 16. There is considerable diversity among Italian regions regarding the existence of a regional public register of personal/family assistants

Existence of a regional public registry of personal/family assistants

Region	Answer	Details/comments	Website
Abruzzo	No		
Basilicata	No		
Calabria	No		
Campania*	No	Presence of municipal records	
Emilia-Romagna	No		
FVG	No	However, there is a public service for demand-supply mediation called "Si CON TE"	
Lazio	No	Presence of municipal records	
Liguria	Yes	Regional register of family assistants and babysitters	https://www.regione.liguria.it/homepage-lavoro/come-fare-per/registro-assistenti-familiari.html
Lombardy	No	Each territorial area has established a territorial registry	
Marche	Yes		https://www.regione.marche.it/Regione-Utile/Sociale/Anziani/Elenco-Assistenti-Familiari
Molise*	No		
Autonomous Province of Bolzano	No		
Autonomous Province of Trento	Yes	Public list of those registered in the provincial register of family assistants	https://icef.provincia.tn.it/rpaf/index.jsp
Piedmont	No		
Puglia	No	Registers at the level of the Social Territorial Area	
Sardinia*	Yes	With municipal-level organisation	https://www.sardegnaambiente.it/documenti/1_19_20071123130444.pdf
Sicily	Yes	Public register of family caregivers	https://www.regione.sicilia.it/sites/default/files/2022-05/000719-S6.pdf
Tuscany	No		
Umbria	Yes	There is a regional public register called "Family Help" which also includes family assistants	https://www.regione.umbria.it/sociale/family-helper
Veneto	Yes	The Regional Register of Family Caregivers, established by Regional Law No. 38/2017 and DGR 910/2019. DGR 1675/2021	https://raf.azero.veneto.it/

Region	Answer	Details/comments	Website
Valle d'Aosta	Yes	Unique Regional Directory of Personal Assistants	https://www.regione.vda.it/servsociali/evidenze/evidenza6_i.asp

Notes: Is there a regional public register of personal/family assistants?
(*) The region did not respond to the questionnaire and the information comes from research conducted by OECD.
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'

Table 17 outlines the requirements for personal/family assistants to access the regional public register of personal/family assistants in various regions and autonomous provinces. These requirements are essential to ensure that assistants are able to provide a quality service, enabling effective interaction with the assisted individuals and their families. Table 17 shows a variety of criteria: while some regions like Marche and Veneto have a broader range of requirements, including possession of relevant qualifications or certificates, previous work experience in the care field, knowledge of the Italian language, residency rights, legal age, and other criteria, other regions like Friuli-Venezia Giulia and Valle D’Aosta have fewer requirements to access the register.

Among the regional experiences analysed, one in particular stands out for the clarity and agility when it comes to accessing and consulting the public register. In Veneto, the choice of family/personal assistant is facilitated by the user's ability to access a significant amount of information about the domestic worker, including their previous work experiences, the types of tasks they have experience in or are available to perform (such as medical-nursing visits, hygiene, house cleaning), and their willingness to be employed in municipalities within the regional territory different from their residence.

Table 17. Various requirements are needed for personal/family assistants to access the regional public register

Requirements for access to the regional public registry of personal/family assistants

	Possession of relevant qualification or certificate	Prior work experience in the field of care	Knowledge of the Italian language	Residence rights in Italy	Over 18 years of age	Other
Friuli-Venezia Giulia						X
Liguria	X		X	X	X	X
Marche	X	X	X	X	X	X
Autonomous Province of Trento	X	X		X	X	X
Sicily			X	X	X	
Veneto	X	X	X	X	X	X
Valle d'Aosta				X	X	
Count	4	3	4	6	6	5

Notes: If one exists, what are the requirements for accessing it? Select all possible answers and report details where necessary. Responses refer only to regional public registers, excluding local or district initiatives.
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'.

The presence of training activities for personal/family assistants is essential to ensure that these professionals are adequately prepared to meet the specific needs of dependent persons. At the national level, a significant development is the unified definition of training pathways and standards for the provision of professional activities in the care and assistance of dependent elderly individuals, including at home. In particular, guidelines will soon be issued by the Ministry of Labour and Social Policies to define training standards so that individuals can improve and standardise the training of personal/family assistants (Article 38, paragraph 1, of Legislative Decree. 29/2024).

Even in the absence of national regulations, in recent years, some regions and autonomous provinces have undertaken training initiatives for personal/family assistants. In response to the question "Are there any training activities for personal/family assistants?", the majority of Italian regions that completed the OECD questionnaire responded affirmatively, except for Basilicata, Calabria, Puglia, and Umbria.Table 18).

Moreover, there is considerable variation among regions and autonomous provinces in the delivery methods of the courses. For example, Friuli-Venezia Giulia, Veneto, and Valle D'Aosta stand out for an integrated approach, with courses delivered by the region, municipalities, and the Third Sector. In other regions, courses are mainly delivered by a single actor, whether it be the region (Lombardy, Sicily), municipalities (Emilia-Romagna), Third Sector (Liguria, Autonomous Province of Bolzano, Piedmont), or other entities (Abruzzo, Marche, Lazio, Autonomous Province of Trento, Tuscany). Some regions and autonomous provinces mention accredited training institutions, patient and family advocacy associations, and Foundations as other training providers for personal/family assistants.

Among the various territorial experiences, some stand out for the intensity and breadth of training activities aimed at personal/family assistants at the regional and provincial levels.

The Autonomous Province of Trento offers an annual and free continuous training course for personal/family assistants registered in the provincial register. The course, organised and delivered by the De Marchi Foundation, an instrumental entity of the Province, consists of multiple modules covering a wide range of topics central to the provision of integrated assistance to dependent individuals (for example: the complexity of individuals affected by dementia, the relationship with the assisted person, safety in the domestic environment) and is taught by various professionals in the healthcare and social sector (such as nurses, psychologists, pharmacists).

As part of the "Si Fa Rete" Project, Friuli-Venezia Giulia, in collaboration with the regional Caritas, offers a free training course for personal/family assistants, which can also be accessed remotely. The course aims to improve knowledge of methods and tools for assisting dependent individuals (for example: managing the domestic environment, caring for the elderly, relationship with the family) and to promote learning of the Italian language.

In Lazio, personal/family assistants can enrol in a wide range of free training courses funded by the region and delivered by accredited private entities the training covers central topics in providing assistance to non-self-sufficient individuals (including caring for domestic environments, proper administration of medications, communication with the assisted person and the family) and takes place over 300 hours (including an internship).

Table 18. Most regions and autonomous provinces have undertaken training initiatives for personal/family assistants

Existence of training activities for personal/family assistants.

Region	Yes, disbursed by the autonomous regions/province	Yes, disbursed by municipalities	Yes, disbursed by the Third Sector	Yes, disbursed by other agencies	No
Abruzzo				•	
Basilicata					•
Calabria					•
Emilia-Romagna		•			

FVG	•	•	•		
Lazio				•	
Liguria			•		
Lombardy	•				
Marche				•	
Autonomous Province of Bolzano			•		
Autonomous Province of Trento				•	
Piedmont			•		
Puglia					•
Sicily	•				
Tuscany				•	
Umbria					•
Veneto	•	•	•		
Valle d'Aosta	•		•	•	

Notes: Are there training activities for personal/family assistants? Select all possible answers.
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'

Use of data on caregivers and personal/family assistants

To the question "*How many personal assistants (carers) and family caregivers are there in your region/autonomous province?*" from the OECD questionnaire, 13 of the 18 Regions/Autonomous Provinces reported that these data are not available or did not answer. From this it can be assumed that many Italian regions/autonomous provinces do not have data for planning public policies for personal/family assistants, either because data are unavailable, or because they do not know where to find this information.

It is interesting to note that, regarding data on personal assistants, most regions and autonomous provinces do not seem to be aware of publicly available data sources. For example, only one region indicates awareness of the data source from the DOMINA Observatory, which provides carer information broken down by regional and autonomous province. Furthermore, only two regions report available data within the public registers of family assistants, although these public registries are active and operational in many regions and autonomous provinces.

Among the regions that responded positively, data on personal assistants came from the following sources:

- Domina Observatory (Friuli-Venezia Giulia)
- INPS Domestic Workers Observatory (Tuscany)
- dedicated information flows (FNA information flow in Lombardy)
- data from the public register of family assistants (Veneto and Valle D'Aosta).

Regarding family caregivers, the few regions that manage to quantify the number of family caregivers operating in the region report using the following sources:

- dedicated information flows (Prometeo flow in Veneto, FNA flow in Lombardy)
- estimates based on the number of people who have received contributions as family caregivers (Valle D'Aosta, pursuant to DGR 484/2022); individuals receiving contributions from the National Fund to Support Family Caregivers (Tuscany).

Ongoing national reforms and interventions

There are numerous reforms, interventions, and investments currently underway at the national level, most of which are envisaged by the National Recovery and Resilience Plan, concerning the care for non-self-sufficient individuals. (Ministero dell'Economia e delle Finanze, 2023). These directly or indirectly involve the legal status, protection, and training of family caregivers and personal/family assistants, as well as the relationship between the demand for care and the supply of informal assistance. Additionally, there are measures related to the training of healthcare, social healthcare, and social services personnel who provide home services, multidisciplinary work in assessing the needs of non-self-sufficient elderly individuals, and the relationship between the demand for and supply of home care services.

Reform of care for dependent elderly individuals

Within Mission 5 "Inclusion and Cohesion", Component 2 "Social infrastructure, families, communities, and the Third Sector", there is provision for the reform of dependency (Delegated Law No. 33 of 2023 "Policies for the elderly population"), aimed at introducing a new comprehensive discipline for active aging and in the long-term care sector for dependent elderly individuals (Cembriani, 2024). At the national level, in implementation of the reform, new provisions and measures have recently been approved concerning both the formal and informal sectors in the field of continuous care for dependent elderly individuals. Of particular relevance are some provisions contained in Legislative Decree 29/2024:31

For family caregivers and personal/family assistants:

- support in the regularisation process for hiring family/personal assistants by trialling supplementary monetary benefits to the care allowance, subject to a usage constraint (Articles 36 e 37)
- Requirement for all regions to establish a specific regional register of family assistants to facilitate the matching between supply and demand for assistance (Article 38, paragraph 3)
- Introduction of homogeneous training standards for personal/family assistants through the definition of national guidelines (Article 38, paragraph 1).

For home healthcare, social healthcare and social services personnel:

- Role of personnel in measures to strengthen the provision of preventive healthcare interventions at home (Article 9)
- Enhanced collaboration among staff, family, community, and Third-Sector organisations involved in caring for elderly dependents to ensure consistent information flow and responses to their care needs (Article 25)
- Collaboration among healthcare, social healthcare, and social services personnel, integrating their professional expertise in the new multidimensional assessment of dependency and in defining the PAI (Article 27)
- Provision of new training paths for the performance of professional activities provided by personnel in the field of care and assistance to dependent elderly people, including at home (Article 38, paragraph 1).

In the coming months, the recently approved legislative decree will be implemented in regional territories. In particular, regions and autonomous provinces will need to adapt their legislation and intervention programmes on dependency to the new national provisions (Gori, 2023), coordinating them with those related to disability that will come into force in the near future.

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[31] Legislative Decree 29/2024 "Provisions on policies for the elderly, implementing the delegation of authority in Articles 3, 4 and 5 of Law 33/2023" available at: https://www.gazzettaufficiale.it/eli/id/2024/03/18/24G00050/sg.

Disability reform

Mission 5 "Inclusion and Cohesion", Component 2 "Social infrastructures, families, communities, and Third Sector", also includes the reform of the condition of people with disabilities. Specifically, Law Delegation 227/2021 "Delegation to the Government on disability" has envisaged the issuance of numerous interventions and measures within multiple implementing decrees, which are still under discussion today.

In addition to the introduction of a new definition of disability, two innovative tools will be introduced that are relevant to building an integrated, person-centred system of care for dependent individuals: The unique basic assessment and the Individual, Personalised and Participatory Life Project (Vivaldi, 2022). Furthermore, there are numerous provisions and measures concerning both the formal and informal sectors of assistance for dependent individuals. Specifically:

For family caregivers and personal/family assistants:

- envisioning the role of family caregivers in defining the Individual Personalised, and Participatory Life Project, and collaboration with the professional figures involved
- strengthening the role of the family assistant in implementing the Individual Personalised, and Participatory Life Project.
-

For home healthcare, social healthcare, and social services personnel:

- collaboration among healthcare, social healthcare, and social services personnel and the integration of professional skills in the new multidimensional disability assessment
- role of personnel in defining the Individual Personalised, and Participatory Life Project, and ensuring the effective enjoyment of rights for people with disabilities
- staff co-operation with the family of the dependent person
- envisioning new professional figures tasked with overseeing the implementation of the Individual Personalised, and Participatory Life Project.

As in the field of dependency, disability reform is still ongoing and will gain new momentum with the approval of implementing decrees over the coming months. Similarly, in this case, regions and autonomous provinces will be called upon to reassess legislation and planning in light of the new national provisions.

Territorial social and healthcare reform

Mission 6, "Health", of the National Recovery and Resilience Plan provides for the reform of community-based social and health care (Component 1 "Neighbourhood networks, facilities and telemedicine for community-based care). The main implementing decree of the ongoing reform is Ministerial Decree 77 of 2022 (DM 77/2022 "Standards for the development of territorial assistance of the national health service"). Among the numerous objectives, the decree envisages the implementation of a comprehensive organisational model for territorial assistance and promotes social and healthcare integration both at institutional and professional levels. Furthermore, it promotes the enhancement of ADI for 10% of the elderly population over 65 by 2026 (Pesaresi F. , 2022). It also includes provisions regarding the role of both informal and formal sectors in home care of dependent elderly individuals. Specifically:

For family caregivers and family/personal assistants:

- recognition of the family caregiver as a resource of the social and healthcare system
- enhancement and promotion of the active involvement of family caregivers in decision-making processes in the social and healthcare sectors, in self-care pathways, and in the drafting of the PAI
- enhancement of the caregiver's role in the implementation of telemedicine

- measures to actively support, guide, mentor, and train family caregivers.

For the formal sector (healthcare, social healthcare, and social services personnel providing home services):

- new tools and ways of integration between health and social professional figures (general practitioners, nurses, specialists, pharmacists, psychologists, social workers and others)
- assigning one of the professional figures involved the role of case manager
- promoting the activities of multi-professional teams within community homes
- introduction of the new professional figure of the family or community nurse aimed at interdisciplinary integration, both in healthcare and social services, to prioritise the individual, and engage with the family and relevant community
- measures for continuous, inter-professional staff training
- new standards on staffing levels in social and healthcare facilities (1 family or community nurse per 3,000 inhabitants) and for the provision of ADI.

Implementation of the decree is still ongoing (Gabriele, 2023) and will continue until 2026. As revealed by the responses to the questionnaire, most of the autonomous regions and provinces indicate that they have encountered some common difficulties in implementing DM 77/2022 and, in particular, staff shortages for the implementation of the new model of community-based health and social care.

Interventions for job training and combating undeclared work

Equally relevant to both the informal and formal sectors in the field of care for dependent individuals are several interventions related to active labour policies, training, and the fight against undeclared work, as outlined in Component 1 of Mission 5 "Inclusion and Cohesion". Specifically, within the National Plan for Combating Undeclared Work (Ministero del Lavoro e delle Politiche Sociali, 2022) and the National Plan for New Skills, (Ministero del Lavoro e delle Politiche Sociali, 2021) the following measures are included:

For family caregivers and family/personal assistants:

- Tools and incentives for the regularisation of domestic work carried out by family/personal assistants (changes to the attendance allowance regulations, bonuses to cover domestic costs, changes to the Family Booklet regulations, vouchers and work coupons, Domestic Work Portal)

For home healthcare, social healthcare, and social services personnel:

- pathways for updating, retraining, and integrated reorganisation of the skills of social and healthcare professionals
- training activities to strengthen digital skills, including for social and health care personnel providing home services.

To date, the regions and autonomous provinces continue to implement the measures and tools described through the planning and organisation of interventions that consider the needs and characteristics of their respective territories.

Proposals for reforming the legal status of family caregivers

At the national level, the evolution of the integrated care system, focused on dependent individuals, recognises and values the central role of the family in providing care and assistance (Borrelli, 2020). Specifically, numerous legislative proposals aimed at organically reforming the condition and regulation of family caregivers are currently under discussion (Orrù, 2021).

Many provisions and measures are included in these legislative proposals (Servizio Studi Affari Sociali della Camera dei Deputati, 2024). An analysis of the content of these proposals reveals several common lines of intervention:

- uniform definition of family caregiver
- provision of tools for the appointment, modification, and revocation of powers and rights exercisable by the family caregiver
- strengthening the relationship between the family caregiver and local public services, and the nature of their role concerning the formal care sector
- modes of participation of the family caregiver in the multidimensional assessment process of dependency and disability, and in the definition of the PAI
- provision of benefits and measures to reconcile work activities and caregiving activities of the family caregiver (rescheduling work hours, telework, leave, transfers, solidarity leave, and supplementary corporate welfare services)
- provision of economic support and services to promote the physical and psychological well-being of family caregivers (respite services, psychological support, information services, vouchers and allowances, tax benefits for care expenses)
- provision of training pathways aimed at recognising and certifying the skills acquired by family caregivers and work relocation programmes
- measures to promote the participation of the most representative associations of family caregivers in the development of healthcare, social, healthcare, and social services policies (public family caregiver registers at regional and local levels).

The discussion of legislative proposals for the reform of the legal status of family caregivers is still ongoing. In any case, future legislation must consider the provisions and measures for family caregivers outlined in the dependency reform. Regions and autonomous provinces will also be required to adjust their regional legislation to align with the new national regulations.

Information systems and interoperability

The importance of social and health information systems for the dependent population is a significant topic in the social and healthcare landscape in Italy. Dependency requires coordinated and constant care, making efficient information systems essential. These systems not only facilitate the management of health and social information, but are also crucial in supporting policy makers, healthcare professionals, and patients themselves.

For health and social policy makers, access to accurate and up-to-date information is vital for making informed decisions. A well-structured information system makes it possible to monitor the situation of the dependent population, evaluating the effectiveness of implemented policies, and planning future evidence-based interventions.

For health and social care professionals, access to patient information is a crucial aspect. An information system facilitates the sharing of information among different practitioners, ensuring that each professional has a complete view of the patient's care pathway. This allows for personalised and targeted assistance, saves time, and improves the effectiveness of interventions and the quality of care.

Finally, for patients, having access to their own health and social data means being more involved in their care journey. This contributes to greater awareness of their health condition and better management of the situation.

Interoperability – the ability of two or more systems to communicate with each other and exchange data efficiently and securely (Slawomirski, et al., 2023) (OECD, 2021) –between health and social systems plays a crucial role in optimising efficiency, reducing management time for professionals, and facilitating more detailed and meaningful data analyses. However, interoperability is still at an early stage in Italy and many OECD countries.

This chapter is structured as follows. First, it provides an overview of the social information system in Italy related to home services for the dependent population, examining the opportunities and challenges associated with it. Second, it discusses the health information system in Italy, highlighting its benefits and drawbacks. The third and fourth parts analyse regional information systems (for both health and social care) and the challenges for interoperability and integration, respectively. Finally, the chapter concludes with examples of international practices, offering a global context and comparative perspectives.

Social sector information systems

The realm of social information systems in Italy is fragmented and less advanced compared to health information systems. Digitisation is not yet a widely adopted approach; instead, paper-based solutions are still favoured by many municipalities and local service providers. Additionally, the literature on this subject is scarce, as this topic has long been neglected both in public debate and academic literature. However, the creation of a national social information system (the Unified Information System of Social Services [SIUSS]) should progressively encourage municipalities and social service providers to collect and report information in a standardised manner, favouring digital solutions. This represents a significant paradigm shift for the sector, steering practices towards greater efficiency and integration.

The national social information system

SIUSS, established by Legislative Decree 147/2017, is a database managed by INPS for the collection of information related to social services provided by all central state entities, local entities, and organisations managing forms of mandatory social security and assistance. Private operators are excluded from data collection.

The establishment of SIUSS aims to ensure a comprehensive understanding of social needs and the services provided by the social intervention system. This includes all the necessary information for planning, managing, monitoring, and evaluating social policies. Additionally, the system is tasked with ensuring compliance with Essential Levels of Provision (LEP), intensifying controls on benefits obtained fraudulently, and providing a unified database useful for the integrated planning and design of interventions. Furthermore, SIUSS is used for the processing of data for statistical, research, and study purposes (OECD, 2023).

Of particular interest for this project within SIUSS are:

- The social benefits (PS) and subsidised benefits (PSA) databases regarding the collection of data on SAD and ADI benefits (for the social component)
- The Disability and Non-Self-Sufficiency Database (SINA) for multidimensional assessment data of dependent persons receiving home-based services

The main challenges

The SIUSS database stands as an extraordinarily valuable information resource. This system significantly contributes to the enrichment of the information landscape by providing detailed data regarding the supply of services, the professions involved, and a wide range of other relevant aspects.

However, regions and autonomous provinces are still adapting their information systems to meet the information needs required by these new standards. Data collection at the regional and local level has historically been configured to meet the specific needs of each regional context, and has only been experiencing a major transformation in recent years, following the introduction of SIUSS (Lisetto, Marcolin, & Tomasin, 2014).

In fact, despite the potential of SIUSS, its power supply remains limited. As a result, the collected data are not representative of reality, significantly limiting the use of this information in policy analysis and decision-making processes.

Pursuant to Article 4 of Legislative Decree No. 147, the transmission of data to the SIUSS by Entities is mandatory (with a frequency not exceeding three months), and failure to comply with this provision results in the application of specific sanctions. For example, the failure to send data and information by the responsible agent, in case of unauthorised use of unreported benefits, constitutes a disciplinary offence and leads to financial liability (INPS, 2022).

Despite the existence of regulations and penalties, many municipalities fail to submit data on time as required by law. According to a recent survey of Italian municipalities32 (PAS, 2020), only 38% of all social benefits disbursed are transmitted to SIUSS (and of this percentage, only 19% are transmitted regularly and systematically). The problem also extends to the SINA database (a component of SIUSS), which is of particular interest to the dependent population: only 29% of the services provided are reported.

In the area of social reporting, a traditional approach that relies on paper-based systems rather than digital solutions still persists. The PAS survey shows that a significant portion of the social work services provided,

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[32] The survey was conducted via an online questionnaire to the 7,876 Municipalities with a resident population of up to 150,000 inhabitants as of 31/12/2019, between 30/07/2020 and 31/10/2020.

77%, is not managed by software (i.e. it is managed through rudimentary paper and/or digital records, such as generic databases like Access or Excel). Only 11% of services are managed using dedicated software solutions, while 10% rely on a mixed approach, combining digital and paper methods.33

The greatest critical issue in populating SIUSS concerns the lack of dedicated staff and adequate training (48%). Other challenges reported by the PAS questionnaire concern technical aspects (availability of technical and IT support) and organisational aspects (co-ordination between external structures and municipal entities). (PAS, 2020)

Another challenge is the diversity of digital solutions used by various service providers: According to the PAS report, there are 263 different software systems in use among municipalities throughout the country (PAS, 2020). This variety of digital solutions creates significant barriers to reporting and integrating information systems, as each software may have unique functionalities, data formats, and compatibility requirements. This is because often ASL and municipalities have digitalised independently over time, leading to significant fragmentation with hundreds of different software in use rather than one, unified system (Lisetto, Marcolin, & Tomasin, 2014).

Finally, as highlighted by some interviewed stakeholders, there is still a lack of full awareness of the importance of data accessibility and interoperability in the social sector. Reporting is often seen as mere paperwork rather than a useful tool for the operator. The perception of the benefits of digitalisation is not yet widespread among operators, many of whom still prefer paper documentation. This view partly stems from the nature of the tools available to social workers, which require them to report on interventions downstream and lead them to perceive reporting as a mere additional compliance task rather than a useful tool and an integral part of their work. Through the adoption of digital solutions like computerised social records, examined in the following section, reporting becomes an integral part of the operator's work and is perceived as a tool that brings direct benefits in terms of access to information and process automation.

The computerised social record

The Computerised Social Record (CSI) in Italy represents a modern approach to social care management that offers several advantages (ANCI, 2022):

- It standardises care management through shared parameters, helping social workers effectively structure the aid process and ensuring consistency in service delivery.
- It helps standardise the vocabulary used among different departments, improving clarity in communication.
- It allows for the immediate reporting of work, improving transparency and efficiency.
- It simplifies the management of information debts and keeps the user register up to date, which is essential for effective service delivery.
- Document management within the system is easily accessible, and the platform can be used remotely, offering flexibility and responsiveness.
- Compatibility with mobile devices such as smartphones and tablets also makes it convenient for social workers.

The implementation of social services in Italy falls within the competence of municipalities, which have the freedom to choose whether to adopt the CSI or not. In the absence of regulatory obligations in this regard, each municipality has discretion in deciding the most appropriate approach according to its needs and resources. Due to this lack of regulatory obligation, significant discrepancies emerge in the adoption of CSIs across Italian territory.

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[33] In addition, an effort is underway to acquire software for 2% of the services provided.

It is challenging to quantify the adoption of CSI accurately: currently in Italy, there is no specific monitoring system to verify the actual implementation and usage of CSI at the national or local level. However, some considerations can be made based on the analysis of the OECD 2024 Questionnaire "Towards integrated person-centred social and health care in Italy", stakeholder interviews, and literature.

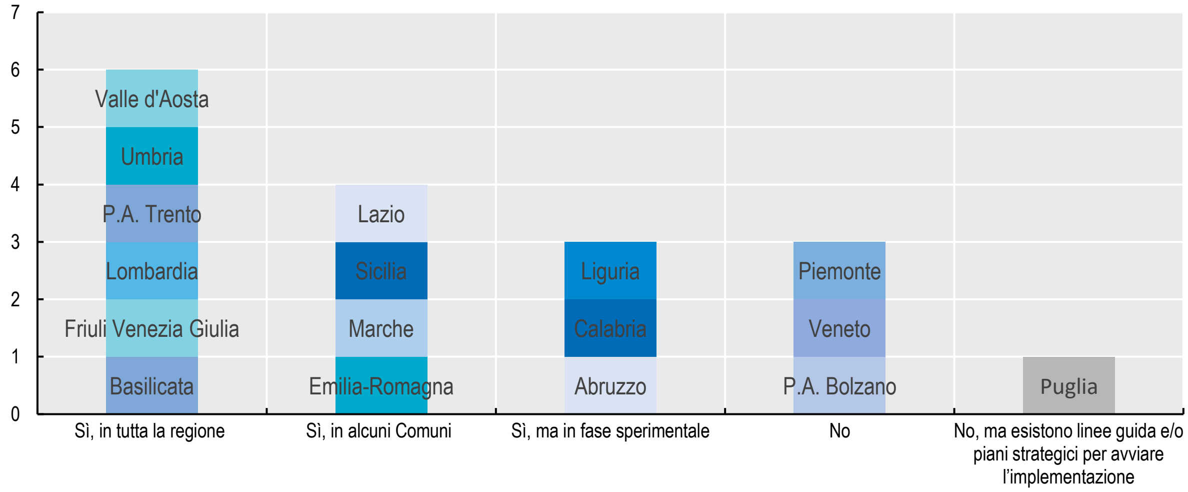
Figure **4** shows that most of the regions responding to the 2024 OECD questionnaire, with the exception of Veneto, Piedmont, and the autonomous province of Bolzano34, have implemented at least one CSI solution, or have put in place guidelines and/or strategic plans to initiate its implementation (Puglia). However, implementation varies among regions: some have adopted the CSI throughout the region, others only in certain municipalities, while still others are in an experimental phase of the process.

Interviews with stakeholders confirm that, compared to the 7900 municipalities, the adoption of these innovative solutions remains limited to a few hundred units. There are significant variations among regions and within the regions themselves. Marche, Umbria, and Lombardy have adopted unique CSI tools for the majority or nearly all of their territory. There are also individual cities, including Turin, Milan, Genoa, Messina, and Bari, which have made independent and innovative investments in the field of computerised social records.

Furthermore, despite the presence of CSIs in some Italian contexts, this digital resource is often used in a limited way, leaving many of its functions and potentials unexplored.

Figure 4. Existence of a computerised social folder in use in the Region-Autonomous Province

Number of autonomous regions-provinces, by response



Notes: Is there a computerised social record in use in your region/autonomous province? Tuscany did not respond to this part of the questionnaire.
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'

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[34] In the Autonomous Province of Bolzano, the South Tyrol Social Home Help service is managed by the Comprensorial Communities and the Social Services Agency, which are autonomous entities. For the time being, they do not use uniform care documentation but are still managed in paper form. In order to be able to support these activities in the future, including through software, the province, which is responsible for coordinating the agencies, has therefore initiated a project with the aim of developing uniform care and support documentation throughout the territory.

There is significant heterogeneity in the implementation processes of CSI adopted by Italian regions and autonomous provinces. While some regions coordinated and led the CSI implementation process, others left municipalities to organise independently.

For example, in Friuli-Venezia Giulia, which has a 10-year history of CSI experience (Lisetto, Marcolin, & Tomasin, 2014), the CSI was made available by the region, and the system was progressively implemented in collaboration with the Social Territorial Areas.

In the Autonomous Province of Trento, the CSI was implemented and disseminated throughout the provincial territory through an intervention guided by the Province. In Lombardy, municipalities have purchased CSI solutions available on the market, complying with Regione Lombardia's guidelines 1.0, also thanks to bonuses promoted by the region.35 In Lazio, the system has been made available to the social and healthcare districts and to the municipalities that comprise them. The region has carried out training activities and approved a draft agreement between the region itself and the districts for their use (Determination March 10, 2022, No. G02801). In Puglia, the region recently launched a project to implement the Regional Electronic Social Record (Cartella Sociale Elettronica Regionale.)

On the contrary, in other regions and autonomous provinces, the implementation of CSI has occurred sporadically and without co-ordination at the regional or autonomous province level. For example, in Liguria, the computerised social record is currently mainly used in the Municipality of Genoa, while in other municipalities, diverse situations are observed. Emilia-Romagna reports difficulty in collecting information regarding implementation, given the municipal management of the CSI.

In this fragmented system characterised by a variety of different approaches and practices, examples of regional best practices are given in Box 8.

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[35] Award criterion introduced by the same region in 2017 with the 2016 FNPS.

Box 8. Regional experiences with the use of the Computerised Social Record

Lombardy has played an active role in promoting and using the CSI in the region, in collaboration with ANCI Lombardia, the Territorial Areas and municipalities. This collaboration has led to significant initiatives to raise awareness among social workers about the increase in the dematerialisation of assistance processes, with the aim of improving the quality of services offered to citizens.

Among the activities promoted are online training courses on the CSI, aimed at providing skills and raising awareness among social workers on the effective use of the CSI (ANCI Lombardia, 2022) (ANCI, 2022). These courses aim to encourage greater adoption and dematerialisation of care processes.

In addition, the Regione Lombardia has prepared a Plan for the Implementation of Initiatives to Support the Use of the Social Record (Regione Lombardia, 2021), through which various initiatives have been prepared to promote the adoption and use of the CSI.

These activities include guidelines to define common informational elements and minimum data for the CSI, contributing to overcoming the heterogeneity of solutions implemented in different territorial areas (Regione Lombardia, 2019).

Through the *Memorandum of Understanding for the Use and Development of the Computerised Social Record* technical rules were also established to ensure the interoperability of different CSI solutions, enabling effective communication between professionals and organisations involved in the social welfare pathway.

In addition, rewards have been provided for the adoption of CSI, incentivising its adoption. Finally, in 2019, the Regione Lombardia conducted a monitoring action to assess the implementation status of the CSI adoption pathways in individual territories, using questionnaires and CSI usage indicators.

To date, all 91 ATSs have adopted, both individually and collectively, a computerised CSI solution for social services management. In addition, the Lombardy region is currently visiting the 91 ATSs to oversee the degree of CSI utilisation in order to take improvement actions. It is estimated that in the second half of 2019, more than 50% of social service users were profiled through the CSI.

An emblematic example of successful implementation of computerised social folder is represented by the Social Information System platform, a product of the Umbria region developed by Umbria Digitale. This system, initially intended for Umbrian municipalities, was later extended to the Marche region. In both Umbria and Marche, the system is widely used by municipalities. Even municipalities that do not directly employ the system use it as a hub to interface with SIUSS, thus ensuring compliance with feeding requirements.

Through the 2024 OECD Questionnaire “Towards Person-Centred Integrated Social and Healthcare in Italy”, regions and autonomous provinces were asked to identify barriers to the implementation and use of CSI. Table 19 illustrates that the most commonly reported obstacles are the lack of adequate technical or IT tools, privacy issues, and resistance from social service workers (indicated by 7 regions). Other difficulties include lack of personnel (reported by 5 regions), low political priority (cited by 4 regions) and lack of funds (mentioned by 3 regions). Finally, two institutions cited lack of training as a challenge in adopting the computerised social record. Other regions report additional difficulties. For example, Liguria mentions that the computerisation process is not uniform in all municipalities. The Marche region points out the lack of integration of the CSI with the health care system. Emilia-Romagna highlights the absence of unified governance as a key obstacle to implementation.

Table 19. Regions and autonomous provinces report various obstacles to the implementation and use of the computerised social record.

	Lack of appropriate technical/information technology tools	Privacy issues	Resistance by social service workers	Lack of personnel	Low political priority	Lack of funds	Lack of training	Other
Abruzzo	X			X				X
Basilicata		X	X	X				
Calabria	X			X			X	
Emilia-Romagna	X				X	X		
Friuli V.G.		X	X					
Liguria								X
Lombardy	X	X	X					
Marche	X	X			X	X		X
Piedmont			X		X			
Autonomous Province of Bolzano								X
Puglia		X						
Sicily		X			X			
Umbria			X	X				
Valle D'Aosta	X		X					
Veneto	X	X	X	X		X	X	

Count	7	7	7	5	4	3	2	4

Notes: What are the main obstacles to the implementation and use of computerised social records? Select all possible answers. Trento, Lazio, and Tuscany did not respond to this part of the questionnaire.
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'

Reforms and measures currently underway at the national level

The analysis presented in the previous section highlights a number of challenges that regions face in successfully integrating technology within social services, emphasising the need for a holistic approach that considers technical, training, organisational, and policy aspects. Faced with these challenges, Italy is taking several innovative measures to strengthen its social information systems.

Training and outreach

The training course on SIUSS, organised by INPS, which began in September 2022 and is aimed at social benefit providers nationwide, was recently concluded. The main objective of the course was to raise awareness of the importance of transmitting benefit information to SIUSS and to illustrate the operation of the system for data transmission and consultation. To this end, training sessions were organised for approximately 100 entities per region. These meetings were designed to be as engaging and motivating as possible, including short videos on specific topics, aimed at guiding users towards a practical and effective use of the SIUSS through the web portal (INPS, 2022).

In addition, INPS has developed a territorial network aimed at intensifying collaboration with universities and municipalities, and promoting local awareness. INPS territorial contacts (about two or three per region) play a key role in this process, organising and participating in training sessions, especially with entities that have not participated in previous INPS-sponsored training initiatives. These representatives serve as the direct interface of the INPS in the territory, facilitating communication and providing clarification, addressing doubts, and meeting the needs of various local entities.

Disclosure of existing data

In order to disclose the data collected through various sources, the Social Analysis Portal (PAS) was created, and has been operational since 2023. (INPS, s.d.) (Invitalia, s.d.). The purpose of the PAS is to provide regions, autonomous provinces, ATS, municipalities, and other social service agencies with advanced business intelligence tools. These tools are designed to facilitate in-depth data analysis, assisting in the planning, monitoring and evaluation of social policy-related initiatives.

The PAS represents a valuable tool as it integrates data from various databases, including SIUSS, SII, SIOSS, and ISTAT, disaggregating it by population segments (age, gender, residence, income brackets), and provides detailed information on the provision of services and the number of beneficiaries.36 It is expected that the effectiveness and informational capacity of the PAS will progressively increase with the quantity and quality of data entered into the SIUSS.

Another objective of the PAS is to promote broader awareness of the importance planning driven by data rather than by historical spending. If top PAS user figures understand the value of data, they will be able to incentivise service providers to digitalise processes, thereby transforming the way the social sector operates and is programmed.

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[36] However, the health component is not yet integrated into this system.

Incentives for digitalisation

The National Recovery and Resilience Plan provides specific funds to incentivise the transition from paper to digital and enable municipalities to develop a CSI. The goal is to solve the root of the SIUSS feeding issue, recognising that this is the only viable way forward.

Information systems in the health sector

The push toward computerisation in the health sectors in Italy dates back to the 1990s, when the nationwide SIAD information flow was introduced. This information flow mandated healthcare entities, particularly health districts, to send digital information at the national level. This represented a significant impetus for the adoption of digital technologies in the healthcare sector.

National information flows

Office of Statistics of the Ministry of Health (General Directorate of Digitalisation, Health Information Systems, and Statistics)

The Ministry of Health's Office of Statistics is responsible for fulfilling the requirements of the European Statistical System and coordinating the Country Health Status Report. The office applies the principles and provisions of the Code of Official Statistics and produces statistical research and publications in the field of health. It is also responsible for monitoring, verifying, processing, analysing, and disseminating of data concerning the structures, resources ,and activities of the National Health System (SSN), providing support to the general directorates of the ministry and other relevant national and international bodies. For example, the office collects data on the number of people receiving ADI each year, and the number of ADI hours provided (OECD, 2023).

SIAD (Home Care Monitoring Information System)

The Home Care Monitoring Information System (SIAD) – managed by the Ministry of Health – aspires to create an integrated, patient-centred national database to collect information on social and healthcare interventions delivered in a planned manner by National Health System providers in the home care setting. The interventions under consideration are exclusively of a social and healthcare nature. The collected information covers areas such as the patient's demographic characteristics (without direct identifying elements), social/health assessment or reassessment and related care needs, care provision, suspension of care, and patient discharge. The actual data collection started in 2009, and it stipulates that data transmission by the regions is, starting from January 2012, a requirement for accessing the supplementary funding provided by the state (OECD, 2023).

Electronic Health Record

The Electronic Health Record (*eHR*) refers to the '*longitudinal electronic record of a patient that contains or virtually links together records from multiple Electronic Medical Records, which can then be shared (interoperable) across various health care settings. Its purpose is to contain a history of contacts with the healthcare system for individual patients* (Slawomirski, et al., 2023) (OECD, 2021).37

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[37] Literature analysis suggests that when data are shareable among different providers and are able to "accompany the patient" in any healthcare setting, facilitated patient care, improved care coordination, and the development of a consistent information base are observed. In addition, the data contained in an Electronic Health Record can provide valuable information for analytical purposes, including supporting public health policies as well as promoting biomedical innovation and health systems research (Slawomirski, et al., 2023) (Agenzia per l'Italia Digitale, s.d.).

The results of the 2021 OECD Questionnaire on the Development, Use and Governance of Electronic Medical Records Systems (OECD, 2021) suggest that these tools are increasingly being used in OECD countries, with levels of implementation and maturity increasing steadily over time (Slawomirski, et al., 2023).

In Italy, the *Electronic Health Record* (FSE) is established through the Prime Minister's Decree of Sept. 29, 2015, No. 178, *Regulation on electronic health records*. It is a digital tool that contains the patient's medical history, represented by a set of data and documents. The FSE enables patients and professionals to access social and social healthcare information nationwide. It represents a significant step in the e-Health culture in Italy, simplifying the interaction between citizens and healthcare professionals and promoting the dematerialisation of paper documentation (Agenzia per l'Italia Digitale, s.d.). The COVID-19 experience has increased awareness of the strategic role of FSE for healthcare and governance.

The New Health Information System Steering Committee is the national organisation responsible for the national strategy and governance of the FSE. This body is composed of representatives from the Ministry of Health, Ministry of Economy, the Digital Italy Agency, and the regions, as well as other stakeholders (Ministry of Economic Development, associations of doctors, nurses and pharmacists, and associations of municipalities). The Steering Committee establishes strategic objectives, evaluates ongoing activities and results, and defines functional and technical specifications for new FSE functions (OECD, 2021).

Italy is among 15 OECD countries that are implementing a nationwide Electronic Health Record system, which is a system where data are created, stored, or linked to the national level (Slawomirski, et al., 2023). The Italian FSE is a federated system: according to Legislative Decree 179/2012, each Italian region has an FSE for each resident citizen, with common specifications in order to ensure interoperability with other regions and document sharing. Documents are nationally defined with mandatory standards (OECD, 2021).

Data sharing among service providers is critical to effectively use the data stored in patients' FSE along the care pathway. In Italy, as is the case in 19 other OECD countries 38 (Slawomirski, et al., 2023), there are provisions allowing for the sharing of patient data on treatments, medications, laboratory test results, and diagnostic imaging between medical practices and between medical practices and hospital systems. Until May 2020, only primary care physicians and public/private providers of the National Health System (SSN) had the right to enter documents into the FSE, and now private care providers also contribute to it.

In Italy, in line with what happens in another 22 OECD countries (Slawomirski, et al., 2023), patients can view their own information in the FSE.39 Patient access is facilitated through an online portal, using credentials and methods established by regulations and defined by the region or autonomous province of care. The user of the FSE has complete control over their own information, being able to decide which data to share and with whom Unlike in other countries, in Italy all patients can access their own data without limits or restrictions40, regardless of the service providers from which the data originates.

The FSE in Italy not only allows patients to view their own data, but also enables them to interact 41 with their records. For example, in Italy, patients have a 'personal notebook' i.e. a private space where users can enter their health data and documents independently, including those not related to the SSN

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[38] Australia, Belgium, Canada, Denmark, Finland, Germany, Hungary, Iceland, Israel, Japan, Korea, Lithuania, Luxembourg, Mexico, Norway, Portugal, Slovenia, Sweden, and Turkey

[39] Any document contained in the FSE can be accessed by the patient.

[40] For example, in some countries, access might only be available for patients in hospitals or other specific contexts.

[41] "Interacting" means that patients can modify information; add additional data such as data from devices or applications and report clinical outcomes, experiences or incidents (PROs, PREMs - see Glossary); or communicate with their healthcare providers (e.g. set or change appointment times) (OECD, 2021).

Additionally, the users have the option to specify their preferences regarding data sharing with healthcare professionals and may decide whether to obscure certain information. Italy seems to be leading the way on this issue compared to what is happening in other OECD countries: while nearly 90% of OECD countries that responded to the questionnaire reported having electronic health records, only 42% reported that the public can access and interact with their health data through the portal (OECD, 2023).

Italy has defined a minimum core of data42 that can be shared among health service providers treating the same patient to promote standardisation and exchange of health data. Minimum core data43, which is required by law, can stand alongside optional supplementary data and documents44. The presence of the latter depends on the decisions of regional authorities and the degree of advancement in the digitalisation of documents produced by healthcare facilities (Agenzia per l'Italia Digitale, s.d.). The minimum core data are accessible to all healthcare providers treating the patient, and in emergency cases, even before the patient gives consent (which is mandatory), to allow doctors to access it. However, by 2021, only around 5% of patients had an FSE containing this minimum core of data (OECD, 2021)

Health data contain sensitive information, and appropriate security measures are needed to protect data storage and transmission. A secure health data infrastructure is necessary not only from a legal, technical, and operational perspective, but is also important to ensure people's trust and use of the FSE. Data encryption is used in Italy, which is also the most commonly used method of protecting FSE data in OECD countries (Slawomirski, et al., 2023).

The composite indicator on technical and operational readiness of Electronic Medical Records-constructed by the OECD based on responses to the 2021 OECD Questionnaire on the Development, Use and Governance of Electronic Medical Records45 shows that the second highest value in 2021 was reported by Italy (after Finland). This highlights how Italy is ahead of other OECD countries using similar tools.

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[42] Italy requires structured data entry to help standardise the information collected and shared through the FSE. Unlike unstructured data, typically free text, structured data are standardised so that it can be easily processed, shared, and understood across different software platforms.

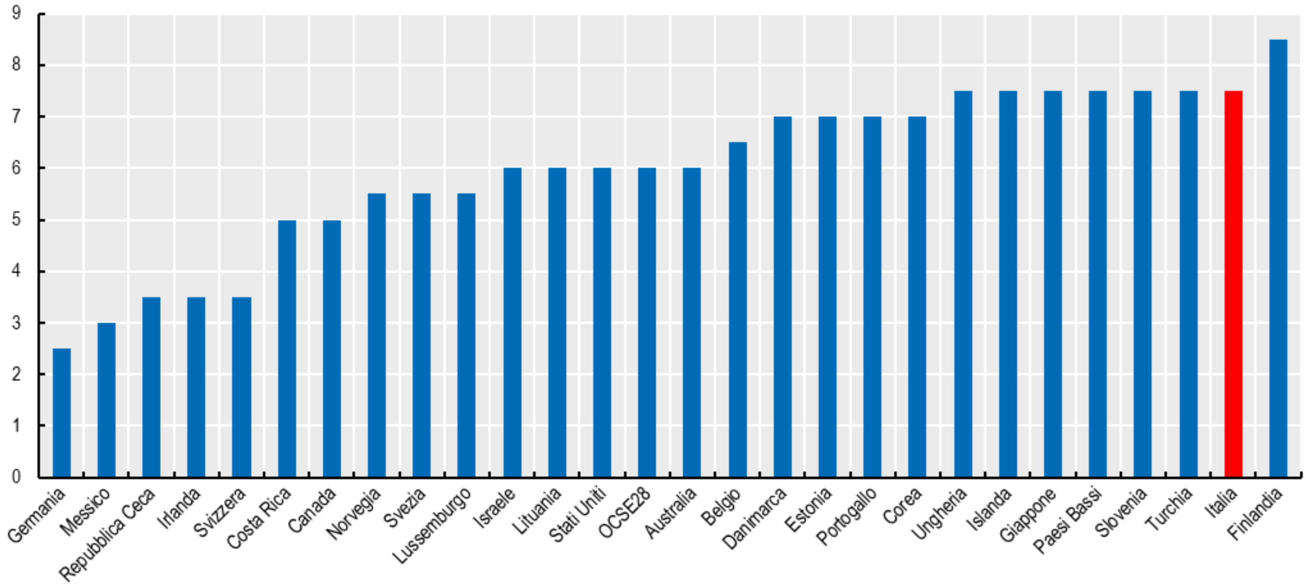
[43] Minimum core data include identifying and administrative information of the assisted person; reports; emergency room records; discharge letters; health profile summary; pharmaceutical report; consent or refusal for organ and tissue donation

[44] Optional data include: prescriptions (specialist, pharmaceutical, etc.) reservations (specialist, inpatient, etc.); medical records; health reports; home care: clinical care record, program, and clinical record-folder; diagnostic and treatment plans-; residential and semi-residential care; multidimensional evaluation form; drug dispensing; vaccinations; specialist care services; emergency services (118 and emergency room); inpatient hospital care services; medical certificates; the person's personal notebook; reports on the services provided by the continuity of care service; self-certifications; participation in clinical trials; exemptions; prosthetic care services; data to support tele-monitoring activities; data to support integrated diagnostic and treatment pathway management activities; other documents relevant to the caregiver's care pathways.

[45] 2021 OECD survey on the development, use, and governance of electronic health record (eHR) systems

Figure 5. Italy is ahead of other OECD countries on the technical and operational readiness of the electronic health record (Fascicolo Sanitario Elettronico, FSE)

Composite indicator on technical and operational readiness of FSE, 2021



Source: OECD survey 2021 on the development of Electronic Health Record systems, data use and governance, 2021 (Slawomirski, et al., 2023)

The literature review shows that data from Electronic Medical Records is extremely valuable for research purposes when collected, governed, and processed appropriately. The use of these data has several advantages over conventional methods, including the relative timeliness and cost-effectiveness of data reuse.

Italian legislation theoretically authorises this data collection/use. Decree-Law 179/2012 stipulates that the Ministry of Health, the regions, and the Ministry of Labour and Social Policies may use FSE data for health planning purposes (health policy making, health service evaluation, quality of care assessment, development of predictive models and scenarios). The Ministry of Health and Regions can use FSE data for studies and research (medical, biomedical and epidemiological) (OECD, 2021).46

One aspect that further facilitates the use of the data for planning/research purposes is the fact that the FSE uses a unique patient identification code and a unique health professional identification code. In addition to the diagnosis and treatment of individual patients, the existence of a unique identification code (for the patient and health professionals) is also crucial for research and for the statistical analysis of population health data.

Despite the existence of an enabling regulatory and operational framework, in Italy, the data collected through the FSE are not fully utilised to create databases for monitoring and analysing health status or healthcare (e.g. disease registries or healthcare quality registries), nor is artificial intelligence being used for processing or analysing FSE data. This is in contrast to what happens in most OECD countries (Slawomirski, et al., 2023). Italy reports legal barriers to the creation and/or analysis of databases. In particular, it is emphasised that the provisions of the General Data Protection Regulation, although very comprehensive, are not oriented towards efficient use of information (OECD, 2021).

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[46] Patients do not have the option to give or withhold their consent for the use of data for planning/research purposes.

In the 2021 OECD questionnaire on the development, use, and governance of Electronic Health Record systems, Italy cites limited budget, lack of awareness among citizens, the digital divide between generations, and the need for specific education/training for healthcare providers as the main barriers to FSE implementation (OECD, 2021).

Based on responses to the 2024 OECD Questionnaire, 'Towards Person-Centred Integrated Social and Healthcare in Italy', Table presents an analysis of the main difficulties reported by Italian regions and autonomous provinces in FSE implementation.

In response to the question "what have been the main difficulties in implementing the EHR?" the issue most frequently cited is related to privacy, mentioned by nine regions/autonomous provinces. This is followed by lack of staff (7), resistance of health workers (6), low political priority (5), lack of training (4) and lack of adequate technical or IT tools (4). It is noteworthy that no region or autonomous province has indicated a lack of funds as an obstacle, which suggests that sufficient investments have been allocated for the implementation of the FSE.

Table 20. Regions and autonomous provinces face various obstacles to Electronic Health Record implementation

Main difficulties in the implementation of the Electronic Health Record

Region	Privacy issues	Lack of personnel	Low political priority	Resistance of health care workers	Lack of training	Lack of appropriate technical/information technology tools	Lack of funds	Other
Abruzzo	•	•		•	•	•		•
Basilicata		•		•	•			
FVG	•							
Lazio	•	•	•					
Liguria	•							
Lombardy								•
Marche	•		•	•		•		
Piedmont				•				•
Autonomous Province of Bolzano	•		•	•	•			•
Sicily	•	•	•					
Umbria		•	•					
Valle D'Aosta	•	•						
Veneto	•	•		•	•	•		
Count	9	7	5	6	4	4	0	3

Notes: If the electronic health record is active in your region/autonomous province, what have been the main difficulties in its implementation? Puglia reports finding no issues due to implementation. Emilia-Romagna reports that there are no particular difficulties in implementing the FSE, other than the difficulty for some types of providers (e.g. nurses, midwives, physical therapists) to enter data on the type of services provided. The Autonomous Province of Trento reports that with intervention 1.3.1.b of mission 2 of the National Recovery and Resilience Plan (PNRR), it is providing for the adaptation of its FSE infrastructure to the technical and interoperability specifications defined by national guidelines. Calabria and Tuscany did not complete this part of the questionnaire.
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'

Some regions/Autonomous Provinces point out additional challenges. For example, the Autonomous Province of Bolzano highlights that there is no feeding of the FSE from the social side. Lombardy stresses that the FSE is not directly applicable to social and healthcare services, which require systems that take into account the specificity of these services. Umbria complains that the FSE to date has been seen only as a regulatory compliance, without decision-making levels paying proper attention to its use and usefulness. Emilia-Romagna does not report particular difficulties in the implementation of the FSE, except for the challenge faced by some types of healthcare professionals (e.g. nurses, midwives, physiotherapists) in entering data related to the type of services provided.

Some of these difficulties have been overcome. In Basilicata, a training plan aimed at overcoming the critical issues highlighted (resistance, lack of personnel, lack of training) is being defined and implemented. In Sicily, the Department for Digital Transformation assigned a support group to implement the FSE, and additional support was provided by the Privacy Guarantor who provided some clarifications. In addition, the implementation of a Training Plan and a Communication Plan is planned.

Specific funds have been allocated to accompany regions and autonomous provinces in the FSE implementation process. The National Recovery and Resilience Plan (PNRR) devotes 1.38 billion euros to the FSE. To implement these investments, the government – in an inter-ministerial decree published in the Official Gazette on Oct. 4, 2022 – recently allocated more than 610 million euros: 311 million is earmarked for improving the digital skills of professionals in the health system[47], while approximately 300 million will be used to upgrade digital infrastructure. These funds will be used according to operational plans developed by the regions and autonomous provinces, which must receive approval from the Ministry of Health and the Department of Digital Transformation. Disbursement of funds to regions/autonomous provinces is linked to the achievement of specific targets for feeding into the FSE (Ministero della Salute, 2024).

In conclusion, the various ongoing projects within the EU could enhance accessibility, sharing, and utilisation of healthcare data and influence collaboration in sharing, using, and protecting healthcare data (OECD, 2022). Italy participates in EU projects aimed at facilitating the sharing and utilisation of FSE data among EU member states.

Regional/local information flows (healthcare and social)

The data shows that there are several information systems at the regional level, both for the social and health fields (Table 21).

Table 21. Among regions and autonomous provinces, there are different information systems in the social and health fields

Management-type information systems in use in regions and autonomous provinces

Region	Social Scope
Abruzzo	A regional information system for social and healthcare data reporting to the social sectors, called 'Regional Social Information System (SISR),' is currently being implemented
Basilicata	Social File
Calabria	SISWelfareCalabria Application
Emilia-Romagna	Social and health interventions are collected in all the Companies with differentiated information systems
Friuli V.G.	Computerised social records, third-party systems in use at SSCs
Lazio	There are no unique systems at the regional level to date. Work is underway to define a single interoperable interconnection system (as per the PNRR target to be developed by March 24) linked to the FSE, SIAD, SIAR, and SIRA
Liguria	Home Folder in the implementation phase ICEF – Assessment of economic condition and submission of benefit applications

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[47] This is especially important, as providers often want to focus on patient care rather than spending time digitising information (Repubblica Italiana, 2021). These training activities can help change providers' perceptions of digitisation by demonstrating the benefits and ease of using information systems.

	GEA – Management of citizen benefit application process, up to the payment of the amounts due – Provincial Agency for Supplementary Assistance and Welfare – APAPI; Provider Software - Management and reporting of services provided by external social assistance service providers. A provincial project is being developed to implement the integrated social/social/health and territorial health information and management system.
Lombardy	Computerised Social Record (ATS)
Marche	SIRPS
Piedmont	For the social sector, there is no single tool, but each local authority adopts its own instrument
Puglia	SIOSS; SIUSS; Regional Register of Licensed Social Facilities, Electronic Social Record
Autonomous Province of Bolzano	ESPRO - SOZINFO
Autonomous Province of Trento	A provincial project is being developed to implement the integrated social/social/health and territorial health information and management system
Sicily	n/a
Tuscany	n/a
Umbria	ISO 15713
Valle D'Aosta	Social folder
Veneto	Electronic Health Record; Enterprise management system for ADI (SAD is managed independently by municipalities, but manual information integration is required for ADI-SAD resource allocation); Gefis (regional portal of health and social-health flows); Atlas (disabled, residential and semi-residential); Prometheus (home-based, elderly and disabled individuals); Home Care Flow; Dependency Flow (GEDI); Elderly residential flow (with different management)

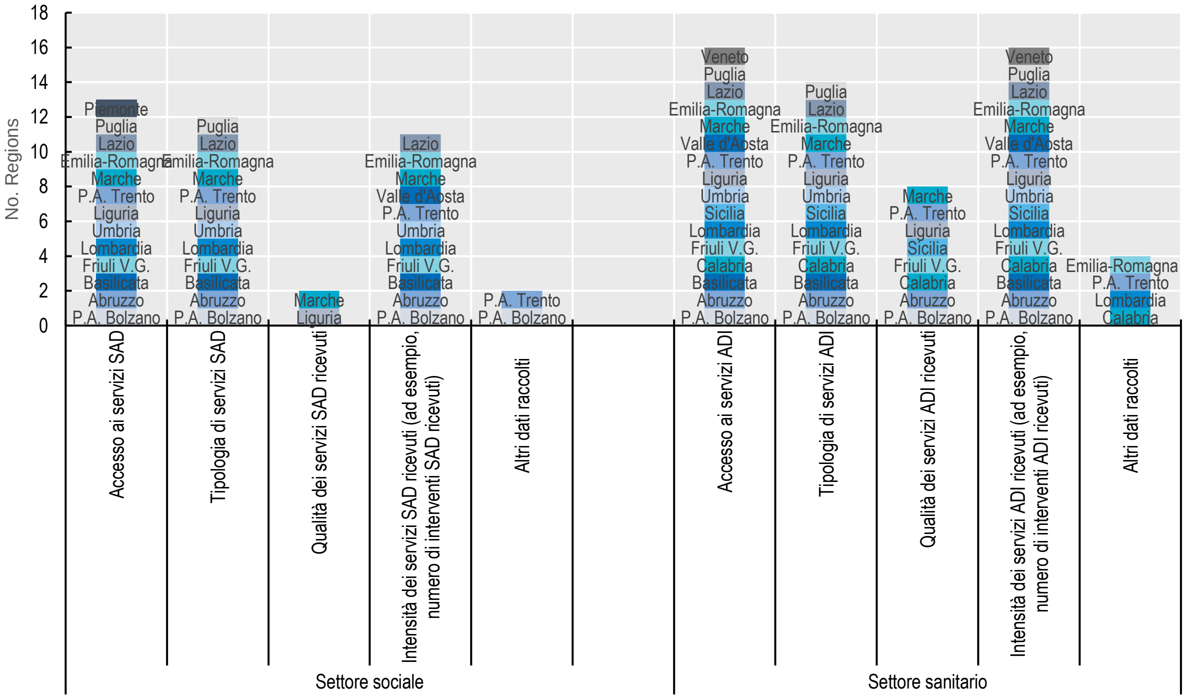
Region	Health Scope
Abruzzo	N/A
Basilicata	Electronic health record
Calabria	SISTE application, as part of the CDI project,
Emilia-Romagna	All USLs are equipped with information systems to collect information on health interventions delivered in the patient's home
Friuli V.G.	FSE, COT (under construction), computerised record of the Districts, ALS and Severe Cases, third-party systems in use by the managing bodies (Disabilities), SIRA (Information System for Nursing Homes)
Lazio	There are no unique systems at the regional level to date. Work is underway to define a single interoperable interconnection system (as per the PNRR target to be developed by March 24) linked to the FSE, SIAD, SIAR, and SIRA
Liguria	Start of the FSE activation process
Lombardy	Electronic Health Record (healthcare company); The digital land management system (SGDT) is being implemented and is being tested in the ADI area in the startup phase
Marche	SIRTE
Piedmont	N/A
Puglia	Electronic health record; Edotto system; FSE
Autonomous Province of Bolzano	ASTER for home care in healthcare
Autonomous Province of Trento	● SIT - Management of services provided by Azienda Provinciale per i Servizi Sanitari (APSS) in the territory ● GOpenCare – Integrative care management system – APSS ● Atlante – Management of UVM activities, access to Nursing Homes, registration and reporting to APSS of services provided ● ASTER – Management of the Legal Medicine Department for disability claims management. ● @Home - Home care management - APSS ● SIO - hospital information system ● A provincial project is under development to create an integrated social/social healthcare and territorial healthcare information and management system.
Sicily	FSE and Home Care Information System (SIAD)
Tuscany	N/A
Umbria	Atlante
Valle D'Aosta	SIRTE, POHEMA, ICARE
Veneto	Electronic Health Record; Enterprise management system for ADI (SAD is managed independently by municipalities, but manual information integration is required for ADI-SAD resource allocation); Gefis (regional portal of health and social-health flows); Atlas (disabled, residential and semi-residential); Prometheus (home-based, elderly and disabled individuals); Home Care Flow; Dependency Flow (GEDI); Elderly residential flow (with different management)

Notes: 'What types of management information systems (e.g. electronic health records, computerised social records) are in use in your region/autonomous province to collect data on healthcare, social healthcare, and social services provided at home and/or for the non-self-sufficient population?' Please list the information systems in use in your region/autonomous province, specifying whether they are distinct for the healthcare and social sectors. The answer N/A means that the region did not answer this question.
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'

Figure **6** presents the type of data collected by regional/provincial information systems. In the social sector, most regions that responded to the questionnaire indicate collecting data on access to SAD, the type of SAD services, and their intensity. However, only a few regions (specifically Marche and Liguria) collect information related to the quality of these services, or other types of data (Autonomous Province of Trento, Autonomous Province of Bolzano).48 In terms of health data, the situation is similar. However, more regions and autonomous provinces (8 regions), appear to collect data on the quality of health services, and other data (4).49

Figure 6. Type of data collected by regional-provincial information systems

Type of data collected by regional/provincial information systems by number of regions-autonomous provinces, by response



Notes: What data are collected through these regional/provincial information systems? Select all possible answers.
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'.

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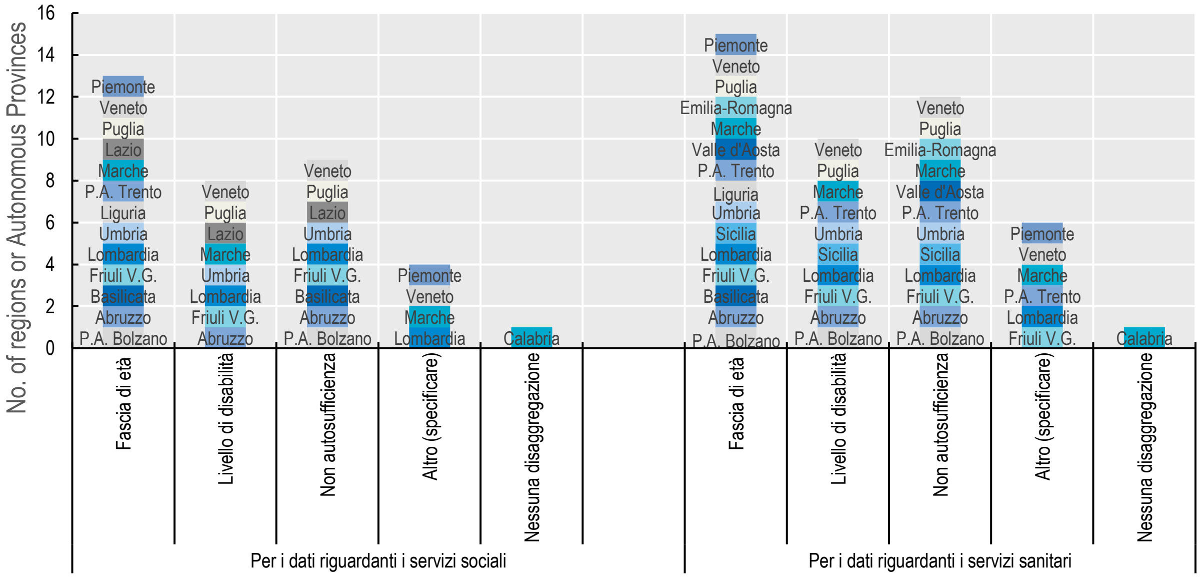
[48] In the Autonomous Province of Trento, other data collected includes information on cost, required cost-sharing fees, and the ICEF index (ISEE).

[49] For example, Emilia Romagna also collects data on pathology, type of caregiver, presence of PAIs, and assessment forms.

Referring to Figure **7**, which illustrates the types of data disaggregation available, a greater advancement is observed in the healthcare sector compared to the social sector. On average, healthcare data presents a greater number of disaggregation modalities. For both the social and healthcare sectors, the most common breakdowns are, in order, by age, by non-self-sufficiency, by level of disability, and others (e.g. gender, income, citizenship, residence).50 Calabria stands out as the only region to report the absence of any form of disaggregation.

Figure 7. Available breakdowns

Number of regions-autonomous provinces, by response



Notes: What breakdowns are available for the data shown in the previous question? Select all possible answers.
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'.

Figure **8** provides a detailed analysis on the entities responsible for data collection in the social and health sectors. In the social sector, it shows that most data are collected by ATSs, followed by municipalities. In the health sector, data collection appears to be more distributed, with significant involvement of both Health Districts and ASLs.

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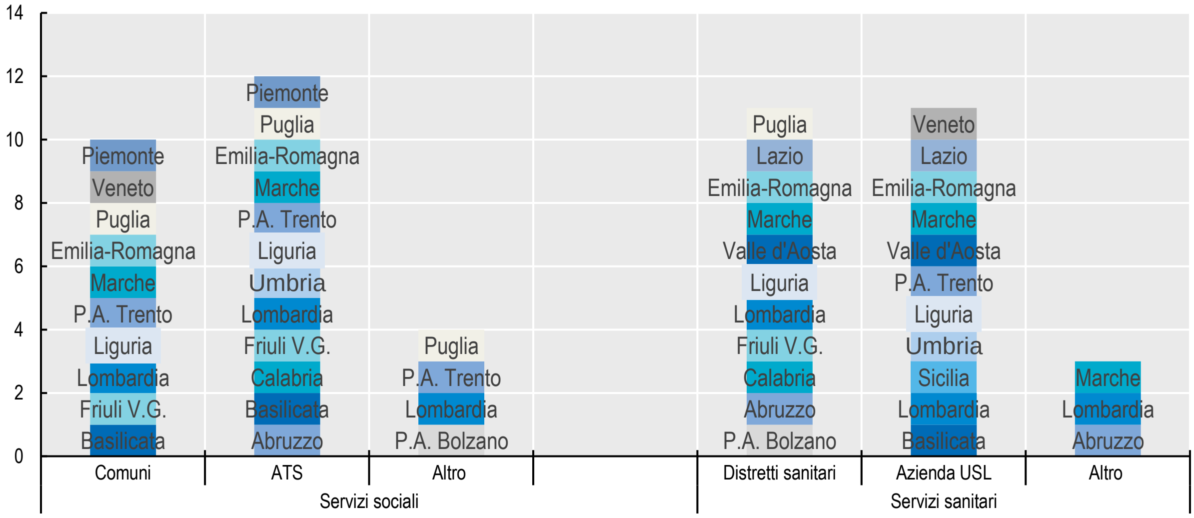
[50] For the social sector, Lombardy collects disaggregated data by gender, ISEE, type of service provided, professional figure employed, number of accesses and duration, type of family unit, and service value. For the health sector, the Autonomous Province of Trento collects data disaggregated by gender, citizenship, and residence. Lombardy collects all the information and de-regulations provided by the SIAD flow.

Figure 8. Entities collecting data

Number of regions-autonomous provinces, by response



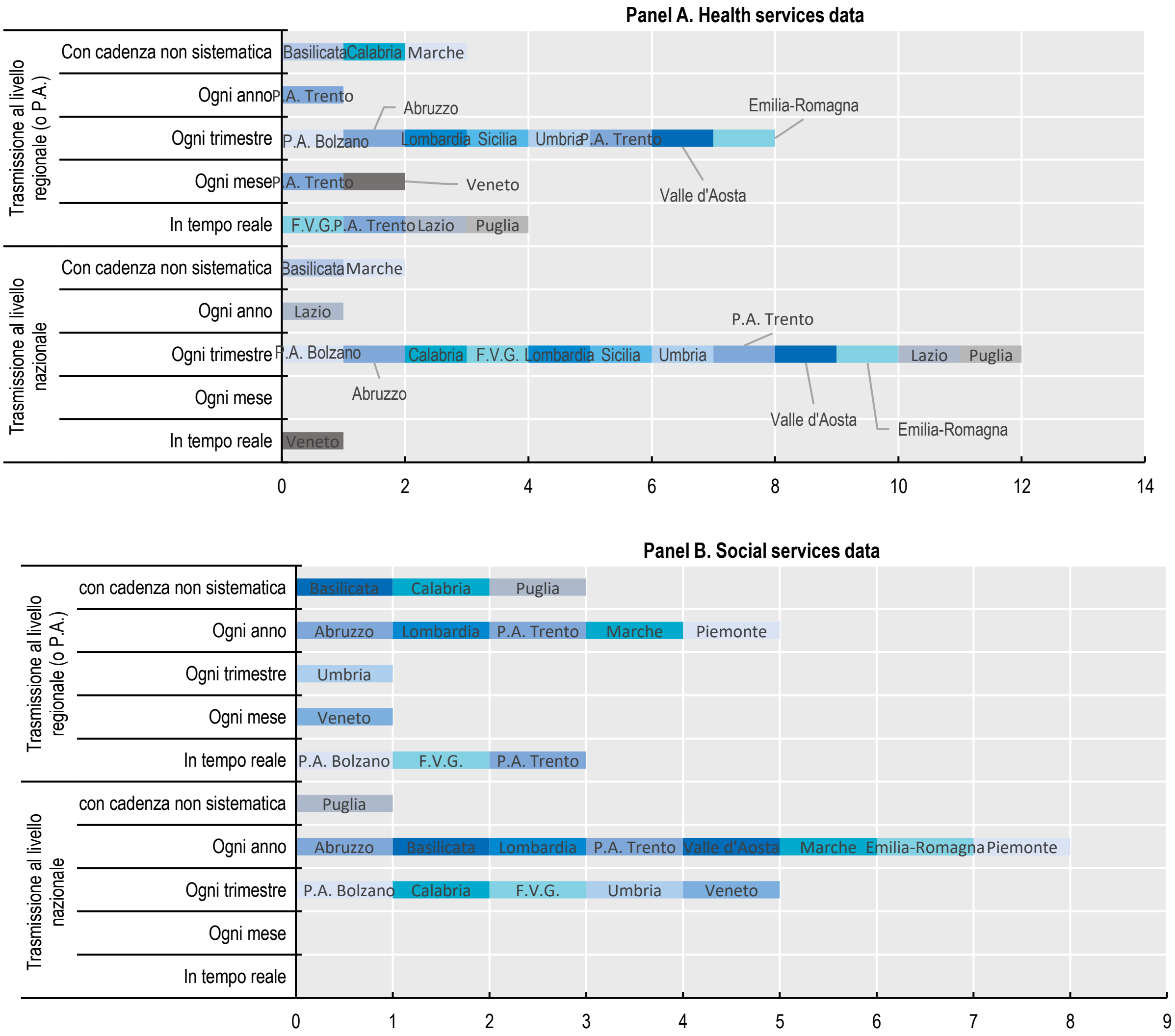
Notes: From what entities is this data collected? Select all possible answers.
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'.

Figure 9 highlights the frequency of data transmission from the social and healthcare sectors to higher levels of governance, a fundamental aspect to ensure that the information reflects the current reality and not past situations. Overall, it is observed that the health sector is more effective in transmitting data to higher levels of governance in a timely manner. Specifically:

- For health data, only four regions report regional-level data transmission on a non-systematic or annual basis, while most other regions transmit data at least every three months. For nationwide transmission, this occurs at least every three months in all regions except Basilicata, Lazio, and Marche, where collection occurs unsystematically or annually.
- In the social sector, data transmission at the regional level occurs annually in 5 regions, or on a non-systematic basis in 3 regions. In Umbria, data transmission occurs every three months, in Veneto every month, and in 3 regions/autonomous provinces, it occurs in real-time. Despite the legal requirement for regions to submit data to the central level (SIUSS) every three months, only five regions meet these deadlines.

Figure 9. Cadence with which aggregate/summarised data are transmitted to higher levels of governance

Number of regions-autonomous provinces, by response



Notes: How often is aggregate/summarised data transmitted to higher levels of governance?
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'.

Integration and interoperability

At a time of rapid technological advances and demographic changes, the integration of information systems between the health and social sectors is proving to be a key step in improving the efficiency, effectiveness, and equity of services delivered. This integration is essential for dependent individuals, who must often navigate through complex and fragmented systems to access the care and support they need.

The benefits of an integrated information system are many[51]:

- First, the centralisation of a patient's health/social information in a single accessible platform is a major step forward in patient empowerment. This integration is crucial for dependent individuals, as it allows them and their caregivers to easily access and manage their information.
- In addition, integrated information systems offer great advantages to service providers working with dependent populations, both on the social and health sides. By providing unified access to a patient's medical history, these systems ensure continuity of care across multiple points of delivery, enabling faster processes. This is especially important for dependent individuals who frequently interact with multiple health and social service providers.
- For policy makers, information systems integration is instrumental in formulating targeted and effective health and social policies. Data available through integrated systems enables policymakers to better understand the needs of dependent individuals.

True integration of information systems between the social and health sectors is still at a very embryonic stage in Italy. The results of the questionnaire indicate that, in response to the question "*Are the management information systems for healthcare, social healthcare, and social services interventions integrated with each other?*" almost no region/autonomous province reported positive integration for ADI and SAD home services.52 As highlighted by Table 22, there is no integrated information system at the regional level in any of the regions and autonomous provinces that responded to the questionnaire, with the exception of Valle d'Aosta and Liguria, where there are ongoing experiments.

Table 22. Existence of a single regionally integrated information system

Region	Answer	Details
Abruzzo	No	
Basilicata	No	
Calabria	No	
Emilia-Romagna	No	
Friuli-Venezia Giulia	No	
Lazio	No	The SIATESS/SIAT system will soon be integrated into the interoperable interconnection system of the Transitional CAR, linked to FSE, SIAD, SIAR, SIRA.
Liguria	Yes	An integrated regional information system called IT-CURA is currently under development. It will serve as the single point of access for citizens, making the different systems used by hospital, territory, and municipal social area professionals involved in local care interoperable.
Lombardy	No	
Marche	No	
Piedmont	No	
Autonomous Province of Bolzano	No	
Autonomous Province of Trento	No	
Puglia	No	
Sicily	No	
Tuscany	No	
Umbria	No	

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[51] An example of how interoperability, even partial, can improve operational efficiency is provided by Friuli Venezia Giulia. In the region, the CSI is integrated with the registry system, enabling access to data through the tax code and facilitating form self-completion. This greatly reduces the time required for data completion, making the work of social workers easier.

[52] Veneto points out in the questionnaire that data integration is not "native" as it is extracted and then assembled.

Region	Answer	Details
Valle d'Aosta	Yes	SIRTE, currently being implemented
Veneto	No	

Notes: Is there a single regionally integrated information system?
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'

Integration of information systems in the social and health sectors faces significant barriers. The responses to the OECD questionnaire highlight privacy issues as the main factor hindering the complete integration of information systems for healthcare, social healthcare, and social interventions, cited by 12 regions/autonomous provinces. This is followed by the lack of adequate technical/information tools, reported by 11 regions/autonomous provinces.[53] In addition, 5 regions/Autonomous Provinces highlighted low political priority as a key challenge. Some regions pointed to additional obstacles, such as lack of resources, lack of single governance (Emilia-Romagna), the fact that the entities managing health interventions are different from those managing social services (Sicily), the difficulty in changing the way interventions are delivered to include other areas (Valle d'Aosta), the complexity and cost of IT systems (Veneto), and respect for institutional autonomy in defining different workflows (Veneto).

Table 23. Factors hindering the full integration of information systems on healthcare, social healthcare, and social interventions

Region	Privacy issues	Lack of appropriate technical/information technology tools	Low political priority	Other
Abruzzo	•	•		
Basilicata		•		
Calabria		•		
Emilia-Romagna	•	•	•	•
Friuli-Venezia Giulia	•			
Lazio	•			
Liguria				•
Lombardy	•	•		
Marche	•	•	•	
Piedmont			•	
Puglia	•	•		
Autonomous Province of Bolzano	•	•	•	•
Autonomous Province of Trento	•	•		
Sicily				•
Umbria	•			
Valle D'Aosta	•	•	•	•
Veneto	•	•		•
Count	12	11	5	6

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[53] According to stakeholders interviewed, privacy legislation in Italy, while fundamental to the protection of personal data, can limit the sharing of essential information among different social and health care providers, thus compromising the quality of care. In fact, current regulations dictate that a health or social worker cannot reconstruct a patient's entire history. A concrete example of this issue is found in Friuli Venezia Giulia, where health information systems assign patients a different code from their tax code, precluding the possibility of a direct correspondence with demographic data. This discrepancy in coding systems makes integrated data analysis impractical, for example in the area of disability, signalling the need to overcome these information barriers.

Notes: "Which factors hinder the full integration of information systems on healthcare, social healthcare, and social interventions?" Tuscany did not respond to this question.
Source: OECD Questionnaire 2024 'Towards person-centred integrated social and healthcare in Italy'

Some regions/Autonomous Provinces point out additional difficulties they face in the process of integrating information systems. For example, Valle d'Aosta reports difficulty in changing the working approach of operators. Emilia-Romagna and Sicily highlight the absence of unified governance between the social and health sectors as a further challenge. Emilia-Romagna also points to the lack of resources as an additional obstacle.

Finally, in the opinion of some stakeholders interviewed, resistance emerges from practitioners in the health and social sector. This resistance is motivated by the concern that data integration may result in an intrusion into their respective professional competencies, with health professionals not wanting interference in their practices from social workers, and vice versa.

Although there are no well-established good practices of information system integration between the social and health sectors at the regional/local level, the analysis of the questionnaire responses was able to reveal some initiatives that, although still in the experimental stage, are worth highlighting:

- An information system (SIRTE) for territorial care is being implemented in Valle d'Aosta. It will provide access to both health professionals and social professionals.
- In the Autonomous Province of Trento, a provincial project is under development for the creation of an integrated social/healthcare and territorial healthcare management information system.
- In Liguria, information systems are integrated when it comes to the management of measures to maintain dependent persons at home, where there is integrated care (such as. Regional Fund for Dependency, Very Severe Disability, Independent Living). Furthermore, the IT-CURA regional integrated information system is under development, which will serve as the single access point for citizens, making the various systems of hospital, territorial, and municipal social area professionals involved in local care interoperable.
- In Basilicata, the implementation of an integrated data analysis system is being defined. Currently, the two streams do not automatically cross, making integrated analyses difficult.

Beyond regional initiatives, Italy is pursuing various initiatives to encourage the interoperability of information systems. Some of the measures taken include:

- *Working groups*. Currently, interoperability is being discussed within the Ministry of Labour and Social Policies (MLPS), with a particular focus on the integration of information between the SINA (SIUSS) and SIAD, which have common information cores that would make interoperability possible.54
- *Welfare as a service:* As part of the implementation of Measure 1.3.1 of the PNRR, "National Digital Data Platform", active work is being done on the “Welfare as a Service” project, which aims to create a platform dedicated to interoperability among various welfare services. The main goal is to make services more efficient and accessible through a platform that enables smooth and secure data exchange between different agencies and institutions. INPS plays a central role in this project, working closely with the Department for Digital Transformation of the Council of Ministers to make the different databases interoperable. This project, which is already operational and was presented at the ANCI (National Association of Italian Municipalities) national assembly (INPS) (ANCI, 2023)

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[54] However, it is important to note that both systems have inherited flaws from their creation, initially with a focus on geriatric health. This approach may not be fully adapted to the management of adult disabilities, requiring an update and adjustment of the language used in the systems.

represents an important step forward in the digitalisation and integration of social welfare services (INPS, 2022).

- Among the PNRR projects is the National Data Digital Platform (PDND), which provides technical tools for the interoperability of public administration databases. Through the PDND, public agencies have the opportunity to create innovative shared services (APIs) by following a marketplace approach, placing them in the PDND catalogue and managing or accessing them through the gateway provided by PDND itself (INPS).
- Territorial Operations Centres (COTs): In the context of current reforms geared toward the implementation of an integrated care process, the experience of Territorial Operations Centres (COTs) emerges as particularly interesting. These entities are developing an organisational model aimed at integrating services between the health and social sectors. To this end, each COT will have a dedicated information system designed to provide integrated information vital to holistic service delivery. It is worth noting that currently, tenders and calls for bids are underway for the development of IT solutions intended for COTs, involving the private sector in this process. These COT information systems will represent an additional layer to the existing systems, allowing for the collection of specific and complementary information related to the services provided by the COTs. This initiative can serve as an important case study in the field of integrated information solutions within the context of health and social services. A document issued by Agenas suggests that, to optimise co-operation between companies, COTs should be equipped with data that enables interoperability and real-time regional monitoring through business intelligence tools. The guidelines suggest developing a common IT system, segmented by company and with strict access policies. This system would promote the integration and effective work of COTs in a specific region (Agenas, 2022).
- Unique Points of Access: the implementing decree of Law No. 33 of March 23, 202355 'General Principles and Measures to Support the Elderly Population' stipulates that multidimensional assessment unit workers in single access points (PUAs) should have access to specific social and healthcare information to assist dependent elderly individuals. This access facilitates the design and monitoring of the care and treatment pathway. Shared information includes health documentation required for PUA access data contained in the FSE about the citizen's position within the INPS platform data on any social records at local authorities.

International experiences

Finland

Kanta, Finland's national digital health and social care information system, stands out as an international best practice example for integrated health and social care systems. Kanta enables Finnish citizens to access their health and social data online at any time. It also allows service providers to access patient data regardless of when or where care was delivered, providing an integrated interface for both public and private services. Kanta is used by citizens, health professionals, social welfare workers, and pharmacies.

Kanta is a collaboration between the Ministry of Social Affairs and Health, Kela (Finnish Social Insurance Institute), the Finnish Institute for Health and Welfare, and other stakeholders. Key features of Kanta include the MyKanta portal, a Personal Health Registry, and the Patient Data Repository, each contributing to a more efficient, user-friendly, and secure healthcare experience.

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[55] Outline of legislative decree containing provisions on policies for the elderly, in implementation of the delegation provided for in Articles 3, 4, and 5 of Law No. 33 of March 23, 2023.

- MyKanta is an online service where citizens can access their health data and medication information. It is a central component of Kanta services which allows individuals to view their health records, lab test results, and X-rays. Users can also request prescription renewals, access their social work service records, and manage data sharing consents. This portal promotes patient engagement and empowerment by making health information easily accessible to individuals.
- Kanta's Personal Health Record is a part of Kanta services where users can store their wellness data. This feature is particularly important for chronic disease management and preventive health care. It allows users record and monitor their own health information, which can be shared with health professionals to support patient care.
- The Patient Data Repository is a national information system for storing electronic patient data. It ensures that health professionals can access patient data securely and efficiently. This repository includes key health data, imaging data, medical certificates, and reports, facilitating a comprehensive view of the patient's medical history. The repository is critical to avoid redundant tests and procedures, thereby improving the efficiency of health and social service delivery.

Initiated in 2007, the development of Kanta required numerous legislative changes. The goal of achieving interoperability has been a crucial element of the project from the outset, with ongoing efforts to integrate thousands of different information systems. This integration ensures that all service providers adhere to the interoperability and security requirements imposed by Kanta, guaranteed through a rigorous process of certification, testing, and continuous monitoring.

To date, all public healthcare organisations and 70% of private ones are part of Kanta. Legislation (the Client Data Act) requires healthcare providers to adhere to Kanta by specific deadlines, providing a transition period. In fact, transitioning to this system entails both technical and professional changes, including standardising documentation and implementing measures for data protection.

Sanctions, incentives, and training programmes have been introduced to support providers in digitising their services and integrating into the Kanta system. During the transition phase, Kanta provides technical assistance and guidance, while the ministry deals with issues such as financing. Specific training for professionals is also planned to ensure effective use of the system.

Kanta places great importance on data protection and privacy. The system follows strict privacy policies and high standards of accessibility, ensuring a secure management of personal information. Users have full control over their data, including the ability to authorise or deny the sharing of their information. This approach not only protects patient data, but also helps build trust in the system.

Kanta also supports the secondary use of data in accordance with national legislation, facilitating research activities and public policy planning. The system collects data and makes it available for various purposes, such as analysing service efficiency and gathering statistics related to treatments.

The services offered by Kanta result in numerous benefits, including improved co-ordination and planning of patient care, decreased duplication of examinations, and increased patient participation in the care process. The system supports the secondary use of data for research, statistical analysis, and the development of health and social services. Kanta facilitates the efficient sharing of information among health and social service providers, reducing the need for unnecessary inquiries and documentation.

Kanta has proven particularly beneficial for patients who move between different regions, as it allows professionals to access their medical history regardless of where they live. Professionals in the field benefit from time savings and easier access to patient information. Patients, including those under guardianship, have full access to their health data, which contributes to informed and conscious care decisions.

England (United Kingdom): Federated Data Platforms

The Federated Data Platform (FDP) is software that will be implemented within the NHS hospitals and integrated care systems in England, allowing collected data to be connected in a safe and secure environment. GP data will not be part of the national platform.

The software will be 'federated' within the NHS. This means that each hospital and integrated care committee will have its own version of the platform, which can connect and collaborate with other data platforms as a 'federation' (e.g. for transferring a patient from the hospital to a care setting) (NHS England, s.d.). This facilitates collaboration between health and assistance organisations, enabling them to compare data and analyse it at different geographic, demographic, and organisational levels.

The FDP is not a data collection, but rather a software that will help connect heterogeneous data sets, enabling more effective use for healthcare. In practice, when a patient receives treatment at an NHS facility, their health data are entered into the local system. These data include medical history, medications, test results, and care plans. The FDP then securely allows sharing of this information among authorised professionals within the NHS network. For example, if a patient is referred to a specialist within a different trust, the specialist can access the patient's records via the FDP, ensuring continuity of care.

Currently in its pilot phase, this platform simplifies sharing patient information among various healthcare and assistance organisations, improving collaboration between healthcare and assistance teams. It securely manages patient information, allowing staff to quickly and efficiently access data. This reduces time spent on administrative tasks and improves patient care efficiency.

Once the pilots are extended to all of England, service providers will be required to adhere to the FDP. Implementing the FDP represents a transformative change, requiring a modification in staff behaviour and how data are input into the platform. To assist health workers in this transition, training activities will be organised. 'Digital maturity' assessments will also be conducted to identify areas in need of investment. In addition, funding will be allocated for service providers to make the digital investments necessary to adopt FDP.

Family caregivers are authorised to access information on behalf of the patient and participate in discussions with health professionals. This aspect of the platform is particularly beneficial for dependent individuals, as it ensures that their care is coordinated with caregivers who become an integral part of the care pathway decision-making process.

The FDP maintains strict data security and privacy measures, ensuring that patient data remains under the control of NHS organisations. Access to this information is granted only to professionals involved in patient care, with strict rules about who can access the information and for what purposes.

In the healthcare industry, the management and sharing of patient data are treated with the utmost care and security. Data exchanged between providers is anonymised to safeguard patient privacy, with identifiable information shared only for direct patient care or when the patient has given explicit consent.

To ensure the security of this sensitive data, a dedicated team focuses on IT protection, implementing robust security measures throughout healthcare organisations. These protections are essential in an age where cyber threats are increasingly sophisticated. Additionally, patients have the option to consent to the use of their data in various projects, particularly for research purposes.

Operational efficiency is one of the key advantages of the FDP. Adopting the FDP facilitates better management of resources, including hospital beds, waiting lists, and medical supplies. Early implementations of the FDP in NHS pilot sites have shown measurable benefits (NHS England, s.d.). Impact assessments show that the system has reduced patient waiting times, led to better utilisation of operating rooms, and quicker diagnosis and treatment. For example, the Chelsea and Westminster NHS Foundation Trust reported faster treatment offers for cancer patients, while the North Tees and Hartlepool NHS Foundation Trust observed a reduction in hospital admissions.

Catalonia (Spain)

In Spain, regional and local initiatives are underway to improve the integration of healthcare and social assistance, information systems, and interoperability of information. For example, in Catalonia, various initiatives are ongoing to strengthen healthcare and social information systems and their integration.

- A new agency for integrated healthcare and social assistance (*Agencia de Integración Social y Sanitaria de Cataluña*) has been established, focusing on the development of governance, financing, and information systems. The goal is to ensure integrated care for the elderly and people with disabilities, as well as individuals facing social issues related to mental health. This agency will involve both the Department of Health and the Department of Social Affairs, providing an ADI service (see the “Governance” chapter for more information).
- Catalonia is developing an interoperability environment in the formal assessment process of dependency and disability, through a Comprehensive Multidimensional Assessment and a Unique Shared Care Plan, called 'My Shared Care Plan'. Currently, there are as many care plans as there are areas (Health and social care), organisations, teams, and professionals involved. (Generalitat de Catalunya, 2024).
- In Catalonia, a digital transformation called "W Social" is underway, which represents a data repository on social assistance interventions. It is expected that this system will provide information collected in the field by social services to the Department of Social Affairs and, prospectively, also to the Department of Health. This initiative includes pilot programmes in which social sector professionals can view a minimum core of healthcare information. This information includes data on health problems, use of health services (hospitalisations, emergency room visits, etc.) discharge reports, rapid fragility assessments, multidimensional assessments, care plans and advanced care planning.
- To address the lack of standardisation (at both national and international levels) in defining social care issues, the TIC Salut Social Foundation of the Department of Social Rights of Catalonia – through the InterSocial project – is developing a standardised language for social assistance. The aim is to facilitate the integration of social service data and streamline the work carried out by professionals in the field of social services. This is a dictionary of interoperable concepts with other systems (e.g. healthcare codes). There are currently 345 concepts that have been encoded according to the SNOMED technological standard, divided into needs/social situations, responses, factors, and observations. The needs/social situations are subdivided into various categories, such as employment, education, legal aspects, environmental aspects, and others. Currently, work is underway to add new categories dealing with issues related to gender-based violence and those concerning childhood and adolescence. To ensure that everyone can benefit from this initiative and use common terminologies, the Social Terminology Dictionary can be downloaded online (TIC Salut Social, 2023).
- Catalonia aims to create an interoperability environment between electronic health records of primary healthcare and electronic records of social care, based on a joint identification number, partner agreement, and individual consent. For example, a minimum core of information (ID, health data, needs assessment, interventions, etc.) will be shared between the Shared Medical History of Catalonia and the Social Service Information System of Barcelona. Since 2021, a new law establishes that it will be possible to share information between healthcare and social care services without the patient's consent, when both healthcare and social care professionals have the need to exchange information (Generalitat de Catalunya, 2024).
- Another project is to integrate health and social data to facilitate joint analysis and evaluation of ADI. It involves agreeing upon and managing a minimum set of indicators related to integrated care to create a scorecard of ADI. The analysis of the impact of ADI shows that nearly 130,000 people are assisted by publicly funded SAD (either healthcare or social). 16% receive a joint service of

Social Home Care (SHC) and Health Home Care (HHC). Through the analysis of these data, it is also observed that the initiation of SHC leads to an increase in the utilisation of primary healthcare services. In areas where ADI is present, the increase is greater. There is also a decrease in cumulative hospitalisation days, including those in nursing homes. Being cared for in an area with Integrated Social and HHC reduces the risk of institutionalisation and admission to a nursing home by 20% (Generalitat de Catalunya, 2024).

Service delivery

The three pillars of service integration analysed so far — service governance, the availability of an adequate formal workforce well integrated with the informal sector, and the development of integrated and interoperable information systems — have a direct or indirect influence on the type of services provided and the methods of delivering such services. The experience of dependent individuals when they develop a condition requiring social and healthcare assistance is strongly influenced by the type of services they can access, the manner in which services are delivered, and the quality of these services. Therefore, person-centred integrated social and healthcare assistance emphasises the necessity of providing integrated services tailored to the person's needs.

Currently in Italy, dependent individuals have access to ADI – services provided mainly by nurses – and to SAD. The latter relate to social and welfare services, often provided by Third-Sector entities mandated by public agencies (OECD, 2023). These services include support in performing personal care activities such as washing, dressing, grooming, meal preparation, domestic chores, and activities outside the home, as well as assistance in managing financial resources and connecting with other social and healthcare services.

At the national level, in 2020, 4.1% and 1.3% of people with disabilities respectively received social welfare SAD and ADI with healthcare services. Among individuals aged 65 and over, 1% and 0.5% respectively received social welfare SAD and ADI with healthcare services (ISTAT, 2020). http://dati.istat.it). The number of users is down from 2011.

The delivery of integrated, person-centred services requires an integrated and individualised approach at every stage of delivery, from needs assessment and service access, through to the development of the individualised care plan. Practices for improving the integration of service delivery are currently being implemented both internationally and in Italy at national and local levels.

This chapter summarises Italian legislation on the integrated assessment of the needs of dependent individuals, the establishment of single access points to facilitate access to integrated care, and service planning based on individual needs through the integrated individual care plan. Finally, the chapter summarises current international practices for integrating needs assessment and the delivery of social and healthcare services, with a particular focus on social prescribing.

Italy's plan for dependency includes initiatives for the integrated delivery of health and social care services

Italian national legislation in recent decades has introduced initiatives aimed at integrated delivery of social and healthcare services for dependent individuals. For example:

- From the needs assessment phase, Italian legislation mandates the adoption of multidimensional assessment tools that encompass both social and healthcare needs of dependent individuals, conducted by a multidisciplinary team.

- National regulations also call for the establishment of single access points where integrated teams perform a multidimensional needs assessment, allowing dependent individuals to access the most suitable social and healthcare services.
- Lastly, the legislation stipulates that the most appropriate services for the needs of the dependent individual should be planned within an integrated individual care plan.

Multidimensional needs assessment tools in Italy

The ways and means of assessing the needs of dependent persons play a key role in defining the right of access to social and healthcare services, consequently influencing the number of services provided and the resources needed to provide those services.

Recent Italian legislation on socio-healthcare services for dependent individuals refers to the introduction of multidimensional assessment tools as a method for the integrated assessment of social and healthcare needs of dependent individuals. Such multidimensional tools would therefore serve to define the most appropriate social and healthcare services for dependent individuals in an integrated manner and would be instrumental in defining an Integrated Care Pathway for the dependent individuals.

In Italy, multidimensional needs assessment and the tools to be used for such assessment are frequently included in the recent national legislation on dependency:

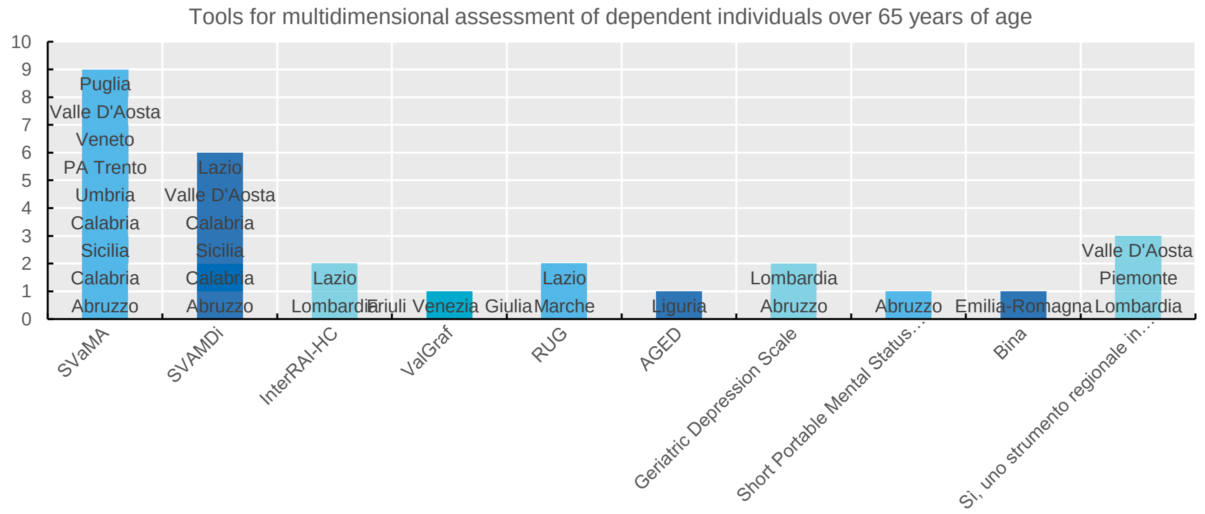
- Law No. 234 of December 30, 2021. (2022 Budget Law) defines, among other things, single access points, indicating them as the location where *multidisciplinary* teams operate to carry out the multidimensional assessment of the needs of dependent individuals. According to Law No. 234, these multidisciplinary teams, in accordance with the provisions of the aforementioned decree of the President of the Council of Ministers dated January 12, 2017, ensure the functionality of the multidimensional evaluation units (UVMs) for assessing the bio-psycho-social capacity of individuals. This assessment aims to evaluate the comprehensive clinical, functional, and social needs of individuals. The goal is to outline the care burden to enable dependent individuals to remain in their living environment with dignity, safety, and comfort, while reducing the risk of social isolation and unnecessary hospitalisations.
- Law No. 227 of Dec. 22, 2021 (Delegation of power to the government in the field of disability) and Law No. 23 of March 23, 2023, (Delegations to the Government on Policies for the Elderly) cite the multidimensional assessment tools and delegate the government to: i) adopt legislative decrees on the improvement of assessment systems for the verification of disability status, the multidimensional assessment of needs, and the individual life project, and ii) implement the multidimensional assessment of needs.
- The 2022-2024 PNNA lists the multidimensional assessment as one of the necessary steps in defining an Integrated Care Pathway for dependent individuals or those with severe disabilities.

Multidimensional assessment tools are currently in use in most Italian regions, but the tools used and the target population vary both inter- and intra-regionally. Although only Basilicata reported not having yet provided for the introduction of a multidimensional assessment tool, all responding regions indicated that more than one tool is in use, highlighting variability in assessment practices at the sub-regional level (OECD Questionnaire, 2024).

Multidimensional assessment tools also vary by type of target population and by type of services for which need assessment is needed. For example, in Lombardy, different evaluations exist based on the services being accessed: for Integrated ADI services, two evaluation steps are required, including triage and

InterRAI (HC) (only for certain levels of complexity), while for the "RSA Aperta" [56] measure, specific scales (e.g. CDR) are used. For social services, the type of system adopted depends on the district/municipality. In many cases, the assessment of needs differs between the population over 65 years old and the disabled population.Figure 10 reports the multidimensional assessment tools used for the dependent population over 65 years of age and the disabled population. In addition to the tools listed in Figure 10, the Barthel Index is used in Abruzzo and Emilia-Romagna, the QVAD in Friuli-Venezia Giulia, the SOSIA and RSA in Lombardy, the VITA form in the Autonomous Province of Bolzano, and the staging certification[57] and the UVMDi form (Multidimensional and Multiperspective Assessment and Planning for Adults with Disabilities) in Valle d'Aosta (OECD Questionnaire, 2024).

Figure 10. Multidimensional assessment tools in use in Italian regions and autonomous provinces



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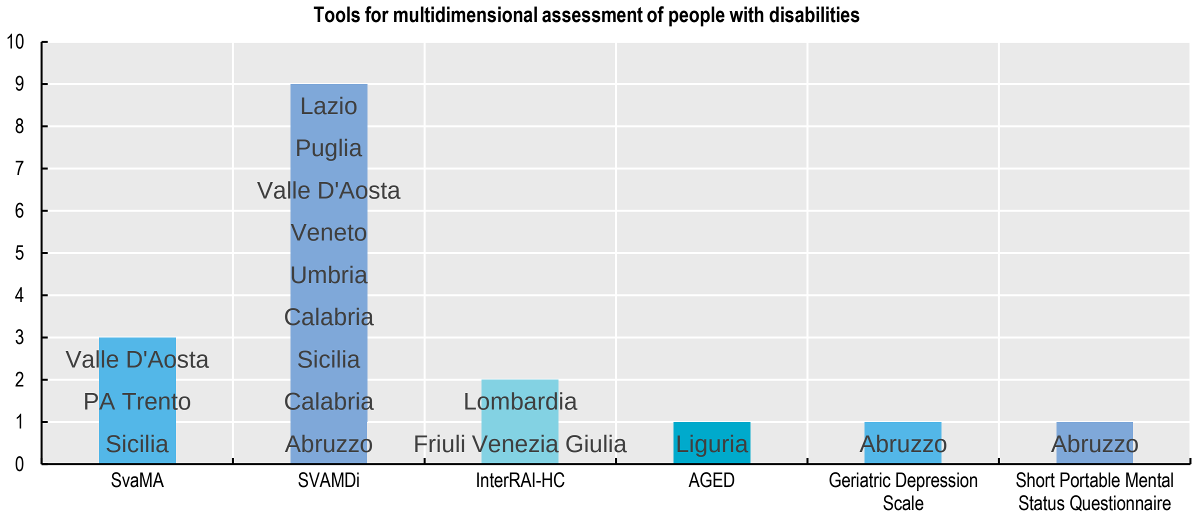
[56] "RSA Aperta" is an innovative measure that offers the possibility of accessing healthcare and social healthcare services aimed at supporting individuals to stay at home for as long as possible, with the objective of postponing the need for admission to a residential facility.

[57] Staging is a document that attests to the biomedical severity conditions, in addition to the disability certificate and the assessment pursuant to law 104/92, taking into consideration both the levels of clinical impairment and the related need for assistance, also accompanying it with the context in which the person lives, the intensity of functional dependence, and the presence or absence of facilitators (OECD Questionnaire, 2024).



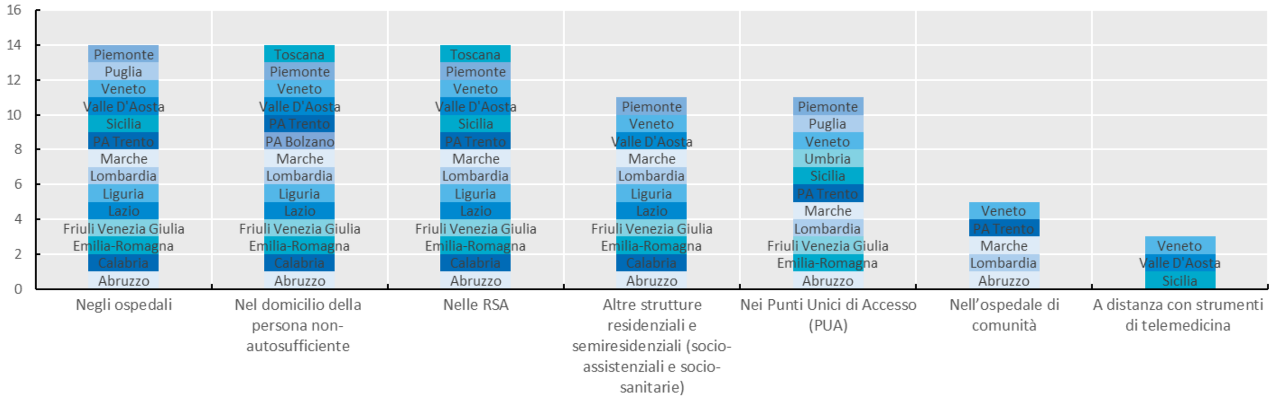
Notes: The graphs are based on •18 regions' responses to the questionnaire
Source: OECD Questionnaire, 2024

The most commonly adopted multidimensional assessment tools in Italy are SVaMA (Multidimensional Assessment Form for Adults and Elderly People) and SVAmDI (Multidimensional Disability Assessment Form). Both assessment tools are based on the concept of disability identified through the ICF classification, which includes the person's health and social needs, their ability to perform ADLs and IADLs, and the support they receive from their surrounding environment. The SVaMA assessment tool considers the person's physical and mental autonomy, health needs, and functional limitations. These limitations are measured through the need for support to perform daily activities (ADLs) and instrumental daily activities (IADLs), with functional limitations in ADLs being measured through the Barthel Index. The SVAmDI assessment tool also relies on the main components of the ICF classification and includes 34 measures in five main components that encompass physical functioning, activities and participation, and environmental factors.

As previously mentioned, Law No. 234 of December 30, 2021. (2022 Budget Law) defines single access points as places where integrated teams conduct the multidimensional assessment of the needs of dependent individuals. Currently, in Italy, multidimensional assessment can be carried out in various care settings. The place where most regions report conducting multidimensional needs assessment is the hospital setting, followed by nursing homes and the home of the dependent person. Ten regions reported being able to conduct the assessment at single access points In contrast, community hospitals and remote assessment via telemedicine tools are the least cited methods by the regions that responded to the questionnaire (Figure 11). In addition, in 5 out of 15 regions, multidimensional assessment can currently also be performed at the multidimensional assessment units of health districts (OECD Questionnaire, 2024).

In some cases, assessments can be carried out in different locations depending on the cases to be evaluated. Emilia-Romagna has implemented a project for the multidimensional assessment of citizens with social frailty in emergency departments. The initiative aims to minimise the risk of inappropriate hospital admissions for elderly people in socially fragile situations for issues that are not strictly medical. The initiative involves the presence of a multi-professional team composed of social and healthcare workers, active in the emergency department, to conduct the multidimensional assessment. The project began in 2018 and is currently still ongoing, with 385 reports and activations occurring in 2022. The implementation of this initiative has included the activation of training modules for doctors and nurses and practices for periodic updates and monitoring. Specifically, a monitoring system has been structured over the past year to periodically analyse the socio-demographic characteristics of the individuals intercepted, the analysis of needs, and the outcomes of the reports (OECD Questionnaire, 2024).

Figure 11. Places where multidimensional assessment can be conducted in Italy



Notes: The chart is based on - 5 regions that contributed to the questionnaire.
Source: OECD Questionnaire, 2024

Following the initial assessment, the needs of the dependent person may change over time. Ageing and advancing disease can indeed change the limitations and self-sufficiency status of individuals using care services. In most regions, the assessment of the needs of dependent individuals is therefore repeated over time to modify and adjust the services offered according to the person's health status. Out of 15 regions, 14 reported that the multidimensional assessment is regularly repeated to reassess care needs, while 7 regions reported that the assessment of needs can be repeated over time at the discretion of the case manager or other professionals responsible for the dependent person, or upon request by the caregiver and/or the dependent person (OECD Questionnaire, 2024).

Single Access Points

Italian legislation has defined single access points (PUA) since 2007, when the Ministry of Health's decree of 10/07/2007 established the "single access desk" (later referred to as the single access point) as part of the experimental "health at home" care model. The aim was to improve the integration of health and social care services. New funds for the implementation of single access points were allocated by the Ministerial Decree of the Ministry of Social Solidarity of 12/10/2007. Single access points were later mentioned in a number of subsequent documents, including the State-Regions Agreement of 25/03/2009 and the Ministerial Decree of the MLPS of 20/03/2013. Ministerial Decree of the MLPS of 07/05/2014; Ministerial Decree MLPS of 14/05/2015; Ministerial Decree MLPS of 26/09/2016.

Law No. 234 of Dec. 30, 2021 (2022 Budget Law) then defined PUAs as the place through which the national health service and the ATS ensure, using the respective human and instrumental resources, access to social and healthcare services for people in conditions of dependency. According to the 2022 Budget Law, PUAs are operationally based in community houses and are the place where integrated teams conduct multidimensional assessment of the needs of dependent persons.

The identification of single access points is handled at the regional level (as well as the sub-regional level, and, often, at the district level) and can therefore vary between regions and autonomous provinces. Some autonomous regions and provinces had already begun to legislate on the opportunity to instal single access points for social and healthcare services even before the national legislation of 2007.

In Campania, for example, legislation repeatedly mentions the 'unified gateway to access' as a resource through which social and healthcare needs can be addressed in an integrated manner (Regional Council Resolution of 22/06/2002 "Regional Social Plan 2002-2004"; Regional Government Resolution of 12/10/2007 No. “Guidelines and forms for the planning and presentation of territorial activity plans”; Regional Resolution of 23-10-2007 No. “Law for dignity and social citizenship. Implementation of Law No. 328 of November 8, 2000”; 2009-2011 Regional Social Plan).

As early as 2004, the Autonomous Region of Friuli-Venezia Giulia indicated the spread of PUAs to social and healthcare services as a strategic system objective within the Guidelines for the preparation of District Activity Plans and Area Plans. The strategic importance of single access points was later reaffirmed by the 2010-2012 Regional Social and Healthcare Plan, adopted by the Regional Council by Resolution No. 465 of March 18, 2010.

In Tuscany, single access points are already defined in the 2005-2007 Regional Health Plan and Regional Resolution of 18/12/2008 No. 66: "Establishment of the regional fund for dependency".

To date, most of the regions and autonomous provinces that provided information through the questionnaire (10 out of 15) reported the possibility of conducting multidimensional assessment at single access points (Figure 11).

Integrated Individual Assistance Project

Law No. 234 of December 30, 2021 (2022 Budget Law) defined the Integrated Individual Assistance Project (PAI) as a plan containing indications of interventions modulated according to the intensity of need. The PAI also identifies the responsibilities, tasks, and methods of implementation of health, social, and welfare operators involved in taking care of the individual, as well as the contribution of the family and other stakeholders collaborating in its implementation. The integrated team responsible for the multidimensional assessment of needs is then tasked with defining the PAI. The planning of interventions and the provision of care benefit from informational co-ordination, including via Internet, with INPS.

The 2022-2024 Plan for Dependency then took up the concept of PAI and integrated it into the planning matrix of measures to improve social and healthcare for dependent persons. The Integrated Care Pathway dedicated to people who are dependent or severely disabled includes five stages: access, initial assessment, multidimensional assessment, personalised care plan development, monitoring of health outcomes (2022-2024 PNNA).

At the regional and autonomous province level, there are initiatives to create PAIs for specific segments of the dependent population. For example, in 2023, Emilia-Romagna launched an initiative for the protected discharge for homeless individuals with disabilities. The project aims to take care of such individuals by overcoming the fragmentation of services and the difficulties in territorially addressing complex health and social issues.[58]

Similarly, Friuli-Venezia Giulia has implemented initiatives to improve the integration of assistance for specific segments of the population. Since 2021, the region has initiated an experimental project for

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[58] The project involves the elaboration of Individual Care Plans (PAIs) by the Territorial Operational Center for the construction of the territorial pathway with the involvement of local social services and Third Sector associations. The project included an initial phase of establishing a multi-professional work group to build a common cultural base. The second phase was then characterised by an analysis of the status quo in the Cesena area, where the project was initially implemented, followed by cooperation with an area where a codified pathway is already in place. The third phase, which not yet in place, will be an in-depth legal-administrative study of migration policies. This analysis was deemed necessary to foster a better understanding of the living conditions of many homeless and/or undocumented people and the resulting barriers to accessing social and health services (OECD Questionnaire, 2024).

community-based care for people with dementia, aiming to prevent their institutionalisation and initiate integrated paths for home care. The initiative is experimental and has been activated in three pilot areas, conducted by the health authorities and social services of the reference municipalities, with the involvement of local Third Sector entities (co-planning and co-designing of services) (OECD Questionnaire, 2024).

There are international initiatives aimed at integrated delivery of health and social care services for dependent individuals

There is significant variability among OECD countries in how the social and health sectors manage and deliver assistance services for dependent individuals. In some OECD countries, the assessment of the needs of the dependent person is done in an integrated way, while in other countries the assessment of the needs of the dependent person is done separately for health and social services. In addition, a growing number of countries are working on establishing a nationally standardised multidimensional assessment tool for dependent persons. For example, in Finland and Sweden, needs assessment tools are defined at the municipal level, while in Lithuania there are separate assessment tools for the different social and healthcare services that dependent persons may receive. On the other hand, Japan has been working on the development of a standardised multidimensional assessment tool at the national level since the end of the last century, and Germany has defined a standardised multidisciplinary assessment tool at the national level since 2017 (OECD, 2022).

In Spain, the Basque Country has implemented initiatives aimed at improving the integration of care services for dependent individuals through the implementation of local ecosystems of integrated care services, as outlined in Box 9.

Box 9. Local ecosystems of integrated care services in the Basque Country (Spain)

In Spain, the Basque Country has implemented experiences of local ecosystems of integrated care services. The initiative, known as *Zaintza HerriLab* was managed by the provincial council of Gipuzkoa in collaboration with a foundation (Adinberri foundation) and was implemented in 2 municipalities in Gipuzkoa (OECD Interview, 2024).

The aim of the initiative is to improve home care services for dependent elderly people through the definition of care plans (similar to the individual PAIs provided for in Italy). The care plans are designed and managed by a team of specialised professionals (case managers) who have a good understanding of the needs of the beneficiaries and the provision of home services at the local level. The care plans are recorded online in computer systems that allow the collection of information regarding social and healthcare services and to follow the beneficiaries throughout their lives, respecting the privacy and the rights of the beneficiaries. (Zaintza HerriLab, 2024).

The process of developing care ecosystems has taken place gradually, starting with the establishment of a *multilevel driving group* that includes governance bodies at the local and regional levels. The process then required the mapping of locally available services and care needs, followed by the establishment of care plans. An initial pilot phase of the project was followed by a phase of defining and implementing collaboration plans between the involved entities and training sessions for the professionals involved. The pilot projects were then further developed and transferred to new settings (Zaintza HerriLab, 2024).

Each phase of the ecosystem development was accompanied by impact evaluation processes. The impact evaluation of the *Zaintza HerriLab* showed positive effects on the dependent individuals assisted and also on informal caregivers. Through a better understanding of people's needs, the initiative led to an increase in the population benefiting from care services and the provision of services more tailored to the needs of the recipients. The programme also extended the duration for beneficiaries staying in their own homes. The evaluation of the initiative also noted an improvement in the integration and co-ordination among the agents involved in service delivery and increased satisfaction among the involved healthcare and social professionals.[59] (Basque government, 2023).

Source: OECD Secretariat.

Social prescribing as a tool to integrate the delivery of health and social care interventions

Countries have long recognised that social determinants of health play an important role in shaping population health and health equity. WHO defines social determinants of health as "the conditions in which people are born, grow, live and age", which are "shaped by the distribution of money, power and resources." (WHO Commission on Social Determinants of Health and World Health Organization, 2008). Social determinants include income, employment, education, living, social and community context conditions and other socioeconomic factors. In fact, research suggests that social determinants, environment, and lifestyles may have a greater impact on health outcomes than healthcare.

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[59] 77.7% of the professionals surveyed reported that they always, almost always, often feel that their work has a positive influence on the lives of others, and 71.7% responded that they always, almost always, or often feel motivated after working in contact with the people they care for.

Forms of "social prescribing" have emerged as a strategy to integrate health and social service delivery (Morse, 2022). In general, social prescribing is a term for a person-centred approach to link people to non-clinical, community-based support (Buck, 2020) to better manage their health and well-being. The goal is to empower individuals to recognise their own needs, strengths, and personal resources and to connect with their community.

Social prescribing primarily aims at prevention, helping to reduce loneliness and social isolation, delaying the development of care needs, reducing the care needs of those who require assistance, and enabling people to live as independently as possible. For example, lonely and/or socially isolated people are at higher risk of premature death, heart disease, stroke, and high blood pressure. They are also more likely to suffer from depression, low self-esteem, and sleep problems.

Social prescription can be used to refer people to a range of activities and services. "Social prescriptions" are specific to each community and care setting, and typically include interventions that support mental health, social inclusion, financial and housing counselling, and interventions that promote physical activity and personal expression. Social prescribing can align with policies supporting healthy ageing (Alberta, Canada) and personalised care improvement policies (England).

he need for non-medical support through social prescribing is evident, as it can improve individuals' health and well-being, reduce anxiety and depression, boost self-esteem, and alleviate loneliness and isolation. With its early preventive approach, social prescribing could help alleviate the burden on frontline healthcare workers (Drinkwater, 2019), and, for the elderly, potential benefits include preventing hospitalisation or admission to care homes (Hamilton-West, 2020).

Social prescribing is an extremely diverse and community-rooted practice: in the various countries analysed in this report, social prescribing interventions have been developed and consolidated primarily from the grassroots, with individual contracted providers, Third Sector organisations, and statutory bodies developing various delivery models. While the *social prescribing* model of primary care, in which individuals are referred by general practice, is the dominant model in some systems, community-centred models have emerged. Within countries, social prescribing practitioners are found not only in health care settings, but also within partner organisations such as Third Sector organisations, housing support associations, local authorities, or educational settings.

A recent report by the National Academy of Social Prescribing (2023) and a recent study by (Scarpetti, 2024) explore the development of *social prescribing* in 24 countries and 12 high-income countries, respectively. They show the different approaches developed by countries, especially at the local level, to address patients' social needs more holistically, overcome the fragmentation of healthcare and social systems, and improve equity by eliminating economic, geographic, interpersonal, or psychological barriers that individuals may encounter in developing new skills, participating in meaningful activities, and connecting with their communities. Below is a description of the reference cohorts, the types of services offered, the workforce, and the impact assessment of *social prescribing programmes*, with particular attention to Canada, England, Portugal, and Spain.

Reference cohorts and referrals

Social prescribing programmes are primarily offered to individuals with chronic conditions, those who are lonely or socially isolated, individuals at high risk of mental illness, and people vulnerable due to age or housing situation.

For example, in Ontario, nearly half of the individuals who participated in social prescribing initiatives were between the ages of 61 and 80, mostly female, and nearly half of them lived with a low income. Mental health was a key factor in social prescriptions, with anxiety and depression being the most frequent conditions. Social prescriptions have focused mainly on food security and housing support (Alliance for Healthier Communities, 2020).

In England, social prescribing is a key component of the personalised care approach for all ages and populations. Social prescribing is particularly effective for a broad group of people, including those with one or more long-term conditions, those in need of support for their mental health, those who are lonely or isolated, and those with complex social needs that impact their well-being (NHS England, 2023). Reference sources for social prescribing practitioners are cross-sectoral and not limited to healthcare/primary care. Individuals can be referred to local *social prescribing* practitioners by a wide range of local agencies, including general practice, local authorities, pharmacies, multidisciplinary teams, hospital discharge teams, health professionals, firefighters, police, employment centres, social care services, housing support associations, and voluntary, community, and social enterprise organisations. Self-referral is also encouraged to promote people's autonomy and empowerment in managing their own health and wellness needs by enabling them to identify and directly contact practitioners who can offer them the support they need (NHS England, 2023).

For example, in Portugal, social prescribing is aimed at people of all ages with social, emotional, or even practical needs. When a healthcare provider realises that there are social and emotional or even daily practical needs affecting the health and well-being of a user, they can refer them to a *social prescribing* consultation where the social worker and the user establish a personalised intervention plan with community responses that can contribute to their health and well-being. Since the start of a social prescribing project launched in September 2018 in Lisbon, about 900 users of all ages and more than 20 nationalities, most of them women, have been addressed; the main reasons for referral are social isolation, access to social benefits, exercise related to sedentary lifestyle and obesity, and immigrant integration. [60]

In Spain, social prescribing can be recommended to any patient of any age. It is recommended as an extension of prescriptions on lifestyles or behavioural risk factors of major chronic non-transmissible diseases for individuals with psychosocial stress, anxiety, depression, and social isolation.

In the United States social prescriptions have largely focused on basic needs (food and shelter), given significant the socioeconomic inequalities and the weaker public social safety net. In the Netherlands, Sweden, and Wales, social prescriptions have often focused on social isolation and general welfare.

In Wales, the sources of referrals to an organisation offering social prescribing are cross-sectoral and not limited to healthcare. For example, referrals may come from community and voluntary organisations, statutory services, and even self-referrals. An organisation offering social prescribing can also proactively reach out to individuals or populations that have a specifically identified need (Welsh Government, 2024).

Type of services offered

The community resources to which individuals can be referred are diverse and intrinsically linked to the target population and the local landscape of available services or activities. These can range from services that address basic material and legal needs (e.g. food, shelter, transportation), to lifestyle interventions to improve health behaviours (e.g. exercise, diet, smoking), to programmes to develop vocational skills (e.g. education, vocational training) or social activities (e.g. volunteering, arts and crafts, nature activities, community engagement). The services offered to an individual under a social prescribing programme can range from a single activity, such as body weight management, to ongoing support for various needs.

Kimberlee R. (Kimberlee, 2015) suggests a taxonomy of social prescribing models ranging from "light" to "holistic". "Light" social prescribing models refer to models in which individuals are informed of support or opportunities in their community that may be relevant to them and their needs, but their access to this support is entirely self-directed. "Holistic" social prescribing models are highly integrated with healthcare

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[60] See https://observador.pt/2023/03/09/cerca-de-900-utentes-recebem-prescricao-social-que-proporciona-saude-e-bem-estar/

and take into account multiple aspects of wellness, often including both physical and mental health. They are often characterised by long-term partnerships between organisations, with support specifically designed to meet the needs identified by the organisations or services in the partnership.

A review by Chatterjee et al. (Chatterjee, 2018) described the different types of social prescription, briefly summarised below:

- Art: Refer people with physical or mental health problems to programmes that offer creative activities such as painting or drawing, crafts, dance, theatre, or music.
- Reading/bibliotherapy: Health professionals who recommend self-help books in addition to cognitive behavioural therapy or recommend leisure reading/joining a book club.
- Education: Refer people to structured learning programmes such as literacy and basic skills courses (e.g. money management, cooking, organisational skills, learning a new language) according to individual needs and interests.
- Exercise: Direct people to structured exercise activities, such as gym sessions, yoga, swimming, and other sports activities. "Green" prescriptions: Support people to intensify their contact with nature, such as walking in parks, gardening or participating in community gardens, and spending time in other natural spaces, such as the beach or national parks.
- Healthy lifestyle initiatives: Target disadvantaged populations, for example, by providing free health screenings and supporting a healthy lifestyle through healthy eating and smoking cessation programmes. Such programmes are often developed by community nurses.
- Reporting/Information: Refer or signpost patients to useful information about local health and welfare services, such as financial counselling, housing support, community health programs, or peer support groups. Information is provided by linking patients to websites or providing brochures with contact details of services.
- Referral support: Provides access to support to meet individual needs, which are usually assessed by a connector or link worker who co-produces a tailored social prescribing program or action plan with appropriate and achievable goals. The link worker can then work with the patient to support them as they develop a plan to achieve their goals, helping them overcome barriers, build confidence, and provide moral support and encouragement. This type of social prescribing can include any combination of the social prescriptions described above.

Link workers

As highlighted in the chapter on workforce, *link workers* play a key role in any social prescribing programme. They have extensive knowledge of the community in which they work and are able to connect patients with community resources that meet their needs effectively and compassionately. The role of the link worker is to empower people to take charge of their own health and well-being. Link workers should aim to build a trusting relationship with the patient, actively listening to their concerns to best understand their needs. They then work with the individual to develop an individualised plan and connect them with locally available services. Link workers must work as a team with health professionals and community organisations and ensure follow-up of the individualised intervention plan. The role of the link worker is not internationally defined and varies from country to country.

In Alberta (Canada), under the Healthy Aging Social Prescribing for Older Adults programme, *link workers* are non-clinical professionals employed by community organisations caring for older adults. They help people develop and achieve a set of personalised goals by accessing community resources and supplementing health care with additional support. *Link workers* connect individuals with recreational and social programmes, assist them in accessing financial benefits, and provide referrals to assisted transportation programmes. They also connect individuals with home care services, such as household cleaning and snow removal. *Link workers* also refer more complex problems to social workers who are part of the community's social prescribing network.

In England, the new professional role of "link worker" has been developed. Link workers connect people with available resources in the community, including activities and services that address practical, social, and emotional needs that impact individuals' health and well-being. They work in collaboration with the health and social care system, targeting populations with greater needs and risk of health inequalities, and collaborating with partners to identify gaps in provision and support community offerings to make them accessible and sustainable.

In the Portuguese social prescribing system, primary care physicians seamlessly refer patients to social workers, who are the link workers responsible for prescribing aimed at lifestyle change, community engagement, mental health promotion, and personalised support.

Integrated into patients' electronic health records, the Spanish social prescribing model allows immediate visits and follow-ups by primary care physicians. Measures to promote the participation of the most representative associations of family caregivers in the development of social, healthcare, and public health policies (public family caregiver registers at regional and local levels).

In Wales, link workers may be employed by a range of different organisations, such as universities, local authorities, health boards, or community and voluntary organisations. They may practice social prescribing as their main activity or as part of their role, and are known by a variety of terms specific to the organisation in which they work. For example, link worker, community connector, or wellness coordinator (Welsh Government, 2024).

Impact assessment

In theory, collaboration between health and non-health organisations at the local level could help improve the health status of the population. But we know little about what types of collaboration work, for whom, and in what contexts. The benefits of collaboration may be hard to achieve, hard to measure, and overestimated by policymakers. Ultimately, local collaborations should be analysed and evaluated in their own political and economic context, as one component of a larger system of factors and interventions that interact to improve the health status of the population (Alderwick H. a., 2021).

The extremely heterogeneous nature of social prescribing poses major challenges for an impact evaluation (Ayorinde, Grove, & Ghosh, 2024). In addition, the available evidence varies because the impact of *social prescribing* depends on the type of model used, the social prescribing practitioners and their background, the location, and the resources available within the community (Polley M. a., 2023).

An evaluation of social prescribing initiatives in Ontario, Canada, found that individuals reported an overall improvement in their mental health and increased ability to self-manage their health. Healthcare providers found social prescribing useful for enhancing individuals' well-being and reducing repeat visits. Social prescribing also facilitated greater integration between clinical care, inter-professional teams, and social support. (Alliance for Healthier Communities, 2020)

Facilitating elements of social prescribing models include knowledge of available community resources and the presence of qualified professionals in the role of link workers (Dias, 2023). Strong commitment from primary care physicians, health authorities, and community sector technicians, along with frequent communication among stakeholders (Alderwick H. a., 2021) and the physical presence of link workers in healthcare services, were also identified as facilitators. Key actions for effective implementation should focus on investing in training for healthcare providers and community partners and promoting user adherence to prescriptions. Interpersonal and organisational relationships that emphasise trust, consent, and collaboration enable addressing the diverse priorities of communities more effectively (Calderón-Larrañaga S, 2021).

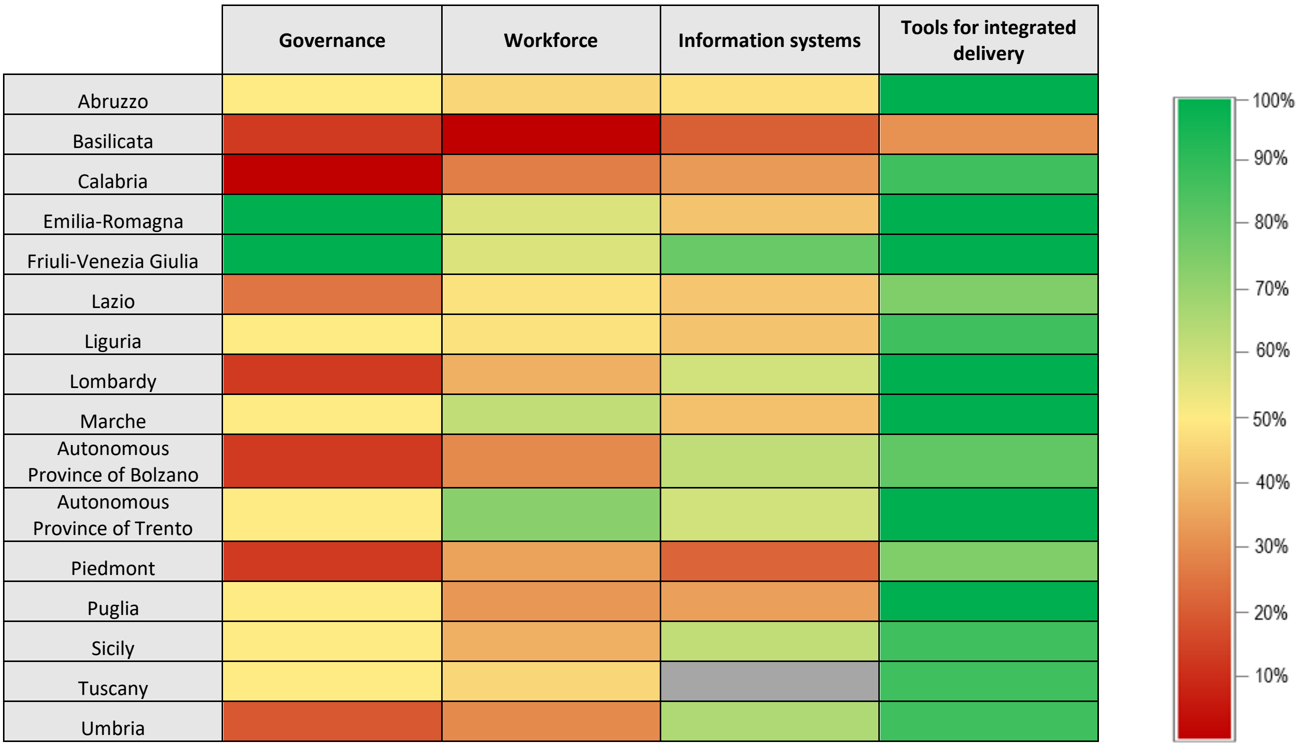
Gap analysis

The distance of regions-autonomous provinces from a model of integrated home-based health and social care interventions

Based on the responses to the OECD questionnaire, the preliminary dashboard provided below allows for estimating, with an acceptable level of approximation, the level of integration achieved in the 18 regions and autonomous provinces that participated in the survey, and the distance from a model of integrated home-based health and social care interventions. This model corresponds to the availability of the entire set of functional tools for integration related to the four dimensions examined: governance, workforce, data and information systems, and integrated social and healthcare service delivery.

The dashboard is based on a set of 34 indicators divided into the four dimensions of the analysis; the colour assigned to each region/autonomous province reflects the non-existence or lack of use of a tool or process (cell coloured in red), or the presence or use of a tool or process (cell coloured in green).

Campania, Molise, and Sardinia did not respond to the survey sent by the OECD regarding the evaluation of the state of integration of services for dependent individuals. Therefore, the real picture of the situation in these regions remains partially unknown, making it difficult to fully assess the policies and resources implemented to assist this population group.



	Governance	Workforce	Information systems	Tools for integrated delivery
Abruzzo	🟨	🟨	🟨	🟩
Basilicata	🟥	🟥	🟥	🟧
Calabria	🟥	🟧	🟧	🟩
Emilia-Romagna	🟩	🟨	🟧	🟩
Friuli-Venezia Giulia	🟩	🟨	🟩	🟩
Lazio	🟧	🟨	🟧	🟩
Liguria	🟨	🟨	🟧	🟩
Lombardy	🟥	🟧	🟨	🟩
Marche	🟨	🟨	🟧	🟩
Autonomous Province of Bolzano	🟥	🟧	🟨	🟩
Autonomous Province of Trento	🟨	🟩	🟨	🟩
Piedmont	🟥	🟧	🟥	🟩
Puglia	🟨	🟧	🟧	🟩
Sicily	🟨	🟧	🟨	🟩
Tuscany	🟨	🟨	⬜	🟩
Umbria	🟥	🟧	🟩	🟩

Valle d'Aosta	🟨	🟧	🟧	🟩
Veneto	🟩	🟩	🟨	🟩

The following tables detail the indicators for the four dimensions analysed.

	Governance		
	1.1	**1.2**	**1.3**
Region/Autonomous Province	Existence of governance tools at the territorial level	Co-planning tools as defined by Decree no. 72/2021	Existence of projects on social and healthcare integration, or other projects that have a significant impact on social and healthcare integration
Abruzzo	🟩	🟩	🟥
Basilicata	🟧	🟥	🟥
Calabria	🟥	🟥	🟥
Emilia-Romagna	🟩	🟩	🟩
Friuli-Venezia Giulia	🟩	🟩	🟩
Lazio	🟩	🟥	🟥
Liguria	🟩	🟥	🟩
Lombardy	🟧	🟥	🟥
Marche	🟩	🟥	🟩
Autonomous Province of Bolzano	🟧	🟥	🟥
Autonomous Province of Trento	🟩	🟥	🟩
Piedmont	🟧	🟥	🟥
Puglia	🟩	🟥	🟩
Sicily	🟩	🟩	🟥
Tuscany	🟩	🟩	🟥
Umbria	🟧	🟥	⬛
Valle d'Aosta	🟩	🟩	🟥
Veneto	🟩	🟩	🟩

	Workforce													
	Formal sector							**Informal sector**						
	2.1	**2.2**		**2.3**	**2.4**	**2.5**	**2.6**	**2.7**	**2.8**	**2.9**	**2.10**	**2.11**	**2.12**	**2.13**
Region/Autonomous Province	Number of professional categories and other actors entitled to initiate the request for a multidimensional assessment	Number of professional categories involved in the assessment of the elderly population	Number of professional categories involved in the assessment of the population with disabilities	Presence of opportunities for discussion among professionals in the multidimensional assessment process	Presence of the role of regional and provincial level case manager	Presence of training pathways among the tools covered to facilitate integration	Presence of integrated training pathways among the tools covered to facilitate integration	Regional legislation that provides for and/or defines the figure of the family caregiver	Regional forms of support provided to support the family caregiver in care activities	Informational training for family caregivers to receive information on issues regarding the individuals being cared for and the rights of both care recipients and family caregivers.	Regional legislation that provides for and/or defines the figure of the personal/family assistant	Tax incentives and/or economic support to encourage formally hiring personal/family assistants	Regional public registry of personal/family assistants	Personal/family assistant training
Abruzzo	🟩	🟧	🟧	🟩	🟩	🟥	🟥	🟩	🟧	🟩	🟥	🟩	🟥	🟩
Basilicata	▨	▨	▨	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥
Calabria	🟧	🟧	🟩	🟩	🟩	🟥	🟥	🟩	🟥	🟥	🟥	🟥	🟥	🟥
Emilia-Romagna	🟧	🟥	🟥	🟩	🟩	🟩	🟩	🟩	🟧	🟩	🟩	🟩	🟥	🟩
Friuli-Venezia Giulia	🟩	🟥	🟧	🟩	🟩	🟥	🟩	🟩	🟩	🟩	🟩	🟥	🟧	🟩
Lazio	🟥	🟧	🟧	🟩	🟥	🟥	🟩	🟩	🟧	🟩	🟩	🟩	🟧	🟩
Liguria	🟧	🟧	🟧	🟩	🟥	🟥	🟩	🟩	🟧	🟥	🟩	🟩	🟩	🟩
Lombardy	🟩	🟥	🟥	🟩	🟥	🟥	🟥	🟩	🟧	🟩	🟥	🟩	🟧	🟩
Marche	🟩	🟧	🟧	🟩	🟥	🟥	🟩	🟩	🟧	🟩	🟩	🟩	🟩	🟩
Autonomous Province of Bolzano	🟩	🟥	🟥	🟥	🟥	🟩	🟥	🟩	🟧	🟩	🟥	🟥	🟥	🟩
Autonomous Province of Trento	🟩	🟧	🟧	🟩	🟩	🟩	🟩	🟩	🟧	🟩	🟩	🟥	🟩	🟩
Piedmont	🟥	🟧	🟧	🟩	🟥	🟥	🟥	🟩	🟧	🟥	🟩	🟩	🟥	🟩

Puglia	🟥	🟥	🟥	🟩	🟩	🟥	🟩	🟩	🟧	🟥	🟩	🟥	🟧	🟥
Sicily	🟧	🟧	🟧	🟩	🟥	🟥	🟥	🟩	🟧	🟩	🟥	🟥	🟩	🟩
Tuscany	🟩	🟥	🟥	🟩	🟥	🟥	🟩	🟩	🟧	🟩	🟩	🟩	🟥	🟩
Umbria	🟧	🟥	🟧	🟩	🟥	🟥	🟥	🟥	🟧	🟥	🟩	🟩	🟩	🟥
Valle d'Aosta	🟥	🟧	🟧	🟩	🟥	🟥	🟥	🟩	🟧	🟩	🟩	🟩	🟩	🟩
Veneto	🟧	🟧	🟧	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟥	🟩	🟩

Region/Autonomous Province	Information systems										
	Social sector						Health sector				3.4
	3.1	3.2	3.3		3.5	3.6	3.1	3.2	3.3		
	Type of data collected through regional/provincial information systems	Available breakdowns	Cadence of aggregate/summarised data transmission at the national level	Cadence of aggregate/summarised data transmission at the regional (or autonomous province) level	Existence of a computerised social record in use in the region/autonomous province	Implementation of computerised social records	Type of data collected through regional/provincial information systems	Available breakdowns	Cadence of aggregate/summarised data transmission at the national level	Cadence of aggregate/summarised data transmission at the regional (or autonomous province) level	Existence of a single regionally integrated information system
Abruzzo	🟧	🟩	🟧	🟧	🟧	🟥	🟩	🟩	🟩	🟩	🟥
Basilicata	🟧	🟧	🟧	🟥	🟩	🟥	🟧	🟥	🟥	🟥	🟥
Calabria	⬛	⬛	🟩	🟥	🟧	⬛	🟩	🟥	🟩	🟥	🟥
Emilia-Romagna	🟧	⬛	🟧	⬛	🟧	🟥	🟩	🟧	🟩	🟩	🟥
Friuli-Venezia Giulia	🟧	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟥
Lazio	🟧	⬛	⬛	⬛	🟧	🟧	🟧	🟩	🟧	🟩	🟥
Liguria	🟩	🟥	🟩	🟩	🟧	🟥	🟩	🟥	⬛	⬛	🟧
Lombardy	🟧	🟩	🟧	🟧	🟩	🟧	🟩	🟩	🟩	🟩	🟥
Marche	🟩	🟩	🟧	🟧	🟧	🟧	🟩	🟩	🟥	🟥	🟥

Autonomous Province of Bolzano	🟩	🟧	🟩	🟩	🟥	⬛	🟩	🟩	🟩	🟩	🟥
Autonomous Province of Trento	🟩	🟥	🟧	🟩	🟩	🟧	🟩	🟩	🟩	🟩	🟥
Piedmont	🟥	🟧	🟧	🟧	🟥	⬛	⬛	🟧	⬛	⬛	🟥
Puglia	🟧	🟩	🟥	🟥	🟥	🟥	🟧	🟩	🟩	🟩	🟥
Sicily	⬛	⬛	⬛	⬛	🟧	⬛	🟩	🟩	🟩	🟩	🟥
Tuscany	⬛	⬛	⬛	⬛	⬛	⬛	⬛	⬛	⬛	⬛	⬛
Umbria	🟧	🟩	🟩	🟩	🟩	🟧	🟧	🟩	🟩	🟩	🟥
Valle d'Aosta	🟥	🟧	🟧	⬛	🟩	🟧	🟧	🟧	🟩	🟩	🟧
Veneto	⬛	🟩	🟩	🟩	🟥	🟧	🟧	🟩	🟩	🟩	🟥

	Tools for integrated service delivery					
	4.1	**4.2**	**4.3**	**4.4**	**4.5**	**4.6**
Region/Autonomous Province	Existence of Integrated Individual Assistance Projects (PAIs)	Existence of single access points	Existence of Multidimensional Assessment Tools for people over 65 years of age	Existence of Multidimensional Assessment Tools for people with disabilities	Frequency with which the multidimensional assessment is repeated	Services that can be received at home as part of the Home Assistance Services (SAD)
Abruzzo	🟩	🟩	🟩	🟩	🟩	🟩
Basilicata	🟩	🟧	🟥	🟥	🟥	🟩
Calabria	🟩	🟧	🟩	🟩	🟩	🟩
Emilia-Romagna	🟩	🟩	🟩	🟩	🟩	🟩
Friuli-Venezia Giulia	🟩	🟩	🟩	🟩	🟩	🟩
Lazio	🟩	🟧	🟩	🟩	🟩	🟧
Liguria	🟩	🟧	🟩	🟩	🟩	🟩
Lombardy	🟩	🟩	🟩	🟩	🟩	🟩
Marche	🟩	🟩	🟩	🟩	🟩	🟩
Autonomous Province of Bolzano	⬛	⬛	🟩	🟩	🟧	🟩
Autonomous Province of Trento	⬛	🟩	🟩	🟩	🟩	🟩
Piedmont	🟩	🟩	🟩	🟩	🟧	🟧
Puglia	🟩	🟩	🟩	🟩	🟩	🟩
Sicily	🟩	🟩	🟩	🟩	🟩	🟧
Tuscany	🟩	🟧	🟩	🟩	🟩	🟩
Umbria	🟩	🟩	🟩	🟩	🟩	🟧
Valle d'Aosta	🟩	🟧	🟩	🟩	🟩	🟩
Veneto	🟩	🟩	🟩	🟩	🟩	🟩

Annex A. The OECD survey

This report draws significantly from a survey conducted by the OECD as part of the project "Towards Person-Centred Integrated Social and Healthcare in Italy".

The survey targeted all Italian regions and autonomous provinces in order to assess the current level of integration of home health and social services for dependent individuals.

The target population of the project under investigation includes:

- elderly individuals (aged 65 years and older) who are not independent and have varying levels of caregiving needs
- people with severe or very severe disabilities, including individuals recognised as legally disabled or disabled, according to the definitions in Italian law.

The survey was initiated on January 31, 2024, with the distribution of a single questionnaire to the representatives of the regions and autonomous provinces. Initially, the distribution was scheduled to end on February 21. However, data collection was extended due to difficulties encountered by some administrations in engaging various relevant offices. Following an initial reminder to participants on February 14, and in light of preliminary feedback highlighting this issue, an extension was granted. Additional informative integrations were requested on February 27 and March 19-20, following an analysis of the clarity and completeness of responses provided up to that point. The last questionnaire was received on April 9.

Data collection and sharing methods

The representatives of the regions and provinces involved were selected independently by each administration. Initially, there was discussion about whether to focus the analysis on specific territories, given the not uncommon coexistence of multiple levels even within individual regions however, it was finally decided that each region should provide a complete picture of its situation and one that reflected its complexity. The role of ProMIS was fundamental in providing technical support and facilitating the participation of the different administrations. These were invited to ensure a shared compilation of the questionnaire among the social and health directorates, appointing a single point of contact for any clarifications from the OECD team. Completed questionnaires were sent tointegratedcare_italy@oecd.org, created specifically for the project. The collected data were entered into a single folder in tabular format, with a sheet for each section of Part A of the questionnaire and made available in protected format to the project beneficiaries to inform their reflections independently of the analysis provided in this report.

Questionnaire

The questionnaire developed for the survey is divided into several subject areas. Part A aims to obtain an updated overview of the regional context and autonomous provinces, divided into four thematic areas:

1. Multidimensional assessment systems
2. Integration of home healthcare, social and socio-medical services
3. Information systems

4. Informal sector.

The collected information has contributed to drafting the corresponding chapters of the report. An additional section, Part B, is dedicated to initiatives and projects implemented at the territorial level, aimed at assessing the impact of such initiatives on service integration.

The questions are formulated in open and closed formats, often including multiple-choice options or binary responses (yes/no), with dedicated spaces for further explanations and regulatory references. Most of the questions aim to gather objective data, attesting to the presence or absence of specific elements under investigation, while others solicit personal opinions, inviting respondents to express their evaluations. The following is the text of the questionnaire.

YOUR PERSONAL DATA

Name:
Surname:
Title:
Region:
Department:
Email:
Phone number:

PART A: REGIONAL AND AUTONOMOUS PROVINCE CONTEXT

A.1. Multidimensional assessment systems

A.1.1 In your region/autonomous province, is there specific legislation for dependency? Report regional regulations and documents derived from these regulations (e.g. policy documents and regulations)

☐ Yes, please provide further details:

State the source:

☐ No

A.1.2 Is there a multidimensional assessment (SVM) tool in your region/autonomous province to identify the needs of the dependent population? Select all possible answers.

1. For the multidimensional assessment of dependent persons over 65 years of age

☐ Yes, SVaMA (Multidimensional Assessment Form for Adults and Elderly Individuals)
☐ Yes, SVAMDi (Form for Multidimensional Assessment of Individuals with Disabilities)
☐ Yes, InterRAI-HC (InterRAI-Home Care)
☐ Yes, ValGraf (GRAPHIC EVALUATION)
☐ Yes, RUG (Resource Utilisation Group)
☐ Yes, AGED (Assessment of Geriatric Disabilities)
☐ Yes, Geriatric Depression Scale
☐ Yes, Short Portable Mental Status Questionnaire
☐ Yes, Bina
☐ Yes, a regional tool integrated with other previous instruments
☐ Yes, other:
☐ Yes, but the type of system adopted depends on the district/municipality

☐ No, but an SVM will be introduced starting:

☐ No, and there are no plans to introduce an SVM yet

2. For the assessment of people with disabilities

☐ Yes, SvaMA (Multidimensional Assessment Form for Adults and Elderly People)

☐ Yes, SVAMDi (Form for Multidimensional Assessment of Individuals with Disabilities)

☐ Yes, InterRAI-HC (InterRAI-Home Care)

☐ Yes, ValGraf (GRAPHIC EVALUATION)

☐ Yes, RUG (Resource Utilisation Group)

☐ Yes, AGED (Assessment of Geriatric Disabilities)

☐ Yes, Geriatric Depression Scale

☐ Yes, Short Portable Mental Status Questionnaire

☐ Yes, Bina

☐ Yes, a regional tool integrated with other previous instruments

☐ Yes, other:

☐ Yes, but the type of system adopted depends on the district/municipality

☐ No, but an SVM will be introduced starting:

☐ No, and there are no plans to introduce an SVM yet

The most relevant normative references, concerning the introduction of the indicated multidimensional assessment system, are given below:

A.1.3 Is the multidimensional assessment system used to assess the need for care in a specific delivery setting (e.g. assisted living residences, nursing homes), or is it preparatory to the definition of an Integrated Care Pathway that includes assistance services in the contexts most suitable to the needs of the dependent individual? Select only one answer.

☐ Specific by delivery context (please specify to which delivery context it applies:)

☐ Holistic assessment for defining a care pathway in the most appropriate setting

☐ Both

A.1.4 Which professionals are assigned to conduct a multidimensional assessment? Select all possible answers. If necessary, distinguish by target population (elderly population vs. population with disabilities).

1. For the multidimensional assessment of dependent persons over 65 years of age

If the regulations provide for a minimum core of professionals in both the social and health sectors needed to conduct a multidimensional assessment, please indicate below the professionals included in that core:

☐ Social worker

☐ Social and health worker

☐ Nursing staff

☐ General practitioner

☐ Geriatrician

☐ Educator

☐ Physiatrist

☐ Psychiatrist

☐ Neurologist

☐ Psychologist

☐ Other medical specialists (please specify:)

☐ Other:

If, in addition to the minimum core indicated above, based on the type of case treated, additional professionals can carry out the multidimensional assessment, please indicate them below:

☐ Social worker

☐ Nursing staff

☐ General practitioner

☐ Geriatrician

☐ Educator

☐ Physiatrist

☐ Psychiatrist

☐ Neurologist

☐ Psychologist

☐ Other medical specialists (please specify:)

☐ Other:

2. For the assessment of people with disabilities

If the regulations provide for a minimum core of professionals in both the social and health sectors needed to conduct a multidimensional assessment, please indicate below the professionals included in that core:

☐ Social worker

☐ Social and health worker

☐ Nursing staff

☐ General practitioner

☐ Free-choice paediatrician

☐ Educator

☐ Physiatrist

☐ Psychiatrist

☐ Neurologist

☐ Psychologist

☐ Other medical specialists (please specify:)

☐ Other:

If, in addition to the minimum core indicated above, based on the type of case treated, additional professionals can carry out the multidimensional assessment, please indicate them below:

☐ Social worker

☐ Social and health worker

☐ Nursing staff

☐ General practitioner

☐ Free-choice paediatrician

☐ Educator

☐ Physiatrist

☐ Psychiatrist

☐ Neurologist

☐ Psychologist

☐ Other medical specialists (please specify:)

☐ Other:

A.1.5 If the assessment is carried out by different professionals at separate times, are there opportunities for co-operation among professionals in the multidimensional assessment process?

☐ Yes (report collaboration modes here:)

☐ No

A.1.6 Where is the assessment conducted? Select all possible answers.

☐ At Single AccessPoints (PUAs)

☐ In nursing homes

☐ In hospitals

☐ In the home of the dependent person

☐ In the community hospital

☐ Other residential and semi-residential facilities (social welfare and social health)

☐ Remotely using telemedicine tools

☐ Other:

A.1.7 Who has the authority to initiate the request for a multidimensional assessment? Select all possible answers.

☐ The general practitioner

☐ The medical specialist

☐ The free-choice paediatrician

☐ The dependent person or a family member by going directly to a PUA

☐ Social worker

☐ Community nurse

☐ Home nursing service

☐ Other:

A.1.8 Does the role of operator exist in the Autonomous Region/Province?

☐ Yes (please indicate which type of practitioners play this role, for example, general practitioners or community nurses):)

☐ No

A.1.9 When is the evaluation conducted? Select all possible answers.

☐ Only once before accessing services, to define the needs of the dependent person

☐ On a regular basis to reassess needs

☐ On an infrequent basis, at the discretion of the case manager or other professionals caring for the dependent person, to reassess needs

☐ At the request of the caregiver and/or the dependent person

☐ Other:

A.1.10 Does the Autonomous Region/Province have a low/high classification of care needs for dependent persons?

☐ Yes

☐ No

A.1.11 How is the care need (low/high) of elderly (≥65 years) dependent individuals defined in your region/autonomous province?

If there is a need assessment scale, please report it along with the definition

Definition of *low* need care:

Definition of *high* need care:

State the source:

A.1.12 How is the level of disability (severe/very severe) defined, in your region/autonomous province?

If there is a rating scale for the level of disability, report it along with the definition

Definition of disability:

Severe disability definition:

Very severe disability definition:

State the source:

A.2. Integration of home healthcare, social healthcare, and social services

A.2.1 How does the regional and autonomous province context facilitate the integration of healthcare, social healthcare, and social services in the home? Select all possible answers.

☐ Area-level governance tools (e.g. Territorial Activity Plan, inter-institutional agreements, and integrated planning between health districts and ATS)

☐ Co-planning tools as defined by Decree no. 72/2021

☐ Funding for the implementation of projects on social and healthcare integration, or other projects that have a significant impact on social and healthcare integration

☐ Training activities for public service, voluntary and Third Sector workers

☐ Integrated training activities among health and social professionals

☐ Multi-professional audit systems

☐ Other:

Please specify which ones:

A.2.2 How do you rate the level of integration of Integrated Home Care with Home Support Services (SAD)?

☐ Widely improvable

☐ Mediocre

☐ Sufficient

☐ More than enough

☐ Adequate

Please justify your answer:

A.2.3 What services can be received in the home as part of Home Assistance Services (SAD)? Select all possible answers.

☐ Support in performing personal care activities (**e.g.**., washing, dressing, grooming, preparing meals)

☐ Support in household activities

☐ Support carrying out activities outside the home (e.g. managing financial resources, liaising with other social and health services, running errands)

☐ Other:

A.2.4 What challenges/critical issues does ADI face in your region/autonomous province today?

A.2.5 What are the challenges/critical issues facing SAD in your region/autonomous province today?

A.2.6 Are there any critical issues that hinder the integration of home healthcare, social healthcare, and social services?

☐ Yes (indicate which ones)

☐ No

A.2.7 What are the strengths and major critical issues of the implementation path of Decree no. 77 of May 23, 2022 at the regional level (Regulations establishing models and standards for the development of territorial care in the national health service)?

A.3. Information systems

A.3.1 What management-type information systems (e.g. electronic health record, computerised social records) are in use in your region/autonomous province to collect data on healthcare, social healthcare, and social interventions delivered in the home and/or the dependent population?

Please report the information systems in use in your region/autonomous province, specifying whether they are distinguished by healthcare and social sector:

A.3.2 What data are collected through these regional/provincial information systems? Select all possible answers.

☐ Access to SAD services

☐ Type of SAD services

☐ Quality of SAD services received

☐ Intensity of SAD services received (e.g. number of SAD interventions received)

☐ Other data collected

☐ Access to ADI services

☐ Type of ADI services

☐ Number of ADI services received

☐ Intensity of ADI services received (e.g. number of ADI interventions received)
☐ Other data collected

Please provide further details and include links to explanatory documentation:

A.3.3 What breakdowns are available for the data shown in the previous question? Select all possible answers.

For data regarding health services
☐ Age group
☐ Level of disability
☐ Dependency
☐ Other (specify)
☐ No disaggregation

For data regarding social services
☐ Age group
☐ Level of disability
☐ Dependency
☐ Other (specify)
☐ No disaggregation

Please provide further details:

A.3.4 From which entities is these data collected? Select all possible answers.

Social services:
☐ Municipalities
☐ ATS
☐ Other (specify)

Health services:
☐ Health Districts
☐ USL
☐ Other (specify)

Please provide further details:

A.3.5 How often is aggregate/summarised data transmitted to higher levels of

governance?

For data regarding health services

Transmission to the national level

☐ Real-time
☐ Every month
☐ Every quarter
☐ Every year
☐ With unsystematic frequency

Transmission to the regional (or autonomous province) level

☐ Real-time
☐ Every month
☐ Every quarter
☐ Every year
☐ With unsystematic frequency

For data regarding social services

Transmission to the national level

☐ Real-time
☐ Every month
☐ Every quarter
☐ Every year
☐ With unsystematic frequency

At the regional (or autonomous province) level

☐ Real-time
☐ Every month
☐ Every quarter
☐ Every year
☐ With unsystematic frequency

A.3.6 Are management information systems on healthcare, social healthcare, and social interventions integrated with each other?

☐ Yes, for all services (please provide details)
☐ Yes, for ADI and SAD home services (provide details)
☐ Yes, for other services (please provide details)
☐ No

Please provide further details:

A.3.7 Is there a single integrated information system at the regional level?

☐ Yes, please specify which one:

☐ No

A.3.8 What factors hinder the full integration of information systems for healthcare, social healthcare, and social interventions? What measures are/could be put in place to overcome these obstacles? Select all possible answers.

☐ Privacy issues

☐ Lack of appropriate technical/information technology tools

☐ Low political priority

☐ Other

Please provide further details on your answer:

Please report what measures are/could be put in place to overcome these obstacles

A.3.9 If the electronic health record is active in your region/autonomous province, what were the main challenges in its implementation? If possible, also report how these challenges were overcome. Select all possible answers.

☐ Privacy issues

☐ Lack of funds

☐ Low political priority

☐ Resistance on the part of health service providers

☐ Lack of personnel

☐ Lack of training

☐ Lack of appropriate technical/information technology tools

☐ Other:

☐ No, the electronic health record is not active

Please provide further details on your answer:

If possible, also report how these challenges were overcome

A.3.10 Is there a computerised social record in use in your region/autonomous province?

☐ Yes, the computerised social record has been in use throughout the region since (insert year here:)

☐ Yes, the computerised social record is in use in some municipalities (if possible, please list the municipalities that use it)

☐ Yes, but it is currently in the experimental stage

☐ No, but there are guidelines and/or strategic plans to begin implementation of computerised social records

☐ No

Please provide further details on your answer:

A.3.11 If the computerised social record is in use, how was the implementation process? Select all possible answers.

☐ Implementation is managed entirely by the municipality

☐ Implementation is entrusted to a private entity

☐ The implementation process included mandatory training for municipal social service workers

☐ The implementation process included a substantial investment to modernise the computer system available to municipal social services

☐ Other:

Please provide further details on your answer:

A.3.12 What are the main obstacles to the implementation and use of computerised social records? Select all possible answers.

☐ Privacy issues

☐ Lack of funds

☐ Low political priority

☐ Resistance from social service workers

☐ Lack of personnel

☐ Lack of training

☐ Lack of appropriate technical/information technology tools

☐ Other:

Please provide further details on your answer:

A.4. The informal sector

The informal sector consists of family caregivers (as recognised by the 2018 Budget Law) and Personal/Family Caregivers (caregivers).

A.4.1 Is there any regional legislation that provides for and defines the figure of *family caregiver*?

☐ Yes (insert normative references here):

☐ No

A.4.2 In addition to the forms of support provided at the national level, are there other forms of regional support to support the family caregiver in their activity? Select all possible answers.

☐ Paid leave

☐ Unpaid leave

☐ Financial incentives

☐ Monetary disbursements

☐ Training courses

☐ Information desks

☐ Psychological support

☐ Respite interventions

☐ Other

☐ No

Please provide further details on your answer:

A.4.3 Are there any training sessions during which information can be received on the issues inherent to the persons being cared for and the rights of caregivers and family assistants?

☐ Yes

☐ No

Please provide further details on your answer:

A.4.4 Is there any regional/provincial legislation that provides for and defines the position of personal/family assistant?

☐ Yes (insert normative references here):

☐ No

A.4.5 At the regional level, are there tax incentives and/or economic supports to encourage families to hire a personal/family assistant with a formal contract?

☐ Yes, please provide details:

☐ No

A.4.6 Is there a regional public registry of personal/family assistants?

☐ Yes, please indicate name and link:
☐ No

A.4.7 If there is one, what are the requirements to access it? Select all possible answers and report details where necessary

☐ Relevant qualification or degree
☐ Previous work experience in caregiving
☐ Knowledge of the Italian language
☐ Residence rights in Italy
☐ Being over 18
☐ Other:

Please share the link to the documentation:

A.4.8 Are there training activities for personal/family Assistants? Select all possible answers.

☐ Yes, provided by the autonomous regions/province
☐ Yes, provided by municipalities
☐ Yes, provided by the Third Sector
☐ Yes, provided by other agencies:
☐ No

Indicate the number training hours

A.4.9 How many personal assistants (caregivers) and family caregivers are there in your region/autonomous province? If there are estimates of personal assistant numbers that do not emerge from official data, please report both numbers

Number of personal assistants (caregivers):
Reference year:
Source:

Number of family caregivers:
Reference year:
Source:

Number of family caregivers and personal assistants:
Reference year:

Source:

☐ These data are not available

PART B: INITIATIVES/PROJECTS ACTIVATED AT THE TERRITORIAL LEVEL

This part of the questionnaire aims to collect information on initiatives/projects activated at the territorial level inherent in the integration of home healthcare, social healthcare, and social services for dependent persons (e.g. social prescribing[61], or other initiatives/projects that aim to improve integration between healthcare and social services). Complete a sheet for each of the three most relevant initiatives/projects in terms of population served, innovative character, and results achieved.

B.1 In your Autonomous Region/Province, are there examples of initiatives aimed at improving the level of integration of home healthcare, social healthcare, and social interventions for dependent individuals? Select all possible answers.

☐ Yes, at the regional (or autonomous province) level

☐ Yes, at the municipal level

☐ Yes, at the corporate level

☐ No

Initiative No. 1

Title/name of initiative:	
Start year:	
End year:	☐ Initiative still ongoing
Brief description of the initiative:	
Brief description of the context (e.g. target territory in which the project is being developed, description of pre-existing experiences)	
Reference standards	☐ Dependent population ☐ Individuals with disabilities ☐ Elderly population (age > 65 years) Other:
Number of subjects enrolled:	

---

[61] Social prescribing, sometimes also known as "community referral," is a means for health care providers to refer people to a range of local non-clinical services **Invalid source specified.**.

Brief description of the purpose of the initiative:	
Brief description of expected results:	
Brief description of the tools and processes used for the governance model:	
What are the critical success factors of the initiative and what are the strengths of the initiative?	
How can integration initiatives on the ground be improved?	
What factors have hindered the implementation of the initiative and what critical issues might arise in the future?	
Have integrated social and health care processes been activated, with common goals, tools and organisational arrangements?	☐ Yes, please describe how ☐ No
Have training activities been conducted for service, voluntary, Third Sector, and informal sector workers?	☐ Yes, please describe the training modules , state training hours, and list the recipients ☐ No
Have telemedicine intervention delivery models been introduced?	☐ Yes, please describe the interventions and who provided these interventions ☐ No
Has the Third Sector been involved (e.g. co-programming, co-design)?	☐ Yes, please describe how ☐ No
Have community outreach networks been activated?	☐ Yes, please describe how ☐ No
Has the impact of the initiative been monitored and assessed?	☐ Yes, please describe the data used for monitoring and impact assessment: , and cite sources here ☐ No
Has the transferability of the initiative to other contexts been assessed?	

Has the long-term sustainability of the initiative been assessed?	

Initiative No. 2

Title/name of initiative:	
Start year:	
End year:	☐ Initiative still ongoing
Brief description of the initiative:	
Brief description of the context (e.g. target territory in which the project is being developed, description of pre-existing experiences)	
Reference standards	☐ Dependent population: ☐ Individuals with disabilities ☐ Elderly population (age > 65 years) Other:
Number of subjects enrolled:	
Brief description of the purpose of the initiative:	
Brief description of expected results:	
Brief description of the tools and processes used for the governance model	
What are the critical success factors of the initiative and what are the strengths of the initiative?	
How can integration initiatives on the ground be improved?	
What factors have hindered the implementation of the initiative and what critical issues might arise in the future?	

Have integrated social and health care processes been activated, with common goals, tools and organisational arrangements?	☐ Yes, please describe how ☐ No
Have training activities been conducted for service, voluntary, Third Sector, and informal sector workers?	☐ Yes, please describe the training modules , state training hours, and list the recipients ☐ No
Have telemedicine intervention delivery models been introduced?	☐ Yes, please describe the interventions and who provided these interventions ☐ No
Has the Third Sector been involved (e.g. co-programming, co-design)?	☐ Yes, please describe how ☐ No
Have community outreach networks been activated?	☐ Yes, please describe how ☐ No
Has the impact of the initiative been monitored and assessed?	☐ Yes, please describe the data used for monitoring and impact assessment: , and cite sources here ☐ No
Has the transferability of the initiative to other contexts been assessed?	
Has the long-term sustainability of the initiative been assessed?	

Initiative No. 3

Title/name of initiative:	
Start year:	
End year:	☐ Initiative still ongoing
Brief description of the initiative:	
Brief description of the context (e.g. target territory in which the project is being developed, description of pre-existing experiences)	
Reference standards	☐ Dependent population:

	☐ Individuals with disabilities ☐ Elderly population (age > 65 years) Other:
Number of subjects enrolled:	
Brief description of the purpose of the initiative:	
Brief description of expected results:	
Brief description of the tools and processes used for the governance model	
What are the critical success factors of the initiative and what are the strengths of the initiative?	
How can integration initiatives on the ground be improved?	
What factors have hindered the implementation of the initiative and what critical issues might arise in the future?	
Have integrated social and health care processes been activated, with common goals, tools and organisational arrangements?	☐ Yes, please describe how ☐ No
Have training activities been conducted for service, voluntary, Third Sector, and informal sector workers?	☐ Yes, please describe the training modules , state training hours, and list the recipients ☐ No
Have telemedicine intervention delivery models been introduced?	☐ Yes, please describe the interventions and who provided these interventions ☐ No
Has the Third Sector been involved (e.g. co-programming, co-design)?	☐ Yes, please describe how ☐ No
Have community outreach networks been activated?	☐ Yes, please describe how ☐ No

Has the impact of the initiative been monitored and assessed?	☐ Yes, please describe the data used for monitoring and impact assessment: , and cite sources here ☐ No
Has the transferability of the initiative to other contexts been assessed?	
Has the long-term sustainability of the initiative been assessed?	

Participation

18 regions and autonomous provinces responded to the survey (non-respondents: Campania, Molise and Sardinia), providing comprehensive information in most cases. However, some respondents were only able to provide limited data, depending on the circumstances, in the social or healthcare sectors, given the difficulties in ensuring the necessary interdepartmental co-ordination for a shared completion of the questionnaire. One area where the information available to respondents was particularly lacking concerned the quantification of personal assistants and family caregivers present in the region or autonomous province concerned (question A.4.9). This is also reflected in the completion of Part B of the questionnaire, with descriptive sheets on current integration practices provided by 8 entities: Emilia-Romagna, Friuli-Venezia Giulia, Liguria, Marche, Autonomous Province of Trento, Puglia, Umbria and Veneto.

Annex B. Social prescribing. National case studies

Canada

The landscape and prevalence of social prescribing in Canada is diverse. Although social prescribing has not yet been universally implemented, there are many programmes, services and initiatives that focus on connecting individuals to non-clinical support interventions that promote a person-centred approach to improving their health and well-being. These initiatives vary in size, approach, and target audience and are tailored to meet the specific needs of communities.

Box B.1. Stages of social prescribing in Canada

The entry stage includes the various points through which an individual can enter the social prescribing pathway. Entry points vary by initiative and may include primary care, community and social services, or self-referral.

The linkage phase refers to the time when an individual co-creates a care plan that may include referral to resources that support their well-being. It also highlights the dynamic role of the case manager and their role within the referral process.

The Waiting phase illustrates how an individual can engage with supports and activities that improve their health and well-being. Services can help support social inclusion, physical fitness, mental health, financial well-being, food security and community connectedness.

The follow-up phase illustrates the ongoing communication between a connector and an individual in order to evaluate the care plan. In this phase, an evaluation of the results can also be conducted at the initiative level.

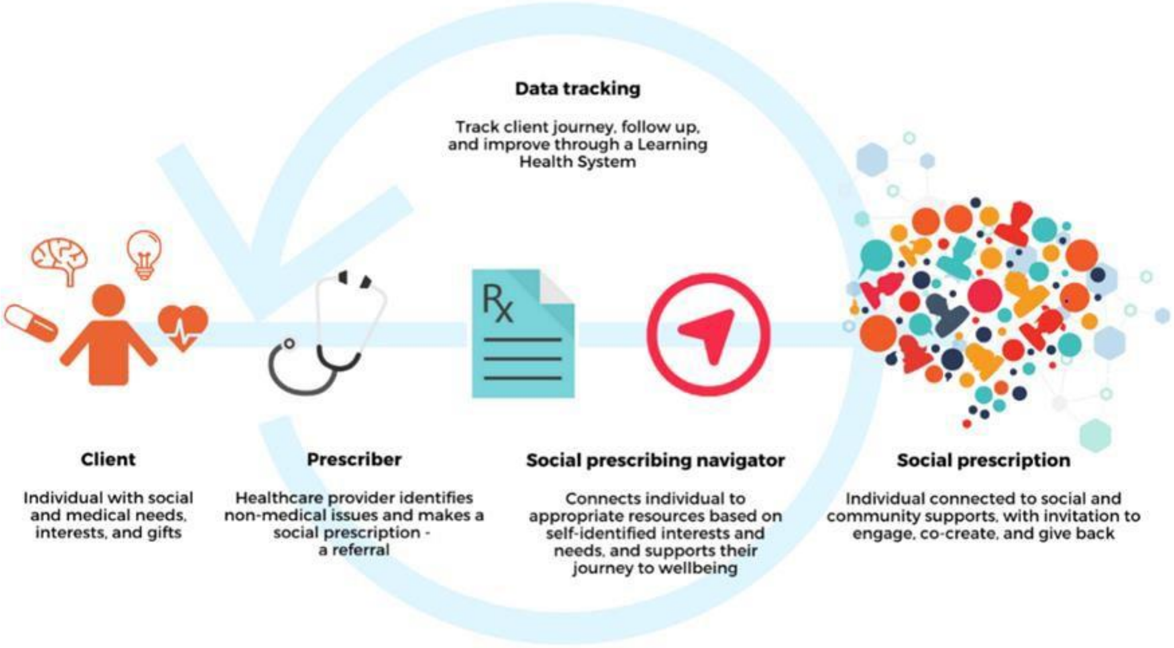
The exit phase illustrates the various points at which an individual may choose to exit the social prescribing pathway, taking into account a possible future re-entry into the social prescribing pathway

Source: (Bridgeable, 2022).

The path of social prescribing also varies among provincial, regional, and local initiatives. It consists of five main stages: entry into the referral pathway, connection with a referral source, participation in a social prescribing programme or service, follow-up by a dedicated individual, and a lukewarm or open exit from the program or service (Bridgeable, 2022) (Box B.1).

A report on social prescribing in Ontario (Alliance for Healthier Communities, 2020) identifies the five essential components of a social prescribing pathway: the individual, the prescriber, the social prescribing navigator, the social prescribing, and data monitoring (Figure B.1).

Figure B.1. Essential components of social prescribing in Ontario



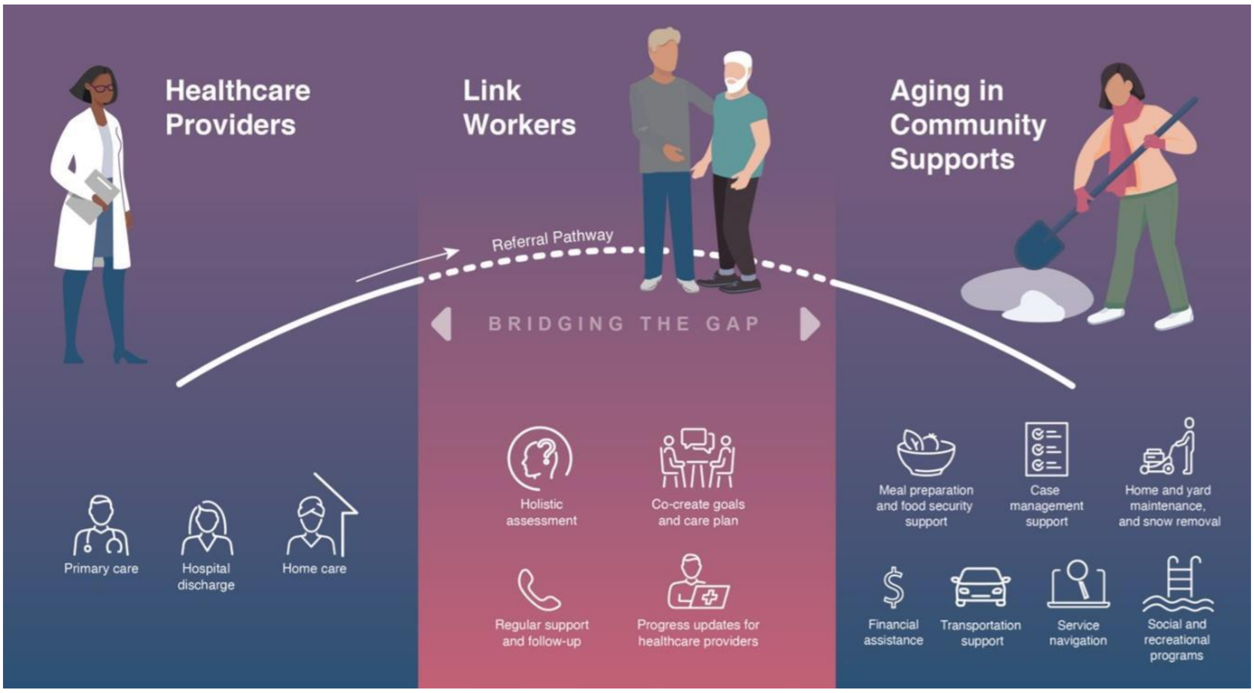
Source: Alliance for healthier communities, 2020

Nearly half of the people who participated in social prescribing initiatives in Ontario were between the ages of 61 and 80, were mostly women, and almost half of them lived on low incomes. Mental health was a key factor in social prescriptions, with anxiety and depression being the most frequent conditions. Social prescriptions have focused mainly on food security and housing support (Alliance for Healthier Communities, 2020).

An evaluation of social prescribing initiatives in Ontario, Canada, found that individuals reported an overall improvement in their mental health and increased ability to self-manage their health. Healthcare providers found social prescribing useful for enhancing individuals' well-being and reducing repeat visits. Social prescribing also facilitated greater integration between clinical care, inter-professional teams, and social support. (Alliance for Healthier Communities, 2020)

Healthy Aging Alberta's social prescribing programme for seniors currently supports 10 regional social prescribing demonstration projects. Healthy Aging Alberta distributes funding to social prescribing networks in these communities, which determine how to functionally incorporate social prescribing pathways into their community in a way that conforms to the principles established by Healthy Aging Alberta. Each of these communities has at least one link worker who receives referrals from primary health care, home care, and hospital discharge providers (https://corealberta.ca/reFontes/a-prescription-for-change). Link workers are non-clinical professionals employed by community-based organisations for older adults who help individuals develop and achieve a range of personalised goals by accessing community resources and supplementing healthcare with additional supportive intervention. Link workers connect individuals with recreational and social programmes, assist them in accessing financial benefits and provide referrals to assisted transportation programmes. They also connect them with home care services, such as household cleaning and snow removal. Link workers also refer more complex problems to social workers who are part of the social prescribing network in the community (Figure B.2).

Figure B.2. Social prescribing in Alberta: connecting health care providers to community-based services for the elderly



Source: https://calgaryunitedway.org/healthy-aging-alberta/social-prescribing/.Source : https://calgaryunitedway.org/healthy-aging-alberta/social-prescribing/:

The Canadian Institute for Social Prescribing is a network that supports people involved or interested in social prescribing, created by the federal government in 2022. Its main goal is to support, scale and spread emerging practices across the country. According to the Institute, the core principles of social prescribing include (www.socialprescribing.ca):

- a supportive bridge between healthcare and community-based non-clinical services and support
- a person-centred approach in which solutions are co-created based on what matters to individuals
- follow-up with individuals, health care providers, and community and social service organisations
- data collection and monitoring.

Challenges to connecting vulnerable people to their communities include the need to develop a learning-based approach to health systems, with useful indicators to help learn and improve what works best and who benefits most, addressing stakeholder concerns about the health system's role in addressing social problems, and ensuring sufficient resources and relationships to support the community sector at the heart of social prescribing.

England

In 2019, NHS agencies announced a new national strategy for the NHS in England – the Long Term Plan – to focus on developing more integrated models of social and healthcare and improving disease prevention. To achieve this goal, the Long Term Plan proposed an additional investment of £4.5 billion in primary care and community health services.

The plan included new contracts to incentivise practices to form primary care networks (PCNs), groups of practices covering a population of approximately 30,000 to 50,000 people. Although the participation of primary care physicians was voluntary, the financial incentives to form PCNs were powerful, as most of the additional funds available for primary care promised in the Long Term Plan were available only through PCNs. The result has been widespread adoption: almost all GP practices in England formed approximately 1,250 PCNs. PCNs are required to provide national service specifications, ranging from structured drug review to improving early cancer detection. PCNs also need to improve co-ordination between primary care and broader community services. PCNs receive annual core funding to support operations (£1.50 per registered patient), payment for a clinical director, and payments for extended service hours. Additional funds have also been made available to PCNs to pay for more staff in outpatient clinics, including link workers for social prescribing, clinical pharmacists, and paramedics. Individual clinics also receive a weighted participation payment per patient.

A standard model of social prescribing has been developed by NHS England in collaboration with stakeholders (Figure B.3), which shows the key elements of a good social prescribing programme and the elements that need to be in place locally (NHS England, 2023).

Figure B.3. NHS England's social prescribing model

Source: NHS England https://www.england.nhs.uk/wp-content/uploads/2020/06/social-prescribing-summary-guide-updated-june-20.pdf.

PCN funding is the main funding mechanism for the national expansion of social prescribing. NHS England reimburses the salary, pension and national insurance contributions of one link worker per PCN (maximum £34,113). NHS England predicted that this would support more than 1,000 link workers by the end of 2020 and that 900,000 patients would be referred to social prescribing programmes by the end of 2024. NHS data show that 852 link workers had been hired by the end of 2020, although only 60% of PCNs had reported data. The number of link operators has increased to approximately 1,200 by June 2021. In addition to the new link workers, primary care physicians in some areas had already developed social prescribing programs prior to the arrival of PCNs and the roles of link workers, with a mix of staff performing them. Additional financial incentives were also introduced to encourage clinics to increase the number of referrals for social prescribing.

The PCN network contract defines the responsibilities of the link worker (Box B.2). PCNs are responsible for identifying the first point of contact to advise link workers and a primary caregiver for supervision. Referrals to link workers must be documented in the family physician's electronic medical record using the new national SNOMED codes. PCNs may also subcontract with community organisations to train and manage link workers.

Box B.2. Key responsibilities of social prescribing link workers

Responsibilities of link workers towards patients:

- Assess the health and wellness needs of patients.
- Co-produce individualised care and support plans to connect patients with community resources.
- Evaluate whether the actions described in the personalised plan meet patients’ needs.
- Provide individualised support to individuals, their families and caregivers.
- Develop trusting relationships with patients, focus on "what matters to them", and take a holistic approach based on patient priorities.

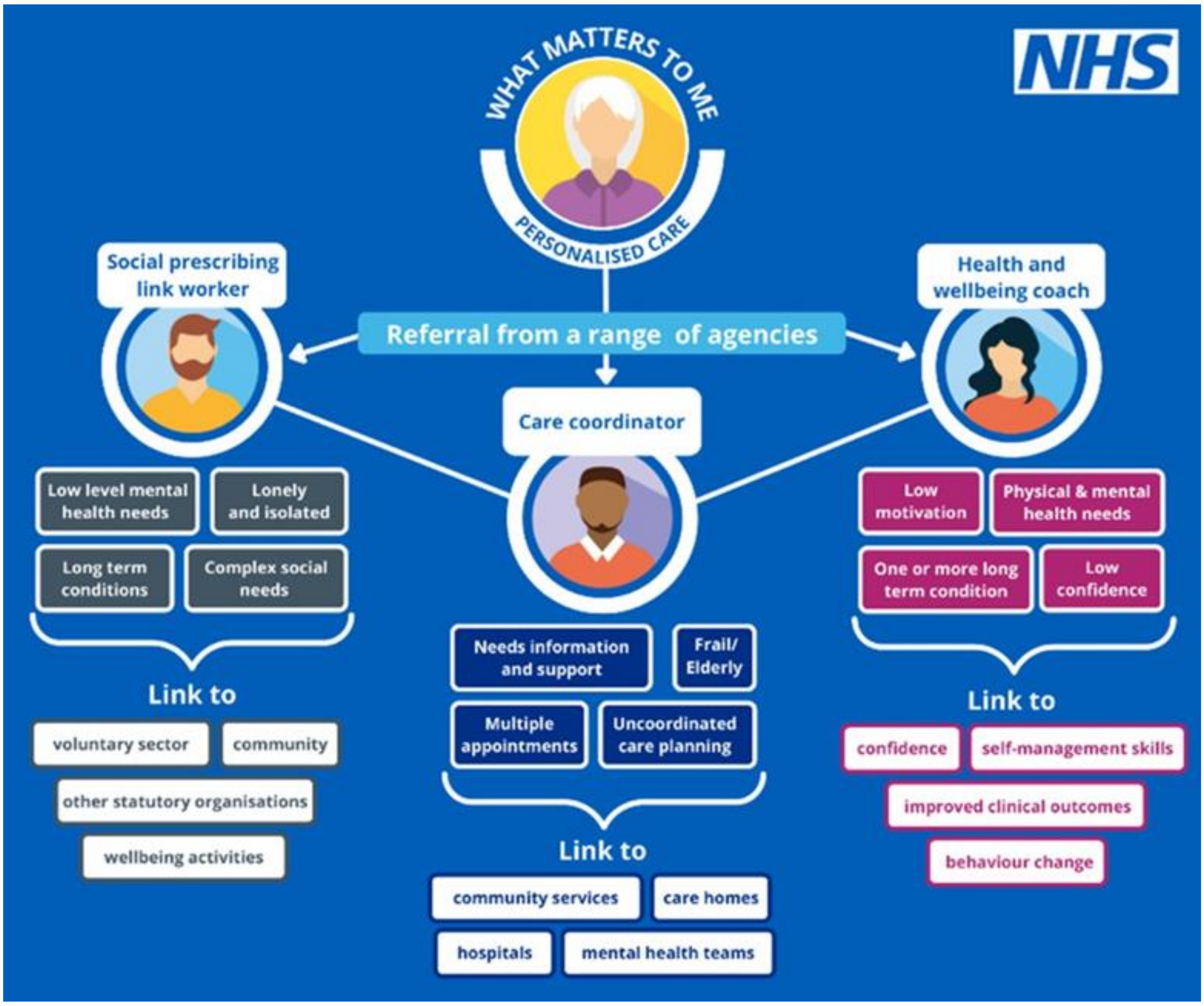
Broader responsibilities of link workers:

- Manage and prioritise workload.
- Take in reports from PCN members and a wide range of health and social service agencies.
- Collaborate with community organisations to receive social prescribing requests.
- Share information about any gaps or problems in community services with principals and local authorities.
- Educate clinical and non-clinical staff about available community services.

Source: (NHS England, 2023).

Link workers also work closely with other personalised care roles, including health and wellness coaches and care coordinators (NHS England 2023). All three of these roles have expertise in personalised care approaches and in working with people to understand their situation and needs, but each has a distinct role and expertise (Figure B.4).

Figure B.4. The role of the link worker in the personalised care pathway



Source: (NHS England, 2023)

Because social prescribing is managed at the local level, different approaches to evaluating and measuring outcomes have emerged in England. To encourage consistent data collection and outcome reporting, NHS England worked with a wide range of stakeholders to develop a Common Outcomes Framework to measure the impact of social prescribing. Working with a wide range of stakeholders, a consensus was reached for all social prescribing programmes to measure the following outcomes:

- Impact on the person, how the person's well-being has improved, whether they are less lonely, feel more in control, and have a better quality of life.
- Impact on the health and welfare system A data summary published by the University of Westminster (Polley & Pilkington, 2017) suggests that when a person receives support through social prescribing, their GP consultations are reduced by an average of 28%, and emergency room visits are reduced by 24%.
- Impact on community groups: NHS England and its partners have conducted periodic surveys on the trust of local community groups to share the ability of community groups to welcome new individuals through social prescribing, assess the number of local volunteers, identify gaps in community offerings, and facilitate the deployment of new community supports.

Rigorous evaluation will be critical to understanding the effectiveness and any unintended consequences of different approaches. The new Social Prescribing Observatory, launched by the Royal College of General Practitioners and the University of Oxford, may be a useful tool to support these efforts. Using data from electronic health records, it provides weekly updates on social prescribing volume. Between January and September 2020, observatory researchers estimated that 250,000 social prescriptions were recorded using the SNOMED codes specified in the primary care network guide.

No evidence is available to support link workers (Kiely, et al., 2022), partly because this approach takes time to develop, take root, and evolve (Westlake, Tierney, Wong, & Mahtani, 2023).

Portugal

The social prescribing model

Social prescribing in Portugal has developed as a multifaceted approach, initiated by Dr Cristiano Figueiredo in 2018. The movement gained momentum with a pilot project in two local health units in Lisbon (Box B.3), demonstrating strong political commitment as evidenced by funding from the mayor of Lisbon to evaluate the pilot project in August 2020. The conceptual framework of social prescribing recognises the holistic nature of health, moving beyond clinical needs to include socioeconomic resources, positive social relationships, and access to health services. The overarching goal is to connect the concepts of illness and care to various resources and to respond innovatively to patient needs.

Box B.3. The social prescribing pilot project in Portugal

The first social prescribing project in Portugal was launched in two Local Health Units - Baixa and Almirante - located in central Lisbon, providing healthcare to approximately 27,500 patients with a high variability of socio-demographic characteristics. All users registered in these primary healthcare units can be referred to social prescribing, except for patients with severe and uncontrolled mental health problems. Intervention begins when a health professional (primary care physician, nurse practitioner, or psychologist), during an appointment with a patient, identifies social needs, particularly related to social isolation, immigrant integration, mental health, physical activity, employment and training, or housing problems. The healthcare provider then makes an internal referral through an online social prescribing platform to the linking operator, who, in the Portuguese context, is the unit's social worker. In this platform, the health care provider enters the reasons for referral, the presence of chronic diseases, and a brief history of the patient. The patient is then invited to make an appointment with the social worker to continue social prescribing support. The social worker conducts a needs assessment and helps the patient identify problems that affect their health and well-being. The social worker then works with the patient to develop an individualised intervention plan based on the person's priorities, interests, values, and motivations. This plan may include an external response provided by community partners within the geographic area of the health unit or at the request of the patient. In the next phase of the social prescribing pathway, the social worker refers the patient to key community partners. Communication between the social worker and community partners occurs via email, providing information on the patient's needs and the social partner's availability to respond, as well as through online forms to monitor the activities the patient participates in and the frequency of adherence. Throughout the duration of the social prescribing intervention, the social worker communicates with the patient through in-person appointments or phone calls to monitor adherence and satisfaction with the activity plan, and communicates with the healthcare provider to provide feedback on the patient's case. The number of appointments with the link worker depends on the needs of each user but typically consists of approximately 4-6 appointments per patient, although if necessary, more follow-up appointments can be arranged. The average length of an appointment is 30 minutes.

Source: (Hoffmeister, et al., 2021).

Portugal uses a primary care-based social prescribing model in which primary care physicians refer patients to social workers in Shared Care Resource Units (Box B.4). This model, integrated with more than 40 Third-Sector partners in Lisbon, goes beyond traditional pastoral care by involving social workers in personalised interventions during 30-minute patient consultations. As the social prescribing network expands, a training course in social prescribing for health workers, link workers, and community leaders is underway. An interview with stakeholders revealed that the main challenge in this framework is to address inequalities, exacerbated by the misuse of the term "social prescribing" in international networks, and the need to define legitimate initiatives.

Box B.4. The Portuguese integrated model of social prescribing

Portugal's social prescribing system takes an integrated approach. In this primary care-centred model, primary care physicians seamlessly refer patients to social workers in Shared Care Resource Units, incorporating social prescribing within primary care. The collaboration between primary care physicians, social workers, and Third-Sector partners expands the competencies of social workers to include lifestyle change, community engagement, mental health promotion, and personalised support, characteristics of a comprehensive and integrated model. Evaluation and monitoring of a local social prescribing pilot project in Lisbon emphasises evaluation of the impact of the intervention, reflecting alignment with evaluation principles associated with integrated social prescribing. The central role of social workers (link workers) in co-producing social prescriptions, identifying patients with social problems and facilitating referrals to community services closely reflects key elements of an integrated approach. The mention of a training course on social prescribing underscores the commitment to capacity building, which is consistent with the emphasis on integrating social workers into the health system in this context.

Source: (National Academy for Social Prescribing, 2023).

Monitoring and impact assessment

In August 2020, the mayor of Lisbon funded the NOVA School of Public Health to conduct the evaluation and monitoring of the local social prescribing pilot project.

NOVA PSOA (Research Group for the Implementation and Evaluation of Social Prescribing) promotes and supports activities related to the implementation and evaluation of social prescribing in Portugal through a participatory approach, involving various stakeholders and based on interdisciplinary research that strengthens and establishes new connections between the academic, healthcare, and social sectors. NOVA PSOA seeks to respond with consultancy services in the design and structuring of interventions, in mapping and engaging with community partners, in communication and dissemination strategies for the intervention, as well as in training activities for involved professionals, in addition to monitoring and evaluation activities (Hoffmeister, et al., 2021).

Overall, the analysis of the pilot project suggests that social prescribing has changed the traditional role of the social worker in health units in Portugal. Healthcare providers used to refer patients to the social work service when the problems were mainly related to administrative issues related to social and healthcare service access, such as assistance in purchasing medications, functional dependence, or end-of-life support. Social prescribing has expanded the role of the social worker in primary care to include counselling and support for lifestyle changes (physical activity, eating habits), community engagement, employment and training, mental health promotion, individualised emotional and social support, and linking people with community groups and statutory services. Within this framework, the difficulty of collecting quantitative data on the impact of social prescribing, particularly on health outcomes, remains, and the limited time available to health professionals often prevents comprehensive evaluations, resulting in predominantly qualitative evidence. Nevertheless, the potential benefits of social prescribing remain predominant, including addressing concerns about isolation of citizens, particularly vulnerable groups, and the recognition of social prescribing as a cross-cutting need for mental health and combating isolation.

The role of the link worker

Initially, the Portuguese primary care model relied on health professionals, such as nurses and psychologists, referring patients to link workers, social workers within the health sector. The main focus was on addressing problems related to chronic diseases and ageing. The concept has undergone a significant shift from viewing health exclusively through the lens of disease to a recognition of the role of social determinants of health, which has led to an expansion of the role of link workers. It is clear from Figure B.5 how link workers act as intermediaries, connecting patients with a range of community services or activities that are fully integrated with the social prescribing program. This dynamic process ensures a holistic approach to patients' needs, including a diverse range of services and activities aimed at promoting wellness and solving specific health problems.

Figure B.5. The role of the link worker in Portugal

Source: (National Academy for Social Prescribing, 2023).

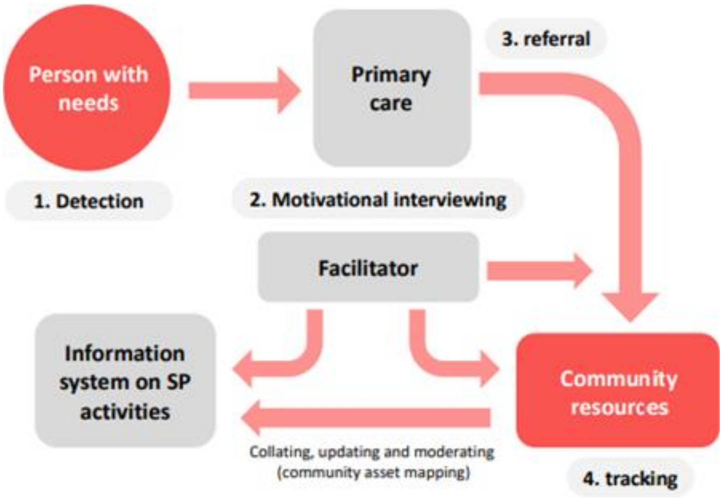
The imminent launch of the Portuguese Social Prescribing Network by the National School of Public Health will highlight the need to adapt social prescribing to the context and resources available. Given the impracticality of a universal model and the need for customised, context-specific approaches, social prescribing would benefit from being a local initiative, implemented at the unit level, rather than by national policy. Municipalities, which provide dynamic opportunities to address health beyond illness, have already taken an active role in coordinating projects, serving as a crucial link between the health and social sectors. Some municipalities have even created specific health units for their areas, improving responsiveness to people's needs with the aim of reducing the current pressure on the national health service. However, interviews conducted with stakeholders revealed the reluctance of municipalities to launch social prescribing initiatives due to a lack of awareness of how beneficial this practice can be to society with minimal resources. Indeed, social prescribing would involve an efficient reallocation of existing resources – such as integrating link workers into a broad network of professionals – rather than introducing a new resource-intensive figure. However, the challenge extends beyond financial aspects to include the need for political will to redistribute resources and train professionals for different roles.

Spain

The social prescribing model

Spain's regional autonomous communities contribute to the diverse implementation of social prescribing. In Catalonia, social prescriptions are integrated into patients' electronic medical records, with a list of community activities that can be filtered by topic. This allows for immediate reporting and follow-up by primary care physicians, nurses, or social workers. Introduced in 2012 as a pilot project, social prescribing in Catalonia has gradually expanded, developing explicitly from and for primary care, using the health assets model. The mapping of health assets is considered essential prior to programme implementation, emphasising the need for regular updating of available resources in the community. The success of social prescribing depends on collaborative efforts between primary care, public health, social services and the community, as evidenced by the programme's emphasis on synergy between the different sectors. The social prescription needs identified in the programme cover specific interventions, such as exercise and social interaction, group activities for women, and cultural integration for immigrants.

Figure B.6. The Spanish model of social prescribing



Source: (National Academy for Social Prescribing, 2023).

In the Spanish social prescribing model, the patient referral pathway is characterised by a structured three-step process (Figure B.6):

- Identification: at the initial stage, health professionals undertake a comprehensive identification process. This involves identifying patients who may benefit from social prescribing interventions, emphasising a proactive approach to recognising a spectrum of non-medical needs.
- Motivational interviewing: this interactive process fosters open communication between health care providers and patients with the goal of exploring individual motivations, preferences, and willingness to engage in social prescribing interventions. Emphasis is placed on understanding patients' perspectives to ensure a personalised and effective approach.
- Referral: after identification and the motivational interview, patients deemed eligible for social prescribing are formally referred to the appropriate community resources. This phase ensures a seamless transition from health facilities to community services.

A key aspect of this model is the continuous "monitoring" of available resources in the community through systematic mapping of services. The mapping process not only identifies currently available resources, but also considers the changing landscape of community services. Regular updates and evaluations are conducted with the aim of ensuring the relevance and effectiveness of the indicated services, strengthening the adaptability and sustainability of the social prescribing system in Spain.

Monitoring and impact assessment

The EvaLRA project (Pola-Garcia, 2023), developed in the Aragon region in northeastern Spain, aims to develop an evaluation model for social prescribing programmes in primary health care. The project has two phases:

- Identification of primary health care teams implementing social prescribing schemes and definition of an initial set of indicators to evaluate social prescribing using qualitative consensus techniques with experts
- Evaluation of relevance, feasibility, and sensitivity of selected indicators after 6 and 12 months in primary health care teams. The results provide a set of indicators that take into account the structure, process and outcomes of social prescribing programmes.

The project aims to provide a comprehensive set of indicators including structure, process, and outcomes for social prescribing programs. In addition, the initiative actively participates in conferences, increasing the visibility of the project and raising awareness of the need for a unified model of evaluation indicators.

The role of link workers

In Spain, GPs directly deliver social prescriptions, leveraging their ongoing relationship with patients to co-produce tailored interventions. The general sub-directorate for drug addiction organises an accredited 8-hour training programme for physicians to ensure accurate and appropriate referral. An additional 3-hour course enables referrers to act as "agents" within their health centres, disseminating information about social prescribing, explaining the intervention model and promoting its adoption within the clinic.

Annex C. Methodological note on Gap analysis

Governance

Indicator		Rating scale		Source
1.1	Existence of governance tools at the territorial level (e.g. Territorial Activity Plan, inter-institutional agreements, and integrated planning between health districts and ATS)	No tools	🟥	Questionnaire - Question A.2.1
		One tool	🟧	
		Multiple tools	🟩	
1.2	Co-planning tools as defined by Decree no. 72/2021	No tools	🟥	Questionnaire - Question A.2.2
		Consolidated co-programming initiatives	🟩	
1.3	Existence of projects on social and healthcare integration, or other projects that have a significant impact on social and healthcare integration.	No project reported	🟥	Questionnaire - Question B.1
		One or more ongoing projects	🟩	

Indicator 1.1 analyses the number of governance tools available to regions, including: the Territorial Activity Plan, inter-institutional agreements, and integrated planning between health districts and ATSs. It is divided into three categories: none of these tools (red), one tool (yellow), multiple tools (green).

Indicator 1.2 assesses the presence of co-programming tools, as defined by Decree no. 72/2021. The rating scale is binary, and the possible options are: "No tool", marked in red, or "Consolidated co-programming initiatives", in green.

Indicator 1.3 investigates the existence of social and healthcare integration projects, or other projects that anticipate a significant impact on social and healthcare integration. The rating scale is binary, and the possible options are: "No project", in red, or "One or more ongoing projects", in green.

Workforce

Indicator		Rating scale		Source
2.1	Number of professional categories and other actors entitled to initiate the request for a multidimensional assessment	0 to 3	🟥	Questionnaire - Question A.1.7
		4 to 6	🟧	
		7 to 8	🟩	
2.2		0 to 3	🟥	Questionnaire - Question A.1.4

	Number of professional categories involved in the assessment of the elderly population	4 to 7	🟧	
		8 to 11	🟩	
2.2	Number of professional categories involved in the assessment of the population with disabilities	0 to 3	🟥	Questionnaire - Question A.1.4
		4 to 7	🟧	
		8 to 11	🟩	
2.3	Presence of opportunities for discussion among professionals in the multidimensional assessment process	Yes	🟩	Questionnaire - Question A.1.5
		No	🟥	
2.4	Presence of the case manager role at the regional and provincial levels	Yes	🟩	Questionnaire - Question A.1.8
		No	🟥	
2.5	Presence of training pathways among the tools covered to facilitate integration	Yes	🟩	Questionnaire - Question A.2.1
		No	🟥	
2.6	Presence of integrated training pathways among the tools covered to facilitate integration	Yes	🟩	Questionnaire - Question A.2.1
		No	🟥	
2.7	Regional legislation that provides for and/or defines the figure of the family caregiver	Yes	🟩	Questionnaire - Question A.4.1
		No	🟥	
2.8	Regional forms of support provided to support the family caregiver in care activities	{{0;}} No	🟥	Questionnaire - Question A.4.2
		1 to 5	🟧	
		6 to 9	🟩	
2.9	Informational training for family caregivers to receive information on issues regarding the individuals being cared for and the rights of both care recipients and family caregivers	Yes	🟩	Questionnaire - Question A.4.3
		No	🟥	
2.10	Regional legislation that provides for and/or defines the figure of the personal/family assistant	Yes	🟩	Questionnaire - Question A.4.4
		No	🟥	
2.11	Tax incentives and/or economic support to encourage formally hiring personal/family assistants	Yes	🟩	Questionnaire - Question A.4.5
		No	🟥	
2.12	Regional public registry of personal/family assistants	Yes	🟩	Questionnaire - Question A.4.6

		No, but there are local public records	🟧	
		No	🟥	
2.13	Personal/family assistant training	Yes	🟩	Questionnaire - Question A.4.8
		No	🟥	

Indicator 2.1 measures the number of professional categories or other figures entitled to initiate the request for multidimensional assessment and is rated on a scale from a minimum of 0 to a maximum of 8 actors, which is: red if less than 3, yellow between 4 and 6, and green if greater than 7.

Indicator 2.2 measures the number of professional categories involved in the assessment of the elderly and disabled population and is rated on a scale from a minimum of 0 to a maximum of 11 actors, which is: red if less than 3, yellow between 4 and 7, and green if greater than 8.

Indicator 2.3 examines the presence of opportunities for discussion among professionals during the multidimensional assessment process. The rating scale is a binary, Yes/No type.

Indicator 2.4 examines the existence of a defined role of case manager at the regional and provincial levels. The rating scale is a binary, Yes/No type.

Indicator 2.5 examines the existence of training pathways among the tools adopted to facilitate the integration of home healthcare, social healthcare and social services. The rating scale is a binary, Yes/No type.

Indicator 2.6 examines the existence of integrated training pathways involving both healthcare and social work professionals. The rating scale is a binary, Yes/No type.

Indicator 2.7 assesses whether regional regulations clearly recognise and define the figure of the family caregiver. The rating scale is a binary, Yes/No type.

Indicator 2.8 analyses the availability of regional forms of support to support caregivers. The rating scale ranges from a minimum of 0 to a maximum of 9, where: zero corresponds to red, 1-5 is yellow and 6-9 is green. The support resources considered are paid leave, unpaid leave, financial incentives, monetary disbursements, training courses, information desks, psychological support, relief interventions, and more.

Indicator 2.9 evaluates the presence of dedicated training sessions for family caregivers focused on issues related to the assisted individuals and the rights of both the assisted individuals and family caregivers. The evaluation is done on a binary scale, where the presence of such training opportunities is indicated as "yes" or "no".

Indicator 2.10 assesses the existence of regional legislation establishing and defining the position of personal or family assistant. The evaluation is done on a binary scale, where the existence of such legislation is indicated as "yes" or "no".

Indicator 2.11 focuses on the existence of tax incentives and/or economic supports to promote the regular hiring of a personal or family caregiver. This indicator is evaluated using a binary scale, indicating the presence or absence of such economic supports in the region under consideration.

Indicator 2.12 examines the presence of a regional public registry of personal or family caregivers, that is, an official repository listing available personal or family caregivers in the region. The evaluation of this indicator is done on a scale with three response possibilities: "Yes", "No, but there are local public records", or "No".

Indicator 2.13 assesses the presence of specific training programmes for personal or family assistants. These programmes offer courses and training sessions aimed at improving the skills of caregivers in crucial areas of home care and nursing. The evaluation of this indicator is done on a binary scale, where the presence or absence of such programmes in the region under consideration is considered.

Information systems

Indicator		Rating scale		Source
3.1	Type of data collected through regional/provincial information systems	{{0;}} 1	🟥	Questionnaire - Question A.3.2
		2 3	🟧	
		4 5	🟩	
3.2	Available breakdowns	{{0;}} 1	🟥	Questionnaire - Question A.3.3
		2 3	🟧	
		4 5	🟩	
3.3	Frequency of aggregate/summarised data transmission at the national level and at the regional (or autonomous province) level	With unsystematic frequency	🟥	Questionnaire - Question A.3.5
		Annual	🟧	
		Real-time/monthly/quarterly	🟩	
3.4	Existence of a single regionally integrated information system	No	🟥	Questionnaire - Question A.3.7
		Under implementation	🟧	
		Yes	🟩	
3.5	Existence of a computerised social record in use in the region/autonomous province	No/No, but guidelines and/or strategic plans exist	🟥	Questionnaire - Question A.3.10
		Yes, but currently in experimental phase/ Yes, but in use only in some municipalities	🟧	
		Yes, in use throughout the region	🟩	
3.6	Implementation of computerised social records	0	🟥	Questionnaire - Question A.3.11
		1	🟧	
		2	🟩	

Indicator 3.1 analyses the completeness of the data collected by information systems present at the regional or autonomous province level, distinguishing between information systems for health services and

for social services. The rating is made on a scale of 0 to 5, considering the presence of the following information: access to ADI/SAD services, type of ADI/SAD services, quality of ADI/SAD services received, intensity of ADI/SAD services received, and other data collected. Values 0-1 correspond to the colour red, 2-3 to yellow, and 4-5 to green.

Indicator 3.2 assesses the amount of disaggregation available for health and social data transmitted by information systems i.e. the level of detail of data made available. The assessment is made on a scale of 0 to 4, considering the availability of the following information: age group, degree of disability, non-self-sufficiency, and other (to be specified). Values 0-1 correspond to the colour red, 2 to yellow and 3-4 to green.

Indicator 3.3 analyses the frequency of transmission of health and social data at the national and regional levels. It is divided into three categories: unsystematic (red), annual (yellow), or quarterly/monthly/real-time (green).

Indicator 3.4 assesses the presence an integrated information system at the regional level, divided into three options: "yes" (green), "no" (red), or "being implemented" (yellow).

Indicator 3.5 concerns the existence of computerised social records in use by the regions. The value is assigned depending on the answer given as follows: "No" or "No, but there are guidelines and/or strategic plans to start implementing CSI" correspond to the colour red; "Yes, but currently in the experimental stage" or "Yes, computerised social record is in use in some municipalities" correspond to yellow; "Yes, the computerised social record is in use throughout the region" corresponds to green (in the latter case the year had to be specified).

Indicator A.3.6 assesses, for regions where the CSI is in use, how the implementation process has been carried out, whether mandatory training has been provided for municipal social service workers, and whether investments have been planned to support municipal social services. Fulfilment of both requirements results in the assignment of the colour green, fulfilment of only one requirement results in the assignment of the colour yellow, and the absence of requirements results in the assignment of the colour red.

Tools for integrated service delivery

Indicator		Rating scale		Source
4.1	Existence of Integrated Individual Assistance Projects (PAIs)	The definition of PAI is not provided in the region or not applied	🟥	Desk review
		The definition of PAI is applied unevenly across the region	🟧	
		The establishment of PAIs is a well-established and widespread practice throughout the region	🟩	
4.2	Existence of single access points (PUAs)	Single access points are not currently active in the region	🟥	Questionnaire - Question A.1.6 {{+}} Desk review [Source: AGENAS]
		Single access points are active, but their use is limited	🟧	
		PUAs are active and in use	🟩	

4.3	Existence of Multidimensional Assessment Tools	No multidimensional assessment tool is in use in the region	🟥	Questionnaire – Question A.1.2
		Multidimensional assessment tools are in use in the region	🟩	
4.4	Frequency with which the multidimensional assessment is repeated	Multidimensional assessment is conducted only once for verification of initial requirements for access to services	🟥	Questionnaire – Question A.1.9
		The multidimensional assessment can be repeated over time, upon request	🟧	
		Multidimensional assessment is conducted on a regular basis	🟩	

Indicator 4.1 assesses the adoption of the PAI in the regional territory. The evaluation of this indicator was categorised into three levels: red for "The definition of PAI is not provided in the region or not applied", yellow for "The definition of PAI is unevenly applied in the region", and green for "The definition of PAI is a well-established and widespread practice throughout the region".

Indicator 4.2 assesses the existence and use of PUAs in the region under consideration. This indicator is evaluated on a three-level scale: red for "Single access points are not currently active in the region", yellow for "Single access points are active, but their use is limited", and green for "PUAs are active and in use".

Indicator 4.3 examines the use of multidimensional assessment (VMD) tools in home care or social services. This indicator is assessed using a binary scale, depending on the presence or absence of multidimensional assessment tools in use in the region under consideration.

Indicator 4.4 examines the frequency with which the multidimensional assessment (VMD) toward the dependent person is repeated. The rating scale includes three categories:

- Red, if the multidimensional assessment is carried out only once, to check initial requirements for access to services.
- Yellow, if the multidimensional assessment can be repeated over time, upon request, to reassess needs.
- Green, if the multidimensional assessment is conducted on a regular basis, regardless of additional specific requests. This approach ensures constant monitoring of the needs and conditions of the people being cared for, enabling timely and individualised interventions.

Annex D. Examples of regional best practices

This Annex provides examples of regional best practices, reported by regions in Form B of the OECD questionnaire (see Annex E). Specifically, 17 practices were identified in eight Italian regions and autonomous provinces. The most comprehensive, innovative and interesting practices are reported in this Annex. The practices are grouped into four dimensions of analysis: governance, workforce, information systems, and service delivery.

Governance

- Emilia-Romagna – Protected discharge for homeless people with disabilities. Emilia-Romagna has launched a three-year project (2023–2026) aimed at the appropriate and integrated care of dependent homeless people in some regional territories. The initiative, which aims to overcome the fragmentation of existing territorial services, responds to the need to ensure a unified response to complex health and social problems. Integration between social and health services is promoted through the establishment of a multi-professional work group and the involvement of Third Sector entities.
- Friuli-Venezia Giulia – “Domiciliarità Comunitaria” experimental project and experimentation of a model of participation of Third Sector entities in the context of social and health integration in the care of the frail elderly. Two projects are underway in the Friuli-Venezia Giulia region to improve the quality of integrated care interventions for dependent persons through co-programming and co-design with the Third Sector. The first, active from 2021 and targeting people with a diagnosis of dementia, involves the co-design of home care services between health authorities, municipalities, and Third Sector entities in order to prevent the person's institutionalisation and support his or her family. The second, launched in 2023 and designed for the frail elderly, promotes the development of a model for taking care of the person based on collaboration between public health and social services and Third Sector entities operating in the territories.
- Autonomous Province of Trento - Spazio Argento. The initiative, promoted in the Autonomous Province of Trento in 2023 and still ongoing, consists of activities of listening, information, orientation, and support in activating social healthcare and social welfare interventions for the elderly and their families. In order to ensure comprehensive care for the individual and promote active ageing, social and healthcare integration is ensured at every level of territorial governance through the coordinated action of Steering Committees composed of social and healthcare representatives.

Workforce

Formal sector

- Emilia-Romagna – Home educator. This project, launched in 2022 in Emilia-Romagna and still ongoing, strengthens the role of the social educator in home care for dependent persons with major neuro-cognitive disorders. In order to tailor home intervention according to the person's needs, this figure carries out personal care activities, particularly cognitive stimulation measures to slow cognitive decline, hygiene of the home environment, and support for the family caregiver. In addition, in planning care goals and interventions, the educator collaborates with health services and Third Sector entities.

- Veneto – Generative and community-based welfare. Inaugurated in 2023 and still ongoing, this Regione Veneto initiative aims to introduce the figure of the community nurse in some regional areas. This figure takes on a new role in the care of the frail population (approximately 500 people), also through collaboration with the GP. In this experience, indeed, the community nurse contributes to identifying frail individuals, facilitates their access to services for assessing the person's needs in constant dialogue with the GP, and promotes the involvement of Third Sector organisations operating in the territory.

Informal sector

- Puglia – Family Care and Support Pact. Since 2013, Puglia has undertaken two initiatives aimed at supporting the care work of the family caregiver (Family Support) and incentivising formal hiring of a family caregiver/personal assistant (Care Pact) for the dependent person. Specifically, these measures, which are active throughout the region, each pursue a main objective: the former promotes the improvement of the quality of life of individuals and their families, while the latter aims to discourage undeclared work in the LTC sector.
- Veneto – Parkinson's and dementia relief. This project, which has been active in Veneto since 2013, promotes training activities for the staff of municipalities, dependent persons, and their families. The training, entrusted to multidisciplinary teams and provided in dedicated spaces on a biweekly basis, focuses on understanding issues connected to the diseases of ageing and family caregiver stress management.

Information systems and interoperability

- Veneto – Programme Agreement between the municipal administration, entro di Servi (IPaB) e ULSS Service to regulate the home care system. In Veneto, a three-year program agreement between the municipal administration and the health authority is active in different territorial areas of the region with the aim of promoting inter-institutional co-ordination in home care. Integration between social and health services is also promoted through interoperability of information systems.[62]
- Marche – Dementia patients improvement group. In the Marche region, a project to link social and health services to improve the care of older people diagnosed with dementia was piloted during 2023. In addition to the creation of a network of services, the initiative included tools to make health and social data interoperable to ensure knowledge sharing and treatment pathways among the health and social professionals involved in the multidisciplinary assessment team.[63]

Provision

- Liguria – “Meglio a Casa” Protected Discharge Project (Better at Home) This project, which has been active in Liguria since 2013, ensures the employment of a family caregiver/personal assistant who provides free and temporary home care for frail, dependent people discharged from the

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[62] the region refers to "perfecting information modalities," but the reference to information systems is present only as an improvement strategy

[63] reference to data interoperability is present but is not fully described

hospital. The initiative, aimed at rationalising the intervention of health and social services, ensures continuity of care and encourages individuals to remain at home. In addition, the assistant works in collaboration with other health and social professionals in the territorial service network.

- Emilia-Romagna – Strengthening Intake and Assessment Activities for Citizens with Social Fragility. Since 2018, Emilia-Romagna has initiated an experimentation involving the introduction of a social service within the emergency department aimed at reducing inappropriate hospital admissions of elderly individuals with chronic conditions and/or social frailty in certain hospital wards (e.g. the Maggiore Hospital in Bologna). The presence of social workers within the hospital allows for multidimensional and inter-professional assessment and delivery of appropriate community-based services. In addition, continuity of care is also ensured with the support of the Continuity Nurse.

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