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Pensions, Health Care and Long-term Care

Italy

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GVG

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1 Executive Summary

In the period covered by this report (January 2010 – May 2011) developments have been rather different in the three social policy sectors of pensions, health care and long-term care.

In the field of pensions, recent reforms of the public pillar have mostly dealt with eligibility conditions for both old-age and seniority benefits. In particular, the link of both age and contribution requirements with changes in life expectancy has represented a major step forward in aligning the Italian pension rules with recommendations by the EU.

In spite of the relevant changes recently legislated, the pension debate in Italy has not been particularly intense in 2010 and early 2011 and policy proposals have pointed at (more or less) limited adjustments to the existing pension architecture. This is the consequence of various factors, among which the most important are: i) the important reforms already adopted in the 1990s-2000s, in combination with, ii) the widespread consensus among politico-institutional and social actors on the need to continue on the path of fiscal consolidation, and iii) the fact that the 2008-9 financial crisis did not have a disruptive impact on supplementary funded schemes which are still in their infancy. Especially concerns regarding the sustainability dimension of the public pension system have been very limited; by contrast, several contributions have stressed the risk of inadequate old-age protection in future decades as a result of the interplay between the "dual" labour market and the emerging multi-pillar pension system based on NDC plus DC schemes.

In a comparative international perspective the Italian NHS seems to function relatively well and the reforms undertaken in the past years seem to improve this functioning. The different laws and agreements passed since 2010 try to focus on different aspects of the NHS (from specific relevant issues, such as palliative care, to more general ones, as prevention or oncological care). Overall, the system seems to be improving, but there are very serious problems that can blur this general picture: social inequalities between individuals and households with different income levels in the access to health care; territorial inequalities in the access to decent health care (the North-South divide); from this point of view it is not clear what the impact of a broader regionalisation of the NHS will be thanks to federalism; a still too weak system of integrated social care and health care for chronic diseases; a forthcoming shortage of medical professionals.

Apart from more strictly health challenges (how to cure cancer better, cardio-vascular diseases, etc.), the four issues just quoted represent the main worries for the future of the Italian NHS: the developments from 2010 have not shown many improvements in this respect.

In comparison to health care, there was not too much policy innovation in the long-term care (LTC) field. Also the Italian public LTC seems to show to different "sides": one positive, the other one more problematic. The positive one is represented by the fact that today more than 10% of the elderly do receive some form of public coverage for their LTC problems. This level of coverage is not distant or different from the ones typical of many other Western EU countries. The more problematic side is related to the fact that this coverage comes mainly from cash programmes and less from the delivery of services. The fact that the system is cash-based (and it is increasingly so) has three effects, strongly linked with each other: still a lot of pressure and responsibilities are on family carers' shoulders; a private care market (quite often "grey" and made up by migrant women) has developed tremendously in the past 10-15 years; the investment in professional human resources in the public sector for facing LTC needs has been limited. Moreover, as for health care, there is a clear (and worrying) territorial divide

with the Southern regions showing a very limited level of LTC service provision in comparison with the north-central ones.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

2.1 Overarching Developments

In 2008-09, the global crisis had a differential impact on Italian financial and economic structures. If, on the one hand, the financial crisis had been less disruptive than in other advanced economies, on the other hand, the economic shock had a dramatic impact by reinforcing an already critical situation. In 2001-2010, the average GDP growth was 0.2% in Italy - compared to 0.8% in Germany, 1.2% in France, 1.4% in the UK and 2.0% in Spain – and figures even turn negative when GDP growth *per capita* is considered - -0.3% in Italy versus 0.5% in France, 0.7% in Spain, 0.9% in Germany and the UK. In 2008, the fall of the Italian GDP was -1.0%, then -5.0% in 2009.

Also, the crisis has put a break to some positive trends registered in the labour market over the past decade (Table 1).

Table 1: Main labour market indicators, Italy 1992-2009

	1992	1995	1998	2001	2004	2007	2009
Employment rate	52.3	51.2	52.2	54.9	57.4	58.7	57.5
Unemployment rate	11.7	11.7	11.9	9.6	8.1	6.2	7.9
Female employment rate	36.5	35.4	37.3	41.1	45.2	46.6	46.4
Long-term unemployed (for more than 1 year)*	58.2	62.7	60.4	63.7	46.2	45.5	42.0

* % of total unemployment
Source: OECD online employment database

The employment rate (15-64) declined, passing from 59.2% in 2008 to 57.1% in December 2009, while unemployment increased from 6.7% in June 2008 to 8.6% at the end of 2009 – with significant variations according to age (unemployment rate was 27.9% for those aged 15-24) and geographical areas (unemployment around 13% in the South vs. 6.1% in the North). Flexible workers were actually the first "victims" of the crisis: in 2009, about 400,000 jobs were lost among fixed-term workers (-7.3%), project workers (-17%), occasional workers (-6.3%) and part timers (-1.9%). This is especially critical in the light of the weaknesses of the Italian unemployment protection system on the side of both ALMPs and cash benefits. As to the former, since 2004 the expansionary trend of expenditure on ALMPs came to an abrupt halt and has subsequently been reversed: In 2007, Italy devoted only 0.5% of GDP to ALMPs. With regard to cash benefits, the Italian unemployment compensation system – though subsequently reinforced in the past two decades - remains highly fragmented and scarcely inclusive. Considering all types of ordinary and special benefits, in 2006 about 69% of the unemployed could not rely on any kind of income protection, and "atypical" workers were among those faring worse. In sum, when the global economic crisis started to "bite" between 2008 and 2009, not only labour market indicators quickly deteriorated but also the shortcomings of "selective flexibility" without security became dramatically evident (Jessoula et al. 2010).

Committed to sound fiscal rigour, the fourth cabinet led by S. Berlusconi has for now refused to exploit the severe recession in order to put forward an encompassing reform of the

unemployment protection system. The government has in fact favoured a strategy that relies on existing programmes to tackle the social consequences of the employment crisis. More precisely, this approach aims to allow firms to reduce the employed labour force temporarily without definitive dismissal while compensating workers in case of working time reduction. This has been pursued through two measures: the extension of wage replacement benefit schemes (CIGO and CIGS[1]) to sectors/firms not covered, and the extension of unemployment benefits to cover temporary suspension from work.

The economy recovered in 2010 (GDP growth +1.3%), but growth remains weak – projected GDP growth 1.1% in 2011 and 1.3% for 2012 – thus widening the gap with respect to most other European countries. Also, there are visible signs of a "jobless growth" syndrome. In 2010, despite the modest recovery, employment continued to diminish, from 57.5% to 56.9% - i.e. 153,000 labour units were lost between 2009 and 2010 – and unemployment increased from 7.8% (2009 average) to 8.4% (2010)[2]. Alarmingly, also inactivity rates are on the rise, especially in central and southern regions.

Slow growth and persistent difficulties in the labour market are the result of both the long-term weaknesses of the Italian economy and the extremely limited "stimulus package" during the global crisis. Actually, in light of the very high level of public debt (119% in 2010) and the increase of deficit levels (4.6% in 2010), the government has pursued fiscal stability and prompted the consolidation of the state budget in order to progressively reduce the deficit level. The National Reform Programme set the following targets with respect to deficit levels in the next years: 3.9% in 2011, 2.7% in 2012, 1.5% in 2013 and 0.2% in 2014. The cost containment interventions adopted in the field of pensions in 2009-10 (*cfr. infra* section 2.2) should contribute significantly to reach the targets. However, in order to achieve these goals, the traditional deficiencies of both the Italian economy and labour market must be addressed: measures must be adopted with the aim to improve competitiveness; relaunch economic development and employment in the southern regions, as well as support stronger inclusion of women in the labour market through reconciliation and active labour market policies. Certainly, these actions may be costly and, due to the public finance conditions presented above, the current debate on the Italian welfare state is therefore focused on "recalibration", that is how to rebalance social protection in order to contain expenditure in some sectors, while expanding others – in particular reconciliation, labour market, and social assistance policies.

2.2 Pensions

2.2.1 The system's characteristics and reforms

In Italy, economic security in old age has traditionally been rather high, due to the (single-pillar) public PAYGO "Bismarckian" pension system - providing generous earnings-related benefits (see Figure 1 below) – and its interplay with a highly regulated labour market (Jessoula 2011*b*). Old-age insurance is compulsory for all dependent workers, the self-employed and "project workers" (the latter being formally self-employed but mostly working as employees); thus, coverage reaches 100% of those employed. Benefits are relatively high, and they represent the major source of income for current retirees, providing a replacement rate around 75% (SPC 2006: 61), and about 72% (on average) of the equivalent income of those aged 65 and older - the rest including wages and other social transfers (Ministry of Welfare 2002). In order to alleviate poverty in old age, a safety net was set up in 1969

1 *Cassa integrazione guadagni ordinaria* and *Cassa integrazione guadagni straordinaria*.
2 Data source: ISTAT (2011*a*).

providing means-tested benefits to elderly over 65: The amount of "social allowance" ranges (in 2011) from 417€ for those in the age bracket 65-70 and 516€ for those over 70 years. In addition to public pensions, employees received mandatory severance pays both in the private (*Trattamento di fine rapporto* or TFR) and the public sector (*Indennità di buonuscita*). These lump-sum payments by employers are due when an employee either changes employers or retires: In the past, given the long tenure on permanent contracts in the Italian private sector and the job security in the public sector, both programmes have *de facto* mostly provided supplementary benefits at retirement.

Reforms adopted in the period 1992-2010, however, have radically transformed the pension architecture by prompting a transition to a multi-pillar pension system based on a first public PAYGO pillar and supplementary (second and third) funded pillars. In the first pillar, a Notional Defined Contribution system (NDC) was introduced for the new entrants in the labour market in 1996, therefore with a long phasing-in period. Though the first pillar is organised along professional lines and is managed by two major institutions - the National Institute for Social Insurance (INPS) and the National Institute for Social Insurance of Civil Servants (INPDAP) – the NDC system has harmonised treatment for the various categories (especially public and private employees and the self-employed)[3].

As for supplementary protection there are different options. Apart from the above mentioned TFR, which can be paid in a lump-sum only, not necessarily at retirement, and should thus be considered as a "quasi" supplementary pension, Legislative Decree 124/93[4] regulated funded pillars. Affiliation to supplementary pension funds is always voluntary and individual, even in case of occupational funds set up by collective agreement, and workers are encouraged to contribute through tax incentives[5]. "Closed" negotiated pension funds (CPF) - as well as so-called "pre-existing funds" (PEF), as they were already operative before the introduction of the 1993 regulatory framework – are typical occupational pensions for specific groups of employees (2nd pillar). Personal pension plans through life insurance contracts (PIP) constitute the third pillar, while "open pension funds" (OPF) are hybrid institutions (comprising both second and third pillar forms depending on affiliation modes). The 1993 regulatory framework reform allowed the transfer of contributions paid for the severance payments TFR to the funded schemes. More precisely, workers employed after April 1993, in case of affiliation with supplementary fund contributions to the TFR – that is, 6.91% of gross monthly wages – would be fully merged into supplementary schemes, whilst for already employed workers collective agreements would define the share of the TFR to be transferred to supplementary schemes. In order to foster the development of funded pillars, the transfer of the TFR was later favoured by the adoption of Legislative decree 252/05 which introduced a quasi-automatic enrolment based on the so-called "silent-consent" formula. According to this mechanism, workers had six months – from January to June 2007 – to decide if they wanted to keep the TFR or transfer it to supplementary pension funds: In the default "silence" option, the TFR is automatically paid into the dedicated occupational pension fund. Similarly, new entrants in the labour market have six months to take this decision.

The expansion of coverage, and more precisely take-up rates of supplementary pensions, is crucial in light of the projected sharp reduction in public pension replacement rates in the period 2010-30 (cfr. section 2.2.5).

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[3] Contribution rates for dependent employees (32.7% and 32.35% in the private and the public sector respectively) and the self-employed (20%) have not changed since the shift to the NDC system in 1995.

[4] Legislative decrees are adopted by government and are equivalent to laws.

[5] The tax regime follows the ETT model (Exemption, Taxation, Taxation), according to which contributions are exempted from taxation, while returns are taxed and benefits are also taxed, though with a favourable rate.

Figure 1: The Italian pension system after reforms of the 1990s-2000s

	First Pillar	**Second Pillar**		**Third Pillar**
		Voluntary – Collective agreement (alternative to *TFR*)	Voluntary - Employer commitment	Voluntary personal pension (alternative to *TFR*)
Second tier (income maintenance)	Public pension (PAYGO): Compulsory: private employees and self-employed (INPS); public employees (INPDAP); other professional categories Contributions: shared (2/3 employers); ceiling (93,000 €) DB benefits for current pensioners; NDC benefits for those insured after 1995; Price indexation	Closed funds (CPF): Default option in the silent-consent mechanism for the transfer of the *TFR;* industry/group/firm/ region wide Open funds (OPF): collective affiliation based on agreement at firm level Both: Funded DC (employees); Funded DB/DC (self-employed) Tax incentives	Pre-existing funds (PEF): mostly PAYG, now shifting to funded DB/DC Tax incentives	PIP Personal plan through life-insurance contracts Open funds (OPF): individual affiliation Both: Funded DC (employees); Funded DB/DC (self-employed) Tax incentives
			TFR severance-pay: Compulsory coverage of employees (atypical workers with continuous collaboration contracts excluded); "deferred wage" paid in a lump-sum; can be converted into CPF, OPF and PIP	
First tier (poverty alleviation)	"Social allowance": means-tested, flat rate old-age pension			

Source: Author's elaboration

Recent reforms and trends

Public pillar reforms

Recent reforms of the public pillar have mostly dealt with eligibility conditions for both old-age and seniority pensions. In fact, previous reforms had introduced contradictory changes[6] as well as provided long phasing-in periods for the implementation of the new measures – especially with regard to seniority pensions – in order to safeguard older workers. As mentioned in the 2010 asisp Annual Report for Italy (in the following ANR 2010), in response to ECJ judgement C-47/07 of 13 November 2008, Law 102/09 had already raised the pensionable age for female employees in the public sector from 60 to 65, to be implemented gradually between 2010 and 2018. In spring 2010, however, the European Commission

[6] The Amato reform (D.Lgs 503/92) increased the pensionable age from 55/60 to 60/65 for women/men respectively, which was later changed into a flexible pensionable age in the age bracket 57-65 for both sexes by the Dini reform (L. 335/95). In 2004, L. 243/04 restored a differentiated retirement age for female (60 years) and male (65) workers. For seniority pensions, see note 6 below.

requested a faster phasing-in of the new eligibility conditions for women employed in the public sector. The Italian government agreed to the Commission's request and, in summer 2010, Parliament adopted Law 122/10 which increases the pensionable age for female workers in the public sector from 61 in 2011 to 65 in 2012, thus harmonising it with the age threshold for male workers. By contrast, in the private sector differentiated pensionable ages (women 60/men 65) remain in place[7].

Also, Law 102/09 had already envisaged to link eligibility conditions to old-age benefits with demographic trends. Law 122/10 has set the rules in order to make this link operative: Starting in 2015, every three years the Ministry of Labour and Social Protection will raise the pensionable age in order to neutralise changes in life expectancy over the last 3 years. After 2015, the second increase is planned in 2019 (derogating to the 3-year rule) in order to align the revision of eligibility conditions with the revision of conversion coefficients in the NDC system. The age threshold for being entitled to the means-tested social allowance as well as the age requirement to receive seniority pensions (60 years for employees, 61 for the self-employed combined with 35 years of paid contributions in 2011, raising to 62 and 63 respectively in 2013) will be increased in accordance with the same procedure. The government estimates a cumulated increase of age requirements for both old-age and seniority pension around 3.5 years by 2050. Consequently, by 2050 the (quasi) automatic link would increase pensionable ages as follows: from 65 to 68.5 for male workers and from 60 to 63.5 for women in the private sector; from 65 to 68.5 for men and from 61 (in 2011) to 68.5 for women in the public sector.

Finally, it must be noted that Law 122/2010 lengthened the waiting period between the fulfilment of age/contributions requirements (for old-age/seniority benefits) and the effective moment of retirement. This period is 12 months for employees and 18 months for the self-employed, thus further raising the actual pensionable ages, as well as tightening contribution requirements for seniority pensions.

Trends in supplementary funded pillars

With regard to supplementary funded schemes, two elements deserve particular attention: i) membership trends, and ii) performance and returns of investments.

On the first front, latest data published by Covip (*Commissione di Vigilanza sui Fondi Pensione*, i.e. the national surveillance authority on pension funds) in January 2011[8] show a modest increase (5.4%) of total members (from around 5 million to 5.3 million, see below Table 2). This confirms the slowdown registered since 2008, after the campaign for the implementation of the "silent consent" mechanism (for the transfer of the TFR to funded schemes) in 2007 had prompted a significant increase of members of both occupational CPF and Open Pension funds (+63% and +69% respectively). Figures also indicate a lower capacity of occupational, second pillar, pension funds to attract employees. Actually, occupational pension funds based on collective agreements (CPF) are losing ground (though

[7] ECJ's action had its foundations, besides those found in the treaties, in Directive 79/7/EEC - on the progressive implementation of the principal of equal treatment for men and women in matters of social security, then modified by Directive 96/97Ce which pursued equality of treatment in the so-called "*professional regimes of social security*," the latter being considered as such if they apply to a particular category of employees. That is why the Court ruled against the regulations for civil servants only. So-called "legal regimes", providing general rules for all workers, are actually safeguarded from EU interventions: Member States may set their rules autonomously.

[8] The annual report by Covip was published on 25 May 2011. No significant changes with respect to membership emerge from the report.

slightly, i.e. -1.4% between in 2009 and 2010), while personal pension plans based on life insurance contracts (PIP, third pillar) have been able to significantly expand their membership, both among dependent employees (+165,000) and the self-employed (+102,000). These developments should also be evaluated in light of the differential performance of the diverse forms of supplementary schemes.

Table 2: Membership of supplementary pension schemes in Italy, 2006-2010

		Members (x1000)					
	Of which private employees (Dec. 10)	Dec. 2010	Dec. 2009	Dec. 2007	Dec. 2006	Variation 2010/2009 (%)	Variation 2007/2006 (%)
CPF	*1,871*	2,012	2,040	1,989	1,219	-1.4	63.1
OPF	*410*	848	820	747	440	3.4.	69.6
PEF	*644*	673[a]	673	681	613	-	11.0
PIP	*911*	1,814	1,547	1,189	959	29.8	—
Total	*3,845*	5,325	5,055	4,560	3,269	5.4	43.2

Note: a: Due to lack of data Covip assumes that membership has not changed from 2009
b: Total excludes double counting and includes members of the residual fund set up by Inps (ca. 40,000 members)

Source: Author's elaboration from Covip 2008, 2011.

In 2008, at the peak of the global financial crisis, Italian pension funds had reported comparatively moderate losses, though with much variation between 2nd and 3rd pillar schemes. Occupational closed fund registered negative returns of around 6%, open funds around 14%, while losses were much higher for PIP, around 25%. All types of supplementary schemes already recovered (at least partly) in 2009 – CPF +8.5%, OPF + 11.3, PIP +16.3 – and the trend was confirmed in 2010, though at a slower pace. Returns were around +3.0% for CPF, +4.2% for OPF and +5.1% for PIP (Covip 2011).

2.2.2 Debates and political discourse

Differently from the past two decades, the pension debate in Italy has not been particularly intense in 2010 and early 2011, and policy proposals have mostly dealt with (more or less) limited adjustments to the existing pension architecture. This is the consequence of various factors: i) the important reforms already adopted in the 1990s-2000s, in combination with, ii) the widespread consensus among politico-institutional and social actors on the need to continue on the path of fiscal consolidation, and iii) the main features and developmental stage of supplementary funded schemes.

The series of pension reforms implemented in Italy (1992, 1995, 1997, 2004, 2007, 2009) has smoothened pressure for further major interventions. Also, the diffuse consensus on fiscal rigor and the need to rebalance expenditure across the different sectors and "functions" of the Italian welfare state (cfr. asisp ANR 2010) has allowed Parliament to legislate some important adjustments in 2010 that will contribute to state budget consolidation after the negative effects of the 2008-2009 economic recession. Both the National Reform Programme (NRP), published by the government in April 2011, and the equivalent "shadow" report released by the main opposition party (PD 2011) share the view that pension expenditure is on the right track and mostly under control. Also, the Democratic Party's document puts emphasis on the

extremely limited room for further cost containment measures in the field of pensions in light of the fast demographic ageing. Thus, the tightening of eligibility conditions to old-age and seniority pensions illustrated above (section 2.2.1) has not given rise to major conflicts, though two trade union organisations - Cgil and Uil – opposed the steep increase of the pensionable age (4 years between 2011 and 2012) for female employees in the public sector. Also, due to the logic of the NDC system which substantially rewards later retirement, the link of eligibility conditions to changes in life expectancy has been praised as a measure that will likely offset (at least partly) the expected reduction of replacement rates in the next decades: The President of the Bank of Italy, Mario Draghi, expressed this view in his annual speech on 31 May 2010. Though not overtly opposing these changes, the "shadow NRP" by the Democratic Party would be more in favour of both a return to a flexible pensionable age and the introduction of a partial pension in order to promote active ageing (PD 2011, p.60). The unions, on their part, agree on the flexible retirement age and stress the need to reintroduce a more favourable indexation mechanism for pensions in payment (currently based on changes of the Consumer Price Index).

While the pension debate has been rather consensual with particular reference to fiscal and economic sustainability, the government and the main opposition party show different attitudes towards the adequacy issue, which is crucial especially for younger cohorts and atypical workers due to the interaction of a more flexible "dual" labour market and adopted pension reforms – particularly the implementation of the NDC system. Official documents by the government (cfr. the National Reform Programme) are completely silent on the adequacy side, despite the projected reduction of pension levels due to the gradual phasing-in of the NDC system; by contrast, the Democratic Party has put forward some proposals in order to guarantee adequate income security in old age to workers with fragmented careers: The possibility to cumulate a contributory pension and the social allowance or the (re)introduction of a minimum pension for workers with rather long contributory records and (too) low pensions. Both measures aim at strengthening the redistributive character of the first pillar and would require more reliance on tax financing in order to counterbalance the purely actuarial imprint of the NDC system. The latter might in fact fall short of providing adequate income maintenance to workers with atypical careers and, more generally, to workers with low incomes. Nevertheless, the political debate on this issue is rather weak while, as we will see below, the topic has more frequently been addressed in the academic debate (cfr. sections 2.2.4 and 2.2.5).

Also with regard to supplementary funded pillars the political debate has remained rather weak. On the positive side, this is the result of the moderate losses of funded schemes in Italy during the financial crisis (see above), as well as the fact that such schemes are still in their maturation phase. Therefore, even the high losses reported by third pillar forms have remained rather "invisible" as they have reduced entitlements for current retirees to a very limited extent. On the negative side, the lack of both a broad public discussion and initiatives by the government in order to further expand coverage of funded schemes is striking in light of the slowdown of membership growth in the past three years. Recently, however, Covip formulated some proposals aimed at re-activating membership growth: On 26 April 2011, the president of Covip suggested to eliminate taxation on returns - thus switching from the current ETT tax regime (Exemption/Taxation/Taxation) to the typical EET model (Exemption/Exemption/Taxation) – while a commissioner from Covip pointed at portfolio allocation choices made by pension funds (5 May 2011), arguing that a larger share of investment in equities and long-term bonds might allow higher returns and, consequently, stimulate demand. Others, like the president of Inpdap (the National Institute for Social Insurance of Civil Servants), proposed to improve knowledge and increase information about

future pension levels in order to allow workers to make better choices about their pension savings.

The identification of viable and effective measures to increase membership in funded schemes is essential - firstly, considering the crucial role that reforms adopted in 1992-2005 assigned to supplementary pillars in order to compensate the reduction of public pensions in the near future; and secondly, because the (still) relatively limited coverage - slightly above 5 million out of around 23 million gainfully employed - is a major obstacle in achieving the goal of adequate old-age protection in the future through the combination of public and supplementary pensions.

2.2.3 Impact of EU social policies on the national level

With reference to the relationship between supranational programmes and constraints and the domestic policy making on pensions, three different aspects are worthy to be analysed. First, the lower capacity of EU initiatives - like the Green Paper on pensions and the Open Method of Coordination (OMC) - to influence the national debate and, consequently, policy decisions. This differs from the early 2000s, when the launch of the OMC and the setting of the three intertwined objectives – sustainability, adequacy and modernisation of pension systems – (indirectly) empowered some national actors – i.e. mainly the unions – thus allowing a partial re-orientation of the policy discourse towards greater concern for the adequacy side, after a decade of sustainability-driven reforms (Busilacchi, Jessoula, Raitano 2009). In other words, "soft" actions at the supranational level seem to have lost "grip" on domestic developments. However, this does by no means imply a reduced role for supranational institutions in contributing to steer the Italian pension policy making. The second point has actually to do with the increased assertiveness of the European Commission on the harmonisation of pensionable ages for men and women employed in the public sector, with the request of a much faster phasing-in of the new age threshold for female workers than it had been legislated in 2009. This actually represents a novelty in two respects. In terms of policy content, it has entailed a rapid change which contrasts with both the previous pattern of pension reforms in Italy and the rather long time span EU institutions have generally allowed for harmonising retirement age in various Member States. As for the actors involved in the policy making, it suggests a stronger role of the European Commission in requiring the adoption of specific policy measures in the field of pensions in the short term that had never been the case in the past two decades. It must be noticed, however, that this change has arguably been favoured by two domestic factors: the willingness of the government to accommodate European requests on the one hand, and the feeble resistance by the unions – that in the past frequently represented major veto players on the pension stage – on the other. Such a more conciliatory approach of the Italian unions might be the consequence of the current divisions between the three major unions (Cgil, Cisl, Uil) as well as the fact that (differently from the 1990s) most of their members are currently retirees, and thus unaffected by the tightening of eligibility conditions.

In sum, developments illustrated at points one and two lead to conclude that "we are progressively witnessing a weakened desire to comply" with "soft" EU stimuli "while supranational constraints continue to drive national policy developments only when "hard" pressure is exerted – e.g. via legal requirements" (Graziano and Jessoula 2011, 171) as in the case of the 2009-10 pension reform.

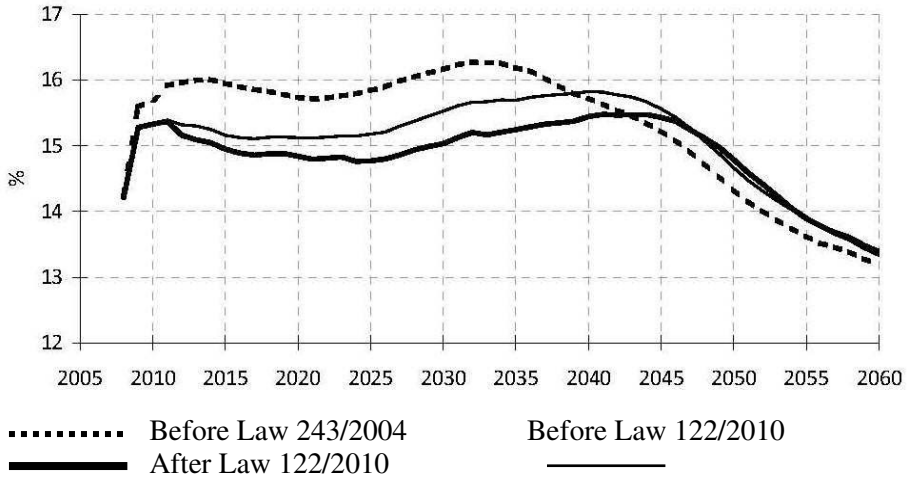
This is also confirmed by looking at both the pension strategy of the government, as reported in the National Reform Programme, and the recently legislated measures in light of recommendations included in the Annual Growth Survey (AGS) and the goals set by the EU2020 strategy. The NRP deals extensively with the medium to long-term sustainability of

the pension system and makes explicit reference to recommendations included in both the AGS and the Pact for the Euro. Particularly, it highlights the substantial progress made by the stepwise process of pension reform launched already in the early 1990s and "completed" with the adoption of the latest reform (Law 122/2010). Also, the NRP stresses that already legislated changes have put the Italian pension system on a sound path with respect to fiscal sustainability and they have also closely followed EU recommendations with regard to linking the pensionable age with increases in life expectancy. By contrast, the NRP is silent on the adequacy dimension, with reference to both poverty prevention and income maintenance in old age. By the same token, nothing is said on the development of supplementary funded pensions and the latter's contribution to economic security after retirement.

2.2.4 Impact assessment

In the covered period, the most relevant official document including projections of future expenditure on public pensions was the National Reform Programme, published by the government in April 2011[9]. Interestingly, the NRP shows that, after the latest reform, public pension expenditure (13.6% of GDP in 2009) is expected to diminish until 2026-27 (Figure 2). This is important in light of the faster demographic ageing in Italy than in most other EU countries: the old-age dependency ratio for Italy was 30% in 2007 and is expected to reach 42% and 59% in 2030 and 2060 respectively, in comparison to a EU27 average of 25%, 38% and 53% in the same years (European Commission 2010). This testifies the major effects, in terms of economic sustainability, of the reforms adopted over the past two decades, as well as the contribution made by the recent 2010 reform (bold line, Figure 2).

Figure 2: Projected public pension expenditure, Italy, 2007-2060



Source: National Reform Plan 2011, page 84.

The NRP also presents in detail the short-term savings allowed by already legislated reforms – 6,300 million € in 2011, 10,300 million in 2012, 11,800 million in 2013 and 13,000 in 2014 – as well as the projected reduction of pension expenditure due to changes adopted in 2004-2010: This reduction is estimated around 1% of GDP for the period 2015-2035 - totalling 26 percentage points of GDP, half of which attributable to the 2010 reform only (NRP page 84).

[9] In 2010, neither INPS has published an annual report, nor the monitoring body of public pension expenditure (Nucleo Valutazione della Spesa Previdenziale) has released an updated version of the report containing the medium to long-term forecast of pensions and health care expenditure.

Also, according to the NRP, the lower pension expenditure should increase GDP by 0.1% in 2015, 0.5% in 2020 and 0.5% in 2030.

These figures, updating those already published in the asisp ANR 2010, have reduced the salience of the sustainability issue in both the political debate and the academic discussion. Nevertheless, a recent contribution (Cardinale 2010) cast doubt on the effective capacity of the Italian public pension pillar to maintain pension "promises" in the next decades. Low economic competitiveness and labour productivity in combination with low employment rates (especially for women and the young) might actually lead to an unbalance between contributions and benefits. In order to tackle this critical scenario, effective economic, employment and reconciliation policies should thus be developed in parallel to recent interventions on eligibility conditions to receive pensions.

Also, raising the effective age of exit from the labour market as well as increasing the employment rate of the elderly would improve the sustainability of the public PAYGO pillar. Actually, until the early 2000s, the increase of the pensionable age was partly offset by the existence of favourable seniority pensions that allowed retiring prior to reaching the standard pensionable age. These have contributed to the very low employment rate in the age bracket 55-64 (35.7% in Italy vs. 46.0% in the EU27), and the exit age from the labour market (60.8 years in 2009) is still closely linked to the age requirements for seniority pensions. The tightening of the latter[10] and their link with life expectancy after 2015 are likely to be effective measures in both raising the average retirement age and increasing the employment rate of workers aged 55-64.

From a relatively different perspective, concerned with both sustainability and equity issues, Boeri (2010a) suggested to modify the current indexation mechanism that links pensions to changes in the Consumer Price Index only. The indexation of pensions to economic growth, Boeri suggests, would on the one hand allow pensioners to share the benefits of economic growth and, on the other hand, help to contain pension expenditure in periods of slow growth and economic recession.

Between 2010 and 2011, however, a growing number of contributions have focused on the adequacy dimension. In particular, the interplay between a more flexible, dual labour market and pension reforms that have transformed the pension architecture has been analysed in order to evaluate the ability of the system to provide adequate income security at retirement in future decades, especially for workers with fragmented and atypical careers. Considering public pensions only, Boeri (2010b) estimated that a worker employed on atypical contracts (project contract and fixed term contract) and experiencing spells of unemployment in the first ten years after entering the labour market would be entitled to a pension which is roughly 30% lower than in case of a standard career (permanent contract and no spells of unemployment). Borella and Segre (2011) calculated that a male worker with a full (uninterrupted) career as project worker (*parasubordinato*) would receive an old-age benefit of around 750€ per month in 2041, slightly above the (adjusted to GDP growth) amount of the means-tested non contributory social allowance (about 700€); female pensions would be even lower – around 470€ - due to even lower earnings[11].

[10] Eligibility conditions for seniority pensions had already been tightened (with a long phasing-in) in 1995. The process was then accelerated by Law 243/2004, later revised by law 247/07. Currently, the minimum age for being entitled to seniority pensions is 60 for employees and 61 for the self-employed (both with 35 years of paid contributions), raising to 62 and 63 respectively in 2013 (or 61 and 62, with 36 years of paid contributions).

[11] For a detailed analysis of the interaction of labour market and pension rules in Italy, cfr. Jessoula (2011).

Pizzuti and Raitano (2011) have analysed the adequacy problems emerging from the interplay of labour market conditions and pension rules, with particular reference to the implementation of the NDC system. The authors also put forward several proposals aimed at tackling the risk of inadequate old-age protection for atypical workers. Among these proposals, the introduction of a minimum pension of around 900€ per month for those workers retiring at 65 with 40 years of seniority who would be entitled to benefits below that threshold.

2.2.5 Critical assessment of reforms, discussions and research carried out

The NDC system introduced in 1995 included two automatic and semi-automatic mechanisms aimed at stabilising pension expenditure. The first concerns the annual valorisation of paid contributions according to the average GDP growth in the last five years; the second regards the periodical revision (every three years) – in accordance with new projections on mortality rates and life expectancy - of coefficients applied to convert accumulated contributions into annuities. Both are powerful instruments to ensure fiscal sustainability because economic crises and slow growth directly reduce the level of future entitlements, and demographic ageing is neutralised by revisions of coefficients for benefit calculations. The latest 2010 reform added another fundamental (quasi) automatic adjustment mechanism which links eligibility conditions to old-age and seniority pensions with demographic trends. Precisely, after 2015, every three years the competent ministry will increase the pensionable age in order to take into account changes in life expectancy over the last three years. After 2015, the second increase is planned in 2019 (derogating to the three-year rule) in order to align the revision of eligibility conditions with the revision of conversion coefficients. In the next years, the gradual implementation of the NDC system will start to give a major contribution to control pension expenditure both in the medium and the long run, and the automatic stabilisers mentioned above should largely insulate the system from economic and demographic shocks. Consequently, as recently confirmed by the forecast of public pension expenditure included in the NRP, the Italian pension system fares comparatively well with regard to economic and fiscal sustainability in the next decades.

By contrast, the interplay between changes in the labour market and the transition to a multi-pillar pension system based on a NDC public pillar and voluntary supplementary defined contribution schemes is likely to give rise to inadequate income protection after retirement for a large share of future pensioners, entailing a major intergenerational rupture. Actually, both labour market and pension reforms have been targeted to younger cohorts: The new NDC system applies to new entrants to the labour market after 1995 only; flexibility has been pursued "selectively", that is, by favouring the spread of atypical – mostly temporary – jobs primarily among younger cohorts.

In future decades, adequate old-age protection should be ensured if three conditions are met: a) workers pay full contributions in the first pillar, b) they have long, uninterrupted careers of about 40 years and, c) they subscribe to supplementary funded schemes by transferring the whole TFR to pension funds and contribute for their entire career. The Social Protection Committee (2009) estimated the replacement rate from public pensions in 2046 to be about 56%, with an additional 12.4% from supplementary pensions, for a total replacement rate just below 70% retiring at 63 with 38 years of contribution. Raitano (2009) calculated a replacement rate of 64.4% from the first pillar plus 19.6% from funded schemes retiring in 2040 at 65 with 40 years of seniority. However, only a limited share of those currently employed is likely to match all the conditions presented above. Even within workers in "standard employment relationship" those conditions are far from being achieved, mainly due to the modest coverage of supplementary pensions that also vary substantially across economic sectors, as well as in relation to firm size. And the various categories of atypical

workers suffer from specific disadvantages. For part timers the main challenge is represented by the low level of wages (due to reduced working time) in combination with declining replacement rates and the neutrality of the NDC system with respect to earning levels; as for fixed term workers, the combination of contractual discontinuity and social security rules – namely, the tight conditions to receive unemployment benefits and, consequently, pension credits - may endanger income security at retirement. The most critical situation regards, however, project workers. These actually pay a lower contribution rate in the first pillar (26%), are not covered by unemployment insurance/assistance and, not being entitled to the TFR, they generally lack resources to pay contributions to supplementary schemes. Therefore, they would rely on very low public pensions only (cfr. above section 2.2.4).

Certainly, the real magnitude of the problem depends on how many years workers remain "trapped" in atypical employment, and it is plausible that most temporary workers - both project workers and fixed term - will switch to a permanent standard job later in their career. Nevertheless, figures for the Italian case indicate the stickiness of temporary employment (Raitano 2007).

These considerations suggest caution when analysing future expenditure trends. Actually, arguments regarding fiscal and economic sustainability should be qualified by considering the adequacy side of the coin in order to identify likely challenges – particularly stemming from the interplay of labour market trends and the effects of pension reforms – potentially leading to pressures for expanding welfare expenditure in the near future.

In this light, also the interplay between the supranational level and the domestic policy making should be carefully evaluated, due to the substantial overlapping, at the EU level, between "hard" requirements and sustainability issues on the one hand, and "soft" incentives and adequacy concerns on the other. The ambivalent relationship between national policy making and the supranational level – presented in section 2.2.3 - is likely to lead to the adoption of policy measures exclusively aimed at improving sustainability while disregarding the adequacy dimension.

2.3 Health Care

2.3.1 The system's characteristics and reforms

Since 1978, Italy has a National Health System (NHS). In the past 20 years the NHS has undergone three relevant reforms: managerialisation, different forms of "privatisation", and decentralisation. To understand what happened in 2010 and the beginning of 2011, it is important to frame the changes inside this broader framework of reforms.

Managerialisation means that since the mid-1990s local health care units (hospitals, ambulatory and territorial health care facilities and services) have been transformed into "Agencies"; "general directors" (DGs) have been put on top of them in order to convert them into more managerial-like organisations.

Managerialisation went along with forms of "privatisation", both in terms of regulation (in 1992 "managed competition", and then, in 1999, "managed cooperation" were introduced in the NHS) and provision (since the 1980s, an increasing role has been played by private health care and ancillary services providers, contracted-out by the NHS).

Regionalisation is the third major reform carried out in the NHS. In the same decade when the NHS was introduced (the 1970s), regions started acquiring an institutional recognition, also in health care issues. However, until the mid-90s their role in the NHS was limited and they were more "policy takers" (mainly concerned with the implementation of centrally set

policies) than "policy makers" (France 2008). Only in the 90s, their role changed thanks to the marked process of strong political devolution. Therefore, the Italian NHS underwent a deep transformation: from a centralised system to a regionalised and semi-federalised one.

In order to understand what happened since 2010 it is important to focus on these three streams of reforms for two reasons:

a) these reforms are still ongoing and therefore both the policies concerning them and their effects are visible and relevant in the Italian health care arena; as will be shown below, a good part of the reforms in the past two years is related to managerialisation, privatisation and, mostly, decentralisation.
b) These reforms have taken place in a country that, at least in Western Europe, presents two very relevant socio-economic features at the macro-level: i) a high public debt with the relative difficulties / need to respect the EU stability pact; ii) very strong and marked territorial socio-economic differences (the GDP per capita in the richer central/northern regions is 76% higher than the one in the poorer southern regions – a distance not found in any other "old EU15" country).

Overall there have not been relevant changes in the health care system with regard to coverage, benefit package, co-payments (with some exceptions – see below), nor did the national consolidation programmes impact negatively on health policies.

Looking at reforms carried out between early 2010 and mid-May 2011, one can distinguish four main headings:

i) legislation concerning the general health care planning as well as specific health care issues and needs;

ii) the financing of the NHS;

iii) legislation concerning organisational issues and the "substantial" access to the NHS, in particular the problem of waiting lists;

iv) the regulation and the remuneration of health care professionals working in the NHS (in particular doctors).

Let us look at each issue.

i) *Legislation concerning the general health care planning, as well as specific health care issues and needs: the Health Care Plan 2010-2012; the National Health Care Plan 2011-2013; Palliative care; Prevention; the National Safe-Birth Plan; the Oncological Plan*

The year 2010 started with an agreement between the national government and the regions on the "Health Care Pact 2010-2012"[12], which is an institutional agreement concerning the financing and planning of the NHS for three years, aimed at improving service quality, appropriateness, and coordination. The parties agreed on a total national NHS funding of 104bn € for 2010, almost 107bn € for 2011, and an increase of 2.8% for 2012. The agreement prescribes a reduction of acute care hospital beds (from 3.8 per 1,000 inhabitants to 3.3) and it deals also with LTC issues (see point 2.3.1).

[12] See: http://www.governo.it/GovernoInforma/Dossier/patto_salute/.

If the "Health Care Pact 2010-2012" focuses mainly (but not only) on financing and cost-efficiency issues, in January 2011, the other main planning tool in the Italian NHS was finally drafted and it is under approval in the current months: the "Piano Sanitario Nazionale 2011-2013" (PSN – National Health Care Plan)[13]. Among the main innovationsw in the PSN are: the dismissal and transformation of small hospitals (into integrated health and social care or ambulatory facilities); the introduction of ambulatory care facilities open 24 hours a day and run by GPs (general practitioners) for non-acute or non-urgent health care needs, also in order to avoid waiting lists in the emergency rooms (ERs).

Apart from these two general acts, the legislation focused on a series of specific issues: palliative care initiatives; guidelines related to the birth and pregnancy experience in the NHS; an oncological plan; a national and regional prevention plan. Between December 2010 and January 2011 a "National safe-birth Plan" with relative guidelines[14] was published, aiming amongst other things at: reducing caesarean births (Italy has the highest incidence rate in EU); closing down small facilities (those delivering less than 500 births a year) and transforming those delivering between 500 and 1,000 births, making delivery safer; improving the quality of perinatal care and professionals' skills. In January 2010, a new three-year "Oncological Plan 2010-2012" was passed by the Ministry of Health focusing on prevention, care networks and innovation, also with the aim of reducing the increasing health inequalities between northern and southern Italy[15]. In March 2010, a law[16] was passed in order to give more support to end-of-life patients thanks to palliative care and a system of more adequate and diversified facilities. The law was passed with a general parliamentarian and bipartisan agreement between the government and the MPs from the opposition. In January 2011, guidelines were agreed between the state and the regions on the same issue, defining more precisely how to implement the law. A specific "Prevention Plan" was drafted in order to improve the effectiveness of the NHS in relation to different types of prevention (primary, secondary and tertiary)[17]: In April 2010, the state and the regions agreed on its implementation.

ii) *The financing of the NHS: Deficit coverage and standard costs*

A good part of government attention to the NHS in the past years has been devoted to strategies for containing costs and promoting a more effective use of financial resources. Compared to other European countries public health funding has been relatively low in Italy: the public per capita expenditure in 2008 was equal to 2,216€ (PPT) in Italy, and 2,304€ in the EU15 (source: OECD, Health at a Glance, 2010). Nevertheless, the majority of Italian regional governments were able to use the limited financial resources given by the central government to manage health care in an efficient way: in the past 20 years only a limited number of regions (most notably five out of twenty-one) have generated relevant deficits. Quite particular, these five regions account for more than 90% of the total deficit. Specific analyses on the causes of health care deficits in these regions show that these deficits were not caused by under financing by the government, but rather by problems in the way the health care delivery system was organised - i.e. an oversized hospital sector, a large number of accredited private providers, weak community-based and outpatient services, incapability to control costs of goods and services (Tediosi, Gabriele and Longo, 2009). Although the majority of regional governments were able to use resources in a more efficient way, the few

[13] See: http://www.governo.it/GovernoInforma/Dossier/piano_sanitario_2011_13/.
[14] See: http://www.gazzettaufficiale.biz/atti/2011/20110013/11A00319.htm.
[15] See: http://www.salute.gov.it/imgs/C_17_primopianoNuovo_264_documenti_itemDocumenti_0_fileDocumento.pdf.
[16] See: http://www.salute.gov.it/dettaglio/phPrimoPianoNew.jsp?id=268&area=ministero&colore=2.
[17] See: http://www.comunitapnp.it/file.php/1/Intesa_S-R_29apr10.pdf.

ones who were not coping have accumulated a relatively large deficit: between 2003 and 2009 the NHS had accumulated around 30 billion € of deficits. On average, this deficit represents around 4% of annual total public funding[18]. One region alone (Lazio) accounts for about 32% of the total deficit. Since the mid-2000s, different governments have tried to limit the growth of these deficits. The government activity in this field in the past 17 months focused on how to avoid accumulation of new deficits by (some) regional governments. The government is trying to use two different tools: one already implemented (the "piano di rientro"); another one just passed in May 2011 (the "costi standard").

The "piano di rientro" is an agreement between the central government and single regional governments who have accumulated health care deficits. The national government agrees to cover part of the debt in exchange of a sustainable "industrial" plan by regional governments to reorganise their health care system in order to prevent future deficits (through cuts in hospitalisation rates, stops in hiring new health staff, stronger control of pharmaceutical expenditure, etc.). In order to avoid possible opportunistic behaviour from regional governments with high deficits, these governments have to introduce automatically increases in their regional taxation system in order to cover a good part of the deficit produced, as well as new or higher forms of co-payments for health care services and goods (drugs). During the past 17 months the central government has engaged in the implementation of "piani di rientro" in eight regions (five of them with severe deficits), and the signing of agreements with two new regions[19].

The other main tool that the government has just developed is a new way to finance the regional health care system. This attempt is part of the more general attempt to transform the Italian centralised state into a federal one. Given the fact that health care represents around 70% of total public expenditure at this sub-national level, the definition of how health care is financed has quite a broad implication in terms of what type of federalism will arise from the reforms (for instance how the interregional financial compensation mechanism will work). The main point of discussion is the following: Given the fact that national health care provision standards (called "LEA" – "Livelli essenziali di assistenza" or 'essential levels of care') have already been defined, there is the need to adopt also similar standards for the costs associated with the provision of these "LEA". In May 2011, with the Law n° 68 the national government has introduced the tool of "standard costs", based on the concepts that, starting from 2013, LEA costs will be defined on the basis of a "benchmark" mechanism: A limited number of regions (three, to be precise: one each from northern, central, and southern Italy; among them one region must have "small" demographical dimensions) with no deficits and a good quality health care system will be considered as the reference point in order to define the amount of resources given to each region in order to fund its health care system[20]. The law defines also the modality of functioning of the "Fondo perequativo" (the national fund created to redistribute resources for health care among richer and poorer regions).

iii) *Legislation concerning organisational issues and the "substantial" access to the NHS*: *Waiting lists*

Even if there has not been a formal change in the access to public health care, an increasing problem affecting access to the Italian NHS are waiting lists. The government responded to this issue in November 2010 endorsing an agreement with the regions on how to tackle the

[18] See: http://www.sanita.ilsole24ore.com/PrimoPiano/Detail/1310287.
[19] See: www.salute.gov.it/pianiRientro/homePianiRientro.jsp.
[20] See: http://www.gazzettaufficiale.it/guridb/dispatcher?service=1&datagu=2011-05-12.&task=dettaglio&numgu=109&redaz=011G0112&tmstp=1305272114707.

issue. The main points of the agreement are the following: definition of specific time limits for the access to different health care services (in ambulatory, specialist and hospital care as well as for diagnostics); specific effort on how to reduce waiting lists in oncology and cardiology[21].

iv) *The regulation of health care professionals working in the NHS: remuneration and the possibility for NHS employees to work also in the private sector*

2010 and the first part of 2011 were characterised by the discussion about the new doctors' national contracts on the one hand, and about new forms of regulation and participation of health care professionals in the NHS on the other. The contract renewal in the first part of 2010 was important because it provided salary increases for doctors. These increases were frozen later in the same year (summer) once the government, due to the crisis and the Italian huge deficit, decided to substantially cut public expenditure. For the NHS, the government's decision meant a freezing of salary increases and a lower cap on public pharmaceutical expenditure. Moreover, regions with "piani di rientro" (see above) were also forbidden to hire new staff. Looking at the regulation of NHS staff there was a series of relevant changes related to: a) industrial relations (due to the Public Administration reform n° 150/2009), with only the first eight trade unions (out of 106 currently existent) being recognised in the health care sector as partners for the government in national agreements and discussions; b) a more precise regulation of private practices for NHS doctors (with more freedom for private practices for NHS employees in exchange of a more strict control and planning on how this private practice is organised by the NHS)[22].

In conclusion of this sub-paragraph it can be stated that relevant changes have been happening in health care organisation and health financing, but they have not substantially changed the entitlements to public health care services with regard to coverage, benefit package and co-payments. A distinction must be made between different parts of the country: Given the fact that deficits are concentrated in a small number of regions which are almost all situated in southern Italy and Lazio, the "piani di rientro" policies are affecting co-payments and NHS staff distribution. As stated before, in the regions with "piani di rientro" higher co-payments and taxes have been introduced. Just as an example, the funds coming from additional taxes on households and enterprises amounted to around 2 billion € in 2009 (almost 2% of the total NHS expenditure)[23].

Within this picture, the role of private provision is relevant and increasing in Italy: around 25% of total hospital discharges took place in 2009 in private contracted-out hospitals, whereas they accounted for around 16% in 1996[24].

2.3.2 Debates and political discourse

Quite many information on the debate and the political discourse in the NHS were already given in the previous sub-paragraph, given the fact that since January 2010 many government programmes have turned into legislation. Apart from these issues, the debate was characterised by the introduction of a system of evaluation of professional performance in the NHS as well as shortages of medical staff. The Ministry of Health (and public administration) is trying to introduce a system to measure the performance of health care authorities (including hospitals) and regions. The government supported one of the main organisations

[21] See: http://www.salute.gov.it/dettaglio/phPrimoPianoNew.jsp?id=295.
[22] See: http://www.salute.gov.it/professioniSanitarie/newsProfessioni.jsp?id=1276&menu=inevidenza&lingua=italiano.
[23] Source: interviews with trade unions representatives (CGIL).
[24] Source: Istat – Health for All database (various years) and Ministry of Health (2011).

representing health care authorities (FIASO) in the beginning of 2010 in an experimental evaluation of professional performance, also in relation to the interactions with patients in a sample group of local health care authorities (less than 20%). There was a quite relevant debate on the issue, considering that doctors' trade unions complained about the proceeding (they were not invited to participate in the drafting of the evaluation) and the methodology used. The end of the experimental evaluation was defined by different ministries a success, but it was also criticised by doctors' trade unions: from the evaluation it turned out that 45% of NHS staff presented a "high level of performance", 44% an "intermediate level", and 11% a "low level" [25]. This experimental evaluation led to the introduction of a "performance system" for the NHS by the Ministry of Health in the winter 2010-2011[26].

If the evaluation has been a field of discussion between health care professionals and the government, another issue at the centre of the debate has been the problem of a future shortage of medical staff. For instance, the Fnomceo (the national federation of doctors, surgeons and dentists), as well as other federations and trade unions of doctors expressed their worries about the future: Their estimates show the eventuality of a reduction of 40,000 doctors in the next 10 years, as the results of a (too) narrow access to medical university courses. Especially GPs risk to be hit by this problem (see also sub-paragraph 2.3.4)27. Moreover, other medical associations, like Anaao, are increasingly worried about the impact of "piani di rientro" on health care staff shortages in southern Italy[28].

In this whole debate about welfare reforms, the Pd (Democratic Party) proposed a document in February 2011 focusing on how to mix federalism with solidarity, given the increasing worries about the relatively worse performance of the NHS in the poorer southern regions[29].

2.3.3 Impact of EU social policies on the national level

The debate on the OMC in the field of health care has not had any relevant apparent impact. In particular, the Italian NRP (April 2011) focuses mainly on the economic sustainability of public health care expenditure. In different parts of the document the main issues are how to contain public expenditure in the field and how to avoid deficits (a typical problem of the sector, as discussed in previous sub-paragraphs). Even if Italy has had a per-capita public expenditure lower than the average EU-15 in the last two decades, the NRP focuses correctly on how to make more efficient and cost-effective public expenditure. The focus is on how to help and also sanction those regional governments responsible for health care delivery unable to avoid annual deficits (using the instrument of the "piani di rientro" and "patti per la salute"); and to make more effective public expenditure transforming the way health care is financed, shifting from a system based on "historical expenditure" (single health care units are financed on the basis of their previous expenditure) to a "standard costs" system.

What is missing in the rest of the document are any in-depth analyses and proposals for the access to health care (all the above stated proposals for health care do not refer to EU2020 targets but to the Annual Growth Survey actions, under the "Fiscal Consolidations" measures). In particular, the NRP seems to not take into consideration the following issue: Looking at the EU-SILC data from 2009 from Eurostat, the percentage of people with unmet needs for medical examination due to costs (it is considered by the interviewees too expensive) is equal to 3.9% in Italy – twice as high as the EU27 average (1.9%); moreover it

[25] See: http://www.sanita.ilsole24ore.com/PrimoPiano/Detail/1308487 and http://www.sanita.ilsole24ore.com/PrimoPiano/Detail/1347111.
[26] See: http://www.salute.gov.it/ministero/sezMinistero.jsp?label=trasp&id=800.
[27] See: http://portale.fnomceo.it/PortaleFnomceo/home.2puntOT.
[28] See: http://www.anaao.it/attivita.php?id=578&anno=2010&mese=12.
[29] See: http://beta.partitodemocratico.it/doc/202917/la-salute-in-tutte-le-politiche.htm.

is the highest in the EU27 after Bulgaria, Rumania and Latvia, and similar to Greece. The situation in Italy in 2009 is consistent with the results in previous years and it has perhaps deteriorated.

The only issue related to the EU debate that has attracted increasing attention in the government analysis is the linkage between health and ageing: Various government acts among which those dealt with in sub-paragraphs 2.3.1, 2.3.2, 2.4.1 and 2.4.2, discussed and passed in the past 17 years, explicitly address the issue of a shift in health care from acute to chronic needs, quite strongly concentrated in the elderly population. The answer to this shift proposed in these documents is a change in the health care delivery system with a strengthening of territorial care and a transformation of a part of the hospital sector into rehabilitation and long-term-care facilities. It is difficult to evaluate whether this increasing attention in the government analysis has been influenced by discussion and interaction at the EU level.

2.3.4 Impact assessment

A recent document from the Ministry of Health is very helpful in order to provide a concise picture of the Italian NHS and its functioning[30]. The Ministry has started to evaluate regional health care systems using a complex and comprehensive set of indicators (21) referring to their performance in terms of prevention (e.g. the percentage of women regularly undergoing mammography screening), ambulatory and territorial health care (e.g. the diffusion of hospice beds in relation to the total number of people who died from cancer), and hospital care (e.g. hospitalisation rate). Through a weighted comparative methodology each region's performance is evaluated. The result for 2009 was that out of 17 regional health care systems studied in the research 8 were considered good performers, 3 partially good performers (which means they have problems just on some dimensions of provision) and 6 with a critical performance (see below). What must be taken into account is the fact that situations of critical performance were found only in Lazio and in southern regions, whereas situations of good performance only in north-central regions. Thus, a first conclusion is that there are very relevant differences in the access to health care (also in terms of quality) not following the urban/rural areas divide, but another territorial divide: the North-South one.

Table 3: Evaluation results, 2009

Evaluation	Regions	Actions to be taken by the regional governments in 2010
Fulfilling all Health Care National Standards	Emilia Romagna (CN); Lombardy (CN); Tuscany (CN); Marche (CN); Piemont (CN); Umbria (CN); Veneto (CN); Liguria (CN)	----
Fulfilling almost all Health Care National Standards with the need to improve on some of those standards	Basilicata (S); Apulia (S)	decrease the percentage of caesarean sections
	Sardinia (S)	improve pharmaceutical care and prevention programmes
Critical situation, not fulfilling many National Health Care Standards	Molise (S), Abruzzi (S), Sicily (S), Campania (S), Lazio (CN), Calabria (S)	improve ambulatory, territorial and home health care reduce hospital care and make it more efficient contain pharmaceutical costs

Note: S = southern region; CN = central-northern region

[30] See: www.salute.gov.it/imgs/C_17_pubblicazioni_1534_allegato.pdf.

Overall, comparing the results of the Italian NHS with other EU countries with similar socio-demographic dimensions (Spain, Germany, France, UK), the Italian situation seems relatively good for many indicators (see Table 4 below).

Using mainly data from OECD (Health at a Glance, 2010), the comparison of health care systems has been made on several aspects: human, financial and technological resources used; prevention activity; hospitals' efficiency; integrated health and social care; the results achieved in terms of health; the level of health equity and inequality.

Looking at the Table, it clearly appears that for the majority of indicators used, the Italian NHS shows a situation in line (or sometimes even better) with the rest of the western European health care systems:

- Italy shows a better performance than the other EU4 (DE; FR; IT; UK) in terms of technology used (measured by the spread of magnetic resonance units), bed occupation rates, relatively low level of children mortality rates, relatively high survival rates after serious cardio-circulatory diseases;
- Italy shows a similar performance in terms of prevention, hospital efficiency (if measured in terms of average length of stay in acute beds hospitals).

These results were obtained using relatively fewer resources compared to the other countries and without a significant difference in terms of private expenditure.

However, there are other issues where Italy's performance seems quite worse than in the other EU4:

- health and social care integration is limited (e.g. given the low level of provision of residential care for the elderly);
- there are relevant differences in the access to services based on income (and social class).

Table 4: The functioning of the Italian NHS in a comparative perspective (years 2005-2008)

Dimensions	**Indicators**	**Italy**	**EU4**
Human, financial and technological resources	N° magnetic resonance units for each 1 million inhabitants	18.6	7.9
	Public health care expenditure as % of GDP	6.7	7.4
	Private out-of-pocket health care expenditure as % of total health care exp.	22.8	22.6
Prevention	% of women undergoing mammography, age 50-69 years	59.6	58.9
	Pertussis vaccination, children	96.6	96.6
	Hospital beds occupation rates	78.4	77.9
Integrated social care and health care	N° of residential facilities beds for frail elderly per 1,000 elderly	17.4	31.6
Results	Infant mortality rates	3.7	4.1
	Mortality rate for heart attack after 30 days of hospitalisation	4.0	6.2
Equity and inequality	% of individuals with a hospital care unmet need due to excessive cost	3.9	0.6
	Ratio between women in income I and V quintile undergoing mammography	0.83	0.60

Source: own elaboration from OECD (2010)

Three main problems seem to put the formal universal coverage by the NHS at risk: territorial inequalities; income inequalities in the access to services; the functioning of integrated social care and health care and the more general issue of LTC (see next section on this specific issue).

We have already discussed the first issue and the third one will be looked at in more detail in the section on long-term care (see 2.4). We can add some more information on the second issue. Looking at the Table below where data from EU-SILC 2009 are reported on the percentage of people with unmet needs for medical examination, Italy presents a relatively higher percentage (7.3%) in comparison with the rest of the EU27 (6.9%); and what is worrying is the distribution of this type of access difficulty along income lines: People with lower incomes (belonging to quintile I) have a four times higher risk of access problems than those in the richest quintile (V), whereas in the EU27 this ratio equals 2.

Table 5: Percentage of people with unmet needs for medical examination: Italy in a comparative perspective (year 2009)

Countries	Total	Ratio I - V quintile of equalised income
Italy	7.3	3.9
European Union (27)	6.9	2.0

Source: Eurostat EU SILC

If we want to get an idea of the impact of the recent crisis on access to health care, we can look at the data presented in the Table below, where it is reported how the situation in Italy has evolved over time: On the one hand, the good news is that the percentage of people with unmet medical needs has remained relatively stable before and during the crisis; on the other hand, the worrying news is that there has been an increase in economic inequalities in relation to health care access: The ratio between quintiles I and V has shifted from 2.9 in 2004 to 3.9 in 2009.

Table 6: Percentage of people with unmet needs for medical examination in Italy: changes over time (years 2004-2009)

	2004	2005	2006	2007	2008	2009
Total	7.0	7.0	6.9	6.6	7.5	7.3
Ratio I - V quintile of equalised income	2.9	2.9	2.6	3.0	3.2	3.9

Source: Eurostat EU-SILC

The presence of a relevant problem of inequalities is confirmed also by other studies published in 2010-2011. For instance, the last Ceis-Tor Vergata "VII Rapporto Sanità" (Health Report 2010), published in 2010, underlines that there are 1.5 million people in Italy who have to give up partially health care due to unaffordable out-of-pocket costs. Marinacci et al. (2010)[31] show that social health inequalities in Italy are strongly connected to territory and are widening. Among other (more traditional) social factors related to education and social class affiliation, living in the South increases the chance of having health problems. The fact that territorial inequalities are quite relevant is perceived also by citizens: A survey conducted in 2010 by the Ministry of Health has shown that Italians living in the South are more unsatisfied with their health care system in comparison to those living in the north-central part of Italy (for instance only 18% of southern citizens consider their hospital care system "good" vs. around 40% of those living in central-north Italy (Ministero della Salute, 2010)[32].

[31] Marinacci, Chiara, Ferracin, Elisa, Landriscina, Tania, Cislaghi, Cesare, Gargiulo, Lidia and Costa, Giuseppe (2010) 'Differenze geografiche o differenze sociali?', in IOHCR (2011), *Rapporto Osservasalute*, pp. 473-484.

[32] Ministero della Salute (2010), *Cittadini e salute. La soddisfazione degli Italiani per la sanità*, in "Quaderni del Ministero della Salute", n. 5.

2.3.5 Critical assessment of reforms, discussions and research carried out

In a comparative international perspective, the Italian NHS seems to function relatively well and the reforms undertaken in the past years do seem to improve this functioning. The different laws and agreements passed since 2010 have tried to focus on different aspects of the NHS (from specific relevant issues, such as palliative care, to more general ones, such as prevention or oncological care). Overall, the system seems to be improving, but there are very serious problems that can blur this general picture:

a. social inequalities between individuals and households with different income levels in the access to health care;

b. territorial inequalities in the access to decent health care (the North-South divide); from this point of view it is not clear what the impact will be of a broader regionalisation of the NHS thanks to federalism;

c. still too weak a system of integrated social care and health care for chronic diseases (see following section on this issue);

d. a forthcoming shortage of medical professionals. A recent study from the FnomCeO (the Italian Federation of Doctors' Associations) shows how relevant the problem is going to be in the near future. In its last National Conference in December 2010, the FnomCeO argues that 38% of the total active doctors' population in Italy is aged between 50 and 59 years. If one adds to this group also the older ones (60+), it means that in the next decade – maximum 15 years – 48% of the total number of NHS doctors are going to retire, as well as 62% of GPs and 58% of paediatricians[33].

Apart from more strictly health challenges (how to better cure cancer, cardio-vascular diseases, etc.), the four issues just given represent the main worries for the future of the Italian NHS. The developments in 2010 have not shown many improvements in this respect.

2.4. Long-term Care

2.4.1 The system's characteristics and reforms

Italy, together with Germany, has the highest proportion of elderly population in Europe. The percentage of over 65-year-olds (around 20% in 2009) is 3-4% higher than the figure for Spain, France, and Great Britain (Eurostat, 2010). Compared with the early 1990s, this value grew by around 37%. In absolute terms, this means an increase of 3.2 million people in just over 15 years, mainly concentrated among the over 74-year-olds (+2.0 million).

This progressive growth in the elderly population has not translated into a parallel increase in the dependent population. According to official estimates (ISTAT – The National Institute of Statistics), in 2005 there were approximately 2 million dependent people aged over 65, equal to around 19% of the elderly. In comparison with the mid-90s and using the standardised rate by age, the relative spread of disability among the elderly population declined significantly (18.8% in 2005 versus 21.7% in 1995).

In Italy, the provision of LTC has traditionally been characterised by a low level of public provision and funding, compared with other continental or northern European countries. A highly selective public system has been set against a considerable capacity of family and kinship networks to internalise caring functions. These two elements have constituted for a long time the principal traits of what has been termed the Italian "familist model", a model

[33] See: http://portale.fnomceo.it/ .

traditionally shared with other European Mediterranean countries (Naldini and Saraceno, 2008).

For many decades the poor extent of long-term care services did not constitute an urgent public policy problem as the strength of family-based intergenerational ties made it possible to absorb large parts of the emerging demands for care. It was only in the past decade that the traditional familist configuration of care arrangements has come under pressure by the emergence of two new trends: the ageing of the population, and a relevant increase in the female participation in the labour market.

The structure of the Italian public LTC system has been traditionally characterised by the presence of two parallel models of intervention, based on heterogeneous criteria for eligibility. The first and most relevant track consists of a cash allowance scheme, the *indennità di accompagnamento* (attendance allowance - IA). The second track, more residual, is based on local welfare schemes, which include the provision of residential and domiciliary services.

IA is a universalistic measure, accessible by all citizens certified as totally dependent, established on a national basis. The right to this allowance, independent from age, is guaranteed to those who are unable to walk and to perform everyday tasks and who require continuous care. It is the National Institute for Social Security (INPS) which manages the programme, without any substantial coordination with local authorities' care provision.

Whilst this measure was introduced in the 1980s primarily to provide disabled adults with benefits, in the past 20 years there was an unforeseen exponential growth of its use by the dependent elderly. While elderly beneficiaries of the scheme were around 200,000 in 1984, they reached 1.3 million in 2009. The coverage level among the elderly was inferior to 3% in 1984 and equal to 10% in 2009. The elderly represented around 20% of all beneficiaries in 1984 and 78% in 2009.

IA does not involve any form of *ex ante* definition (or *ex post* control) on how the cash granted is actually used: Once the right of a citizen to the benefit is recognised, it is given without any restriction placed on its use. Consequently, IA can be used to purchase services on the private market without restrictions and may indirectly encourage the growth of a grey care market.

The second track of public LTC consists of local welfare programmes, including the provision of residential and domiciliary services. The very fragmented provision of such LTC services is the result of the considerable division of responsibilities among local and health authorities. Health services (hospitals, home health care etc.) are distributed on a universalistic basis and almost free of charge, but they are strictly limited to medical and nursing services, while social services are provided by local authorities on the basis of highly selective and extremely territorially varied criteria of access.

As a consequence of this lack of coordination, not only is the provision of these services subject to great geographical variation, but intervention is limited to a very small number of people, if compared with most of the other north-central European countries (Ministry of Employment and Social Affairs, 2010). It is estimated that around 4-4.5% of the elderly population in Italy benefits from public home care programmes (1.8% of home care provided by local authorities and 3.0% by the NHS) and 3% have access to residential care. Data for other European countries are different: Around 7-8% receive home care in Germany and in France, and around 5-6% receive residential care in Germany, in France and in the UK (Pavolini and Ranci, 2008; Ministry of Employment and Social Affairs, 2010; OECD, 2011).

The overall public expenditure for LTC in 2007 was 17.3 billion €, equal to 1.13% of the GDP and it is mainly concentrated in NHS interventions (0.46% of the GDP) and the Cash Allowance programme (0.54%) (*ibidem*). It should also be added that this figure does not consider "inappropriate" discharges by frail elderly in the hospital system: The Ministry estimates that 20-25% of total hospital discharges are related to elderly patients with chronic conditions, using often (acute) hospital services in an inappropriate way. If this type of expenditure were to be added, the total LTC expenditure would be around 2% of the GDP.

Given the increase in the elderly with LTC problems, the weakness of public service provision and the spreading of cash allowances (the IA), a substantial proportion of families with frail elderly has turned to the private market. The phenomenon grew quickly: In 2009, it was estimated a presence of more than 700.000 foreign paid care workers, mostly working on an individual basis at frail elderly people's homes, equal to at least one third of the total female migrant labour force (Gori, 2010).

The practical absence of administrative controls contributes to the high amount of irregular work in this field: The rate of irregular jobs in the "domestic services" sector is estimated by ISTAT at 64%.

Given this general context, we can look at what happened in Italy since 2010. The first consideration is that, in comparison to health care (see the previous paragraph), reforms and legislative production were quite more limited.

Below, the main acts passed or discussed by the government are quoted:

- the "Health Pact 2010-2012" (see also section 2.3.1);
- the "National Health Care Plan" PSN 2011-2013 (see also section 2.3.1);
- the "Guidelines for rehabilitation care"[34];

All three acts were drafted by the Ministry of Health and not the Ministry of Social Affairs. They concern mainly health issues, opening up to LTC as a "sub-field" of policy. The Health Pact and the PSN both share the same view. Given the change in health needs (away from acute care toward chronic and LTC needs), the whole health care sector must be transformed by decreasing the traditional hospital beds supply and shifting the resources to domiciliary care as well as residential care, tailored specifically for people with LTC needs (nursing homes, etc.).

The guidelines for "rehabilitation care" focus on three issues, related to the ones indicated in the other two above documents: an interdisciplinary approach to care, continuity of care and individualised care. Three different types of rehabilitation are set by the guidelines, depending on the specific type of need.

In contrast to health care, LTC was comparatively harder hit by the austerity programmes due to the recent financial and economic crisis. Even with a public intervention relatively limited, the recent budget planning laws have deliberated quite relevant expenditure cuts. In particular the state financing of social care and social assistance was reduced between 2008 to 2011 by 79%, and the forecast for 2013 sees a reduction (in comparison with 2008) of 89% (Ires, 2012).
Inside this cut, there is also the one to the National Fund for Dependent people (*Fondo Nazionale per la non autosufficienza*), introduced in 2007, whose total amount was equal to 400 million € in 2008 and now has been reduced to 0 €. Of course, LTC financing was not

[34] See: http://www.governo.it/backoffice/allegati/60192-6299.pdf.

based only on this State source, but in a situation of dire straits for local governments (those running the LTC services), this reduction might mean the suspension of part of the provision.

At the same time, the national government is experimenting more intensely on a "social card" programme, transferring financial resources to the most vulnerable and needy (and among them quite often the frail elderly). The resources allocated to this programme do not match the cuts in all the other social care and assistance programmes.

Given the fact that the LTC coverage is relatively limited in comparison with actual needs, the government has been developing, since 2008 and increasingly since then, the idea of fostering integrative private health care funds (*fondi sanitari integrativi*) in order to cover citizens' extra-NHS expenses and LTC expenses. In specific, the Ministry of Social Affairs at the end of 2009[35] introduced a potential relevant change in the regulation of private health care funds. In order to obtain fiscal advantages, the funds have to use at least 20% of their provision in order to cover specific needs. Among those needs funds can provide services for LTC.

Until a few years ago, these funds were scarcely spread (in comparison with many other EU countries, the great majority of private health care and LTC expenditure in Italy was out-of-pocket and not from private insurances), in the past two years they seem to start covering a broader proportion of the population but the data on the issue are still limited and the impression gathered from different sources (interviews with key informants, statistics, etc.) is that these funds are, on the one hand, not just "integrative" but substitutive of public expenditure, and, on the other hand, still scarcely affecting the overall distribution of resources in the field of health care and LTC.

Overall, given the fact that still LTC public services are limited and the main form of public intervention is through cash allowances, the Italian system relies mainly on family care and private paid care (through migrant workers) (NNA, 2010).

Within this situation, as already for health care, there is a big divide between north-central regions and southern ones. The former have developed also a relatively robust model of service provision (home care and residential care) (some regions cover up to 12-14% of the elderly – figures similar to those found in other EU countries); the latter rely mainly on national cash transfers, thus putting even more pressure on informal family care (Ranci, 2008).

2.4.2 Debates and political discourse

In comparison to health care, again, the debate on LTC since January 2010 has been quite more limited. If, on the one hand, all the main actors in the public policy arena recognise the change in social and health needs, with an increasing relevance of LTC and chronic problems, on the other hand the discussions did not seem to have developed an answer similar to what happened in other western European countries (Ranci and Pavolini, 2008). In particular the government has been focusing its proposal and actions on two issues:

- fostering new forms of private funding for LTC;
- fighting inappropriate access to cash allowance programmes.

As already mentioned, the Ministry of Social Affairs seems to focus mainly on how to foster private "health care funds" coverage of LTC; the line of reasoning of the government can be

[35] See: http://www.normativasanitaria.it/jsp/dettaglio.jsp?id=31878&query=TITOLO%3A%20fondi%20sanitari%20DATA%20GU%20DA%3A%2016%2001%202010%20DATA%20GU%20A%3A%2016%2001%202010%20ORDINA%20PER%3A%20dataAt%20.

quite well understood quoting what Minister Sacconi said in a public speech in July 2010[36]. He argued that there is the need to improve the private-public partnership, avoiding wasting resources for inappropriate LTC spending (for instance close inefficient small hospitals and transform them into residential care facilities), fostering private funds, and adopting a model that "sees first an adoption of a funded system on a voluntary basis, a system that might turn into a compulsory one".

The other main issue debated in the past one and a half year is the (correct) access to the cash allowance system (*indennità di accompagnamento*). As already stated, there has been quite a huge increase in the take-up rate of beneficiaries of this programme in the past years. Whilst some observers argue that this is the result of a public LTC system lacking services (more and more households with frail elderly try to enter into the IA, given the fact they cannot look for many other sources of public help) (Ranci, 2008), the government seems more convinced that there is also an increase of misuse in the programme[37]. Therefore, on different occasions during parliamentary hearings, the Minister for Labour and Social Affairs has illustrated the strategy of the government in order to limit abuses in the access to IA through a stricter control of the way citizens become beneficiaries (also introducing sanctions for doctors working in the needs' evaluation commissions).

Even if other actors (for instance, pensioners' trade unions) try to campaign in order to get a "National Fund", as in other European countries, the discussion in Parliament does not seem to improve at all in this direction.

As a matter of fact, the only main proposal from the Parliament came in spring 2010, and it was related to helping informal family carers of frail relatives. The proposal focuses on conciliation, fostering the possibility of an earlier exit from the Labour market for caring needs[38]. This solution seems to not fine tune with the transformations in the labour market and the need to avoid an even higher inactivity (female) rate in a country as Italy which is already lagging behind Lisbon Strategy targets on (women) employment (Saraceno, 2010).

Given this situation, the debate on access to and quality of LTC seems quite weak and it is not at the core of social policy consideration at this very moment in Italy. The situation changes when we shift from the national to the regional level. In north-central Italy local actors (public and private ones) are quite more involved in a discussion on how to improve the LTC system and in the past few years an increasing amount of resources has been devolved to this field of policy (Ministero del Lavoro e degli Affari sociali, 2010). In the South, there is almost no sign of such a debate (apart from regions like Puglia and Basilicata). Therefore, the distance between the two areas of the country seem to be wide and increasing: on average north-central regions have LTC services coverage rates three times higher than in the South (Ministero del Lavoro e degli Affari sociali, 2010).

2.4.3 Impact of EU social policies on the national level

The debate on the OMC in the field of LTC has not had any relevant apparent impact. In particular, the Italian NRP (April 2011) focuses on the economic sustainability of public health care expenditure. In many parts the document focuses on how to contain public expenditure in social policy and how to avoid deficits.

[36] See: http://www.sanita.ilsole24ore.com/PrimoPiano/Detail/1330471.
[37] See: http://www.lavoro.gov.it.
[38] See: http://www.fraxa-sarda.ingross.it/index.php?option=com_content&view=article&id=31:norme-in-favore-dei-lavoratori-che-assistono-familiari-gravemente-disabili&catid=2:ultime&Itemid=5.

Given the relevance of economic sustainability, what is missing in the rest of the NRP is any in-depth analysis and proposal for the access to long-term care (all the proposals contained in the NRP do not refer to Europe 2020 targets but just to the Annual Growth Survey actions, under the "Fiscal Consolidations" measures).

In particular, LTC is almost not being considered at all. Just two pages (NRP, pages 60-61) make reference to using more resources also for LTC and especially home care. The problem is that, at the same time, there is no reference in the NRP document to the fact that, as already stated, Italy has mainly a cash-based LTC system, partially less developed in terms of service provision; the recent budget planning laws have deliberated expenditure cuts (in particular the state financing for social care and social assistance has been reduced from 2008 to 2011 by 79% and the forecast for 2013 sees a reduction of 89% in comparison with 2008). Of course, LTC financing is not only based on state resources, but in a situation of dire straits for local governments (who also run LTC services), this reduction might mean the suspension of part of the provision.

The issue of the linkage between poverty and LTC is not very much taken into consideration in the scientific literature and partially in the public debate, apart from general statements by associations and some politicians on the risks of impoverishment due to the costs households have to sustain when they care for their frail relatives.

The only recent study on the issue is one that has been quoted already in the health care policy section (2.2.4): The last Ceis-Tor Vergata "*VII Rapporto Sanità*" (Health Report 2010), published in 2010, underlines that there are 1.5 million people in Italy who have to give up health care in part due to unbearable out-of-pocket costs. In the definition of health care in the Ceis-Tor Vergata study LTC costs are also included. The conclusion of the report is that 2.6% suffered impoverishment due to costs often associated with LTC.

2.4.4 Impact assessment

The Italian LTC can be described as in the latest available document from the Ministry of Employment and Social Affairs (2010): ""*Indennità di accompagnamento*" (the national care allowance system), (migrant) care workers, families and volunteering play the main role in frail elderly care and they are, in a certain number of regions, the main substitute for missing LTC public services" (p. 26).

In sum, in recent years the Italian LTC public system has finally reached a level of needs coverage (at least in terms of elderly population covered) quite similar to Central European countries (like France and Germany). However, there are two peculiarities about the Italian LTC model. First, this increase in the coverage rate was mainly politically unintentional and driven by inertia. Secondly, the needs coverage extension came thanks to a broader universalism in financing, going along with more privatisation in the delivery and organisation of the LTC services.

In order to understand which factors have influenced this transformation, we need to take into account the following aspects:

1. In the last two decades the familist care model, historically dominant in Italy, has entered into a deep crisis (Pavolini 2004); this fact is not only the result of an increase in the number of elderly with disabilities (as many would expect), but also the effect of profound labour market transformations following a consistent growth in women employment; therefore, it is also the increasing difficulty of reconciling work and care in

a context of unchanged family organisation that has weakened the traditional intergenerational solidarity on which the familist system was historically grounded.

2. The national public welfare system has formally reacted to this crisis with institutional inertia, as opposed to the reforms introduced in this field in most other European countries (Pavolini and Ranci, 2008). Given a dual LTC public system, based on highly residual in-kind services and a more diffuse cash programme, the institutional inertia has meant that more and more dependent elderly started requesting cash benefits. As a consequence, the Italian public care system has strongly radicalised the cash-based and unconditional characters of its long-term care provision, reaching a level of coverage similar to the one of other continental countries.

3. The reduction in families' caring capacities has been indeed counterbalanced by the dramatic growth of a private care provision; this growth has been largely favoured not only by migration policy implicitly tolerating the entry of a tremendous number of (female) undeclared immigrants, but also by the availability of public transfers; therefore the inertia of public policy related to LTC services, tied to a 'natural' increase of cash-based schemes beneficiaries, has driven the Italian dependent population (and their families) towards a new self-made, market-oriented, but publicly financed solution (Bettio et al., 2006).

4. The growth of this private care market is built on a complementarity between private paid care and family care; therefore the huge reliance on "family assistants" is to be considered as an adaptation of the traditional familist system to an increased female employment rate and following increased reconciliation difficulties (ibidem).

The growth of a private market of care in Italy can be understood as a consequence of changes taking place in the domestic labour market, asking for a reorganisation of family care arrangements that can combine working and caring responsibilities more easily than in the past; the inertia of public policy has paradoxically facilitated a solution that makes it possible to adapt the traditional care regime under new labour market and social conditions.

Given the fact that the Italian LTC model is mainly built around cash transfers, private market and family care, the impact of the crisis has been limited on beneficiaries. In particular, if it is true that the government has reduced some of the funds (see sub-paragraph 2.4.2), at the same time, due to the relative scarcity of LTC service provision, households have to keep on relying on their own caring capacity and, mainly in the richer central and northern regions, to the private care market made up of migrant women: Even if there was a general reduction in employment between 2007 and 2009, one of the few segments of the labour market with increased employment during the crisis was exactly the one related to "services to households" and, among them, also those related to care (Fellini and Zaccaria, 2011).

Given the fact that the system relies mainly on private and informal care, partially financed through the national cash allowance programme, a series of consequences arises:

a. the set of indicators used to assess quantity and quality of long-term care services is not too much developed; usually coverage data are used (e.g. the percentage of frail elderly receiving home care, etc.), together with hospitalisation rates for individuals over 75 as an indicator of possible inappropriate use of the hospital sector, and care intensity indicators (average no. of hours per beneficiary in a year);

b. from own calculation based on different sources (OECD, 2008; Istat, 2010, 2011*b*), it is possible to estimate that there are around 115,000 (full time equivalent) public professionals (doctors, nurses, care workers) working only in the LTC field for the frail elderly, whereas in the private sector (made up mainly of migrant women) they are more than 700,000 workers.

In this situation the issue of LTC quality and training for LTC workers has been framed referring less to the public workforce and more to private care workers. Anyway, even in relation to this last issue, no national policy has been implemented so far, but single regions have tried to train private care workers and improve the quality of their skills, but with relatively scarce results (Pasquinelli and Rusmini, 2010).

Looking more deeply into the way public LTC works, from a strictly medical point of view, the main worry so far deals with GPs. GPs are a central element in the Italian LTC (and health care) system, because they represent the crucial players (theoretically) ensuring the coordination between families and the public system in issues related to territorial care and the continuity of care once patients are discharged from hospitals. Given the ageing of the population, more and more of these GPs patients have LTC needs. The problem here lies on the fact that 62% of total GPs in Italy have are aged between 51 and 59. This means that in 10-15 years the majority of the actual GPs will retire and there is no sign so far of a relevant increase in the number of new GPs entering the profession in order to replace the ones retiring[39]. This issue will be a dramatic one for the future and so far it seems that no specific policy measures have been adopted to face it.

In a mainly cash-based LTC system it is difficult to offer information on the overall quality:

- LTC beneficiaries who receive residential care do receive generally a service of good quality in terms of staff-beneficiaries ratio, type of assistance, etc. (NNA, 2010); as already stated, the problem is that the availability of residential beds is relatively limited if compared to other EU countries;

- LTC beneficiaries who receive (nursing) home care are not well covered in terms of hours intensity: The Ministries of Health (2010) and of Labour and Social Affairs (2010) report that a beneficiary of nursing home care and a beneficiary of (social) home care respectively receives 19 hours of assistance per year and less than 4 hours a week;

- LTC beneficiaries who do not receive public services but only the attendance allowance (*indennità di accompagnamento*) and/or do use private (migrant) care workers find themselves in a situation where the need to cover LTC is quite more relevant than the quality of provision; there seems to be a trade-off between coverage and paid carers' professionalism: Families accept not to pretend too much professionalism in exchange for a (cheap) access to (migrant) paid carers' help (Ranci, 2008). Public policies do not offer too much help from this point of view, given the fact that they have not been able so far to regulate and improve the quality of this private carers market (see comments above).

If the Italian LTC system is characterised by such a cash-based and informal/private carers provision system, the forecasts and estimates for the future tend not to focus on future demand

[39] See: http://portale.fnomceo.it/PortaleFnomceo/home.2puntOT.

for facilities, staff, and services but only on future expenditures. The most recent figures, given by the OECD (2011), estimate that the expenditure could shift from 1.7% of GDP at the end of last decade to up to 4% in 2050, given the ageing of the population.

2.4.5 Critical assessment of reforms, discussions and research carried out

The Italian public LTC seems to show two different "sides" - one positive, the other one more problematic.

The positive side is represented by the fact that today more than 10% of the elderly do receive some form of public coverage for their LTC problems. This level of coverage is not distant or different from the ones typical of many other western EU countries.

The more problematic side is related to the fact that this coverage comes mainly from cash programmes and less from the delivery of services. The fact that the system is cash-based (and it is increasingly so) has three effects, strongly interlinked with each other: still a lot of pressure and responsibilities are on family carers' shoulders; a private care market (quite often "grey" and made up of migrant women) has developed tremendously in the past 10-15 years; the investment in professional human resources in the public sector for facing LTC needs has been limited. Moreover, as for health care, there is a clear (and worrying) territorial divide with the southern regions showing a very limited level of LTC service provision in comparison with the north-central ones.

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MINISTERO DELLA SALUTE (2010), *Cittadini e salute. La soddisfazione degli Italiani per la sanità*, in "Quaderni del Ministero della Salute", n. 5.

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NALDINI, MANUELA and SARACENO, CHIARA (2008), Social and Family Policies in Italy: Not Totally Frozen but Far from Structural Reforms**,** in *Social Policy & Administration*, vol. 42 (7), article.

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PAVOLINI, EMMANUELE and RANCI, COSTANZO (2008), Restructuring the Welfare State: Reforms in long-term care in Western European countries, in *Journal of European Social Policy*, n° 3.

PIZZUTI, Felice Roberto and RAITANO, Michele (2011), Le prospettive del sistema previdenziale: problemi e proposte, in PIZZUTI, Felice Roberto (eds), Rapporto sullo Stato Sociale. Anno 2011, Simone editore.

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3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R5] BOERI, Tito and GALASSO, Vincenzo, Is Social Security Secure with NDC?, IZA Discussion Paper No. 5235 /retrieved from: http://www.iza.org/en/webcontent/publications/papers/viewAbstract?dp_id=5235

The article presents an evaluation of NDC systems implemented in Italy and Sweden. By carrying out simulation of the future pension benefits for the current generation of young workers with fragmented careers in Italy and Sweden, they suggest that the replacement rates will be low, unless the retirement age is significantly increased. This may lead to the political sustainability of the NDC systems in the future, unless important labour market reforms are introduced. Consequently a discussion of the effects on the future generation of retirees in Italy and Sweden of a current labour market reform is provided: the introduction of a unique labour market contract, aimed at reducing the dualism between temporary and permanent workers.

[R5] DEKKERS, Gijs et al., The flip side of the coin: the consequences of the European budgetary projections on the adequacy of social security pensions, in European Journal of Social Security, vol. 12, n. 2.

The authors argue that the adequacy and sustainability of pensions are two sides of the same coin and a full assessment of pensions therefore requires integration. Therefore they apply the dynamic micro simulation model MIDAS to assess the consequences of the AWG-projections and assumptions on the future adequacy of public pensions in Belgium, Germany and Italy. A comparison of the simulation results suggests that the impact of the parametric pension reform in Belgium and Germany and the systemic reform in Italy on (re)distribution and the risk of low income go into the same direction, but that the magnitudes differ.

[R3] JESSOULA, Matteo, Recalibrating the Italian welfare state: a politics too weak for a "necessary" policy?, in GIULIANI, Marco and JONES, Erik (eds.), 2010, Italian Politics 2010, Oxford, Berghahn Books.

The chapter focuses on the attempts to recalibrate the Italian welfare state by focusing on the fields of pensions, unemployment protection and social assistance policies. The analysis shows that social policy developments of social policy in 2009 seems to confirm, with a

significant exception, that while the retrenchment component of the rebalancing of the Italian welfare state is effectively pursued, the expansive component is much less dynamic. This recalibration, in fact, risks being "choked" by the constraints of public finance, on the one hand, while on the other hand, it is characterised by a weak politics that (often) does not allow for the seizing of the opportunity that it has been presented.

[R2] JESSOULA, Matteo, Italy: from Bismarckian pensions to multi-pillarisation under adverse conditions, in EBBINGHAUS, Berhnard (ed.), 2011, The Varieties of Pension Governance: Pension Privatisation in Europe, Oxford, Oxford University Press.

The volume chapter provide a detailed analysis of supplementary funded pillars in the Italian pension system by focusing on: the changing public-private mix, the different types of supplementary schemes, their development, coverage, financing and level of contributions, type of benefits, administration and surveillance.

[R5] PIZZUTI, Felice Roberto and RAITANO, Michele, Le prospettive del sistema previdenziale: problemi e proposte, in PIZZUTI, Felice Roberto (eds), 2011, Rapporto sullo Stato Sociale. Anno 2011, Simone editore.

"The prospect of the pension system: problems and solutions"

The chapter deals with problems stemming from the interplay of labour market conditions and pension rules, particularly the implementation of the NDC system in Italy. Also the authors propose a number of solutions aimed at tackling the risk of inadequate old age protection for atypical workers.

[H] Health

[H1] BORDIGNON, Massimo and DIRINDIN, Nerina, Costi standard: nuovo nome per vecchi metodi, La Voce, 28-9-2010, La Voce/retrieved from:http://www.lavoce.info/

"Standard Costs: new name for old methods"

The article takes a critical view at the new way the Italian State will finance the NHS, arguing that the system is not so innovative as it might seem at first sight.

[H] CEIS – TOR VERGATA, VII Rapporto Sanità, 2010, CEIS (Rome)/retrieved from: http://www.ceistorvergata.it/public/CEIS/file/doc/rapp_sanit09_ITA.pdf

"VII Health care Report"

The Health care Report is, together with the OASI – Cergas and Osservasalute, the most comprehensive annual publication on health care transformation in Italy. The 2010 edition, apart from a series of chapters on different aspects of health care (domiciliary care, hospital care, etc.) focuses on the issue of health care performance measurement.

[H] CERGAS, Rapporto OASI 2010, Milano, Università Bocconi Editore (Egea), 2010.

"2010 OASI Report on the Italian NHS"

The OASI Report is, together with the Osservasalute Report and the CEIS-Tor Vergata publication, the most comprehensive annual publication on health care transformation in Italy.

The 2010 Report provides a comprehensive overview of the structure and operational arrangements of the Italian NHS. It also provides detailed statistical information on the financial management of individual regional systems, and sheds light on the criteria which are used to set the tariffs for the various medical services. Other aspects which the report discusses include among others: a) primary health care in the light of the new contractual arrangements with general practitioners; b) the interaction between medical staff and health managers; c) ageing of medical staff and its consequences; local health agencies' strategies and goals in the context of budgetary discipline by regional governments.

[H4, H5] HEALTH SEARCH, VI Report Health Search, 2010, Genomedics, Florence, page/retrieved from: http://www.healthsearch.it/documenti/Archivio/Report/VIReport_2009-2010/HS_VReport-2010_HiRes.pdf

The book analyses how it changing in Italy the role of GPs and what it will be the future challenges.

[H4, H5] NERI, Stefano, Il medico di famiglia e le sfide dell'aggregazione, Nel merito, 28-5-2010, Nel Merito/retrieved from: http://www.nelmerito.com

"GPs and the challenge of joint working"

The articles analyses of the main problems in the regulation of the health care workforce: the shift from a system based on single GPs working by themselves to one where they work jointly.

[H] OECD, VII Help Wanted. Providing and Paying for Long-Term Care, OECD (Paris)/retrieved from: www.oecd.org/health/longtermcare/helpwanted/

The latest OECD study on LTC focuses on the impact for LTC policies an increasingly ageing society and the transformations in the labour market will have. The study focuses on many countries and among them also on Italy, considering issues such as: the impact of LTC on carers; the LTC professional world; current and expected LTC expenditures.

[H] OSSERVATORIO SULLA SALUTE NELLE REGIONI ITALIANE, Rapporto Osservasalute 2010, 2010, Rome/retrieved from:
http://www.osservasalute.it/

"2010 Report on health in the Italian Regions"

The Report "Osservasalute" is, together with the OASI – Cergas and the CEIS-Tor Vergata publications, the most comprehensive annual publication on health care transformation in Italy. In 2010 publication, among other articles, it is quite interesting and relevant the essay on territorial health inequalities.

[H3] QUADERNI DEL MINISTERO DELLA SALUTE, Cittadini e salute. La soddisfazione degli Italiani per la sanità, journal issue: n° 5, sept-oct. 2010, Ministero della Salute/retrieved from: http://www.salute.gov.it/dettaglio/phPrimoPianoNew.jsp?id=298

"Citizens and Health. Italians' satisfaction with their health care system"

The research presents the results of a survey on a sample of Italians interviewed on how they judge their health care system. The study confirms a deep differentiation in citizens'

satisfaction depending on the geographical area where they live, with quite higher satisfaction rates in Central and Northern Italy.

[L] Long-term care

[L] BASILE, Rossella, Tagli al welfare. C'è un futuro per le politiche sociali?, RPS – Rivista delle Politiche Sociali, 23-5-2011, RPS/retrieved from:
http://www.ediesseonline.it/riviste/rps

"Welfare cuts. Is there a future of social policies?"

The article takes into consideration the recent expenditure cuts to social policy budget in 2010-2011 and, in particular, it provides data on LTC.

[L] GORI, Cristiano (ed.), Il sistema di protezione e cura degli anziani non autosufficienti, 2010, Irs, retrieved from:
http://www.lavoro.gov.it/NR/rdonlyres/8540EA88-D25E-42B2-B352-EDC8D23BC2DE/0/RicercaIRS_nonautosufficienzaott2010.pdf

"The LTC system for frail elderly"

The research analyses in the first part the actual LTC system in Italy from different point of view (coverage, funding, types of services, etc.). The second part of the book focuses on possible policy innovation in order to make the system more effective.

[L] MINISTERO DEL LAVORO E DELLE POLITICHE SOCIALI, Rapporto sulla non autosufficienza in Italia. Anno 2010, 2010, Roma, retrieved from:
http://www.lavoro.gov.it/NR/rdonlyres/9B939247-1A95-468A-9A54-6E58BE0DD85C/0/210710rapportosullanonautosufficienza.pdf

"National Report on LTC. Year 2010"

The Report is the most updated government document on LTC. The first part of the report deals with the transformation of needs (ageing, etc.). The second part focuses on dependency and the third one on LTC public provision. The last part of the document analyses more in depth the main issue concerning LTC: home care, funding, residential care, dementia, etc.

[L] NNA, Network Non-Autosufficienza, L'assistenza agli anziani non autosufficienti in Italia. 2° rapporto, Maggioli Editore, 2010, Sant'Arcangelo di Romagna (RN)/retrieved from:
http://www.maggioli.it/rna/2010/index.htm

"Elderly care in Italy. Second Report"

The report analyses the situation of elderly care in Italy, focusing both on needs and the structure of LTC supply, between informal, private and public provision.

[L] SARACENO, Chiara, Dilettanti allo sbaraglio sulla non autusufficienza, La Voce, 18-5-2010, La Voce/retrieved from:
http://www.lavoce.info/articoli/-famiglia/pagina1001738.html

"Incompetents and LTC"

The article is quite critical with the bills proposed in Parliament aiming at helping conciliation for relatives who provide LTC help.

4 List of Important Institutions

AGENAS, Agenzia Nazionale per i Servizi Sanitari Regionali – National Agency for Regional Health Services

Webpage: http://www.agenas.it

AGENAS is a public agency which provides technical support to the Ministry for Labour, Health and Social Policies but also to the Regions, concerning development strategies for the National Health Service. AGENAS also works in close cooperation with the State-Regions Board. Its mission includes evaluating whether and to what extent the Regions effectively guarantee health care standards. Further, it is responsible for monitoring health costs, system innovations but also waiting lists, and elaborating proposals on how to improve organisational arrangements.

Banca d'Italia – Central Bank of the Republic of Italy

Address: Via Nazionale, 91, 00184 Rome
Phone: 0039 (0) 06 47921
Webpage: http://www.bancaditalia.it

The Bank of Italy is the central bank of the Republic of Italy and part of the European System of Central Banks (ESCB) and the Eurosystem. It is a public-law institution and pursues aims of general interest in monetary and financial matters: price stability, the primary objective of the Eurosystem under the Treaty establishing the European Community (the EC Treaty); the stability and efficiency of the financial system, thus implementing the principle of the protection of savings embodied in the Constitution (Article 47(1) "The Republic encourages and protects saving in all its forms, it regulates, coordinates and controls the provision of credit"); and the other duties entrusted to it by Italian law. In performing its tasks the Bank operates autonomously and independently, in compliance with the principle of transparency and the applicable provisions of Community and Italian law. Consistently with the public nature of its functions, the Bank prepares information and data for maximum dissemination. It publishes various economic and legal publications, among others Annual Reports, Economic Bulletins, Regional Reports, Legal Research Papers, Economic Working and Occasional Papers.

CEIS, Centre for economic and international studies – University of Rome "Tor Vergata", Rome

Webpage: http://www.ceistorvergata.it/

The Centre of Economic and International Studies (CEIS) is an internationally recognised research centre within the Faculty of Economics at the University of Rome, Tor Vergata. Its mission is to conduct high quality policy-relevant research on emerging economic issues that call for innovative and impact-oriented responses from the academic community; promote advanced training leading to post graduate degrees in key areas of economics thus empowering graduates to forge ahead and succeed in the field of economics. CEIS is dedicated to the generation and dissemination of outstanding research and analysis for the promotion of sustainable economic development, expanding and improving public policy options in Italy and around the world. Its research agenda covers diverse areas and fields of economics emphasising global macroeconomics topics, development and growth theory, international money and finance, energy and environment among others. One of the most important publications is the annual Health Report.

Centro Studi Investimenti Sociali (CENSIS) – Centre for Social Investiments Studies
Webpage: http://www.censis.it
Description: Censis was founded as a social study and research institute in 1964, becoming a legally recognised Foundation in 1973 through Presidential Decree. In the last years Censis has conducted more than 60 research projects annually for a variety of clients, for the private and for the public sector, at local, national and international level. The most important areas of interest of Censis activities include: Education; Labour market; Welfare policies; Health; Local development; Cultural policies; Information; Mass media; Security, irregular migrants flows, trafficking of human beings. It has gained the reputation of being one of the most prestigious national research institutes in social sciences and economics. The main publication is the Annual Report.

CERP – Center for Research on Pensions and Welfare Policies
Address: Moncalieri, Turin
Webpage: http://cerp.unito.it/
CeRP is a research centre in Italy with a specific focus on pension economics and the economics of ageing. The main research topics include pension systems design, reform and evaluation; households' saving; retirement patterns, paths and choices; life insurance and annuities; intra/intergenerational redistribution induced by different pension systems; public policies and incentives towards retirement savings; intergenerational accounting; welfare policies directed at the elderly; participation in supplementary pensions; governance and financial aspects of pension funds. Research is performed both at the micro and at the macro level, and a special attention is devoted to policy aspects. CeRP is a research centre of the "Collegio Carlo Alberto". An important role is given to the dissemination of the research output, through conferences, seminars, publications and contributions to the debate on pension issues. CeRP has published several volumes and produces an important Working Paper Series.

CNEL, Consiglio Nazionale dell'Economia e del Lavoro – National Economic and Social Council
Address: Rome
Webpage: http://www.cnel.it
The National Economic and Social Council has a consultative role with respect to Parliament and the Executive. CNEL was established in 1957, according to article 99 of the Italian Constitution. It can initiate legislation and contribute to policy making in the economic and social field within the limits set by ordinary laws.

COVIP, Commissione Vigilanza Fondi Pensione – Pension Fund Supervisory Commission
Webpage: http://www.covip.it/homepage.htm
COVIP is an administrative authority which is responsible for controlling the management and activity of supplementary pension funds. It submits a yearly Report to the Minister for Labour, Health and Social Policy covering its monitoring activity and providing statistical information on supplementary pension schemes. It should guarantee information transparency and appropriateness in the management of private pension funds. It can also propose legislative reforms in the relevant field.

FEDERSANITA' ANCI – Local Health Units and Municipalities' organisation for health and social care services

Webpage: http://www.portal.federsanita.it/

Federsanità-ANCI is one of the two main national representative bodies of Local Health Units (together with FIASO) and Municipalities concerning all the aspects related to the integration of health and social care services.

FIASO – Federazione Italiana Aziende Sanitarie e Ospedaliere – Italian Federation of Health Agences

Address: Rome

Webpage: http://www.fiaso.net/

FIASO is one of the two main national representative bodies of Local Health Units (together with Federsanità-ANCI) concerning all the aspects related to health care and the integration of health and social care services.

IRS, Istituto per la ricerca sociale – Institute for social research

Address: Via XX Settembre 24, Milan; Via Castiglione 4, Bologna; Via Etruria 47, Rome

Webpage: http://www.irs-online.it

IRS is a wholly independent, non-profit cooperative currently counting 60 members. Its proceeds derive exclusively from activities developed specifically for its clients. Its work is based on a multidisciplinary, fully integrated approach. IRS is part of various international research centre networks and closely collaborates with prestigious universities and qualified experts. IRS is articulated in seven areas: The Labour Market and Industrial Relations; Non-profit; Administrative Policies; Training and Labour Policies; Enterprise and Industry Policies ; Social and Health Policies and Services; Urban Policies. One of the main publications is Prospettive Sociali e Sanitarie.

ISFOL, Istituto per lo Sviluppo della Formazione Professionale dei Lavoratori – The Italian Institute for the Development of Vocational Training for Workers

Address: Rome

Webpage: http://www.isfol.it

ISFOL is a public research body implementing and promoting studies, research and evaluation activities as well as information, advice and technical assistance actions in the area of vocational training, social and labour policies. The Institute's activities mainly contribute to improving human resource standards and increasing labour placement and social inclusion.

ISTAT, Istituto nazionale di statistica – The Italian National Institute of Statistics

Address: Rome

Webpage: http://www.istat.it

The National Institute of Statistics (Istat) has been working since 1926 as the main supplier of official statistical information in Italy. It collects and produces information on Italian economy and society and makes it available for study and decision-making purposes. Istat is a public research body acting in full autonomy, governed by a President and a board of directors that plan, direct and evaluate its activities. Books published by Istat – all available in the Virtual Bookshelf in Italian language – are collected in series (Yearbooks, Information, Subjects, Methods and Rules, Statistical Annals, Statistical Indicators, Essays) and by

subjects. Among the general publications the Annual Report analyses emerging phenomena, the Italian Statistical Yearbook summarises the results of the main surveys conducted by Istat and other National Statistical System bodies, the Monthly Statistical Bulletin updates current information.

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en