ESPN Thematic Report on Challenges in long-term care

Italy

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European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Summary

The Italian public long-term care (LTC) system shows the following main facets.

- *Amount of resources*: in 2016 around EUR 19 billion (1.13% of GDP) was spent by the Italian state on covering the needs of the elderly population; in real terms the expenditure increased only slightly between 2005 and 2016 (+3%), but it decreased strongly if considered on a per capita (elderly) base (-12.6%); the Italian expenditure level appears similar to, if not higher than, (in terms of share of GDP) what happens in western Europe (EU-15).
- *Type of financing*: mostly financed through general taxation with a certain role played by beneficiaries' fees.
- *Balance between institutional and home care services*: limited diffusion of institutional care and a medium level of development of home care services (although with problems of care intensity more than care coverage).
- *Cash vs in-kind benefits*: the system is disproportionally unbalanced toward cash benefits, and trends in the last decade have strengthened this characteristic.
- *Balance between, and levels of, informal and formal care*: the pivotal role of a cash allowance programme within the LTC public system, not matched by an adequate supply of professional services, has created a situation where there is a marked unbalance between formal professional care and both informal care and also private care paid for by families (often thanks to the presence of a public cash allowance).
- *Evaluation of needs and eligibility criteria for the various LTC cash benefits and services*: heterogeneous criteria for evaluating needs and defining eligibility.
- The *formal workforce*: although an exact estimation is difficult to provide, it can be argued that around 1.1 million workers are involved in LTC activities, with a marked imbalance between a relatively small number of professional workers, employed by the state or private (non-profit) providers, and the vast majority made up of individual workers, often migrants, employed directly by the beneficiaries and their families.
- The *quality of jobs provided in the formal workforce sector*: given that the vast majority of workers are directly employed by households, the quality is relatively low in terms of contracts and labour conditions.
- Mainly because of a generally limited availability of services, the Italian LTC system has a negative impact on carers' participation in the labour market and on the reconciliation between work and family life.

Given these characteristics, there are several shortcomings in the functioning and regulation of the LTC system, which are not related to expenditure but to other issues such as: the regulation and functioning of the main cash programme (the companion allowance – CA); the investment needed in residential care; the strengthening of home care services; the regulation of migrant care work and employment conditions in the sector; the reconciliation of work and care activities for the children and other relatives of frail elderly people; the presence of marked social inequalities in access to formal LTC services; and institutional difficulties in the governance model of the LTC system between the national and regional/local levels.

Along with these challenges, the production of good-quality data is another goal for the Italian LTC system.

1 Description of the main features of the country's long-term care system(s)

Around EUR 19 billion (equal to 1.13% of GDP) was spent in 2016 by the Italian state on long-term care (LTC) provisions, specifically addressing the needs of elderly people (MEF-RGS, 2017) (Table 1).

The level of LTC expenditure on the elderly in 2016 increased only slightly in real terms in comparison with 2005 (+3%). Growth took place before the austerity plans (2011). The expenditure increase took place during a period in which the number of elderly people living in Italy increased by 17% (around +1.9 million over 65). Therefore, the overall per capita expenditure for each elderly person decreased strongly (-12.6%).

Ministry of Finance projections for the next 15 years (MEF-RGS, 2017) show that LTC expenditure, as a share of GDP, should increase over time and by 2030 could reach a value equal to 1.31-1.39%, depending on the different scenarios adopted (three out of four scenarios lead to estimated values of around 1.31-1.32% of GDP). At the same time, the expected expenditure for 2025 should be similar to that reached in 2011 (1.28%).

It is hard to make a comparison with other EU countries due to the lack of data. The only and latest information available refers to the year 2013 and to LTC in general, and not only the elderly. Using this type of data, it appears that public expenditure on LTC in Italy (measured as a share of GDP) is higher than the average for western Europe (respectively 1.8% and 1.5%; however, it should be kept in mind that the Italian GDP in recent years suffered from low growth compared with many other EU-15 countries) (EC, 2016).

Looking at the organisation of the Italian LTC public system, it must be outlined that it is organised around two institutional pillars (Table 2).

The most important pillar is the 'companion allowance' (CA), a cash allowance programme for individuals with severe disability. In recent years the CA has absorbed more than half of public resources invested in LTC (around 55% in 2016). The role of the CA within the LTC system for the elderly in Italy has increased over time: in 2005 the CA absorbed around 46% of public resources invested into LTC. The National Institute of Social Security (INPS) runs the CA system, which is financed through general taxation. Italy spent around EUR 13.6 billion on the CA in 2016, covering around 1.83 million beneficiaries (INPS, 2017). Among these beneficiaries, most (78%) were 65 years old or older[1]. In particular, just on the elderly, INPS spent EUR 10.4 billion in 2016. The coverage level ensured by the CA is high: around 13.5% of individuals over 65 received it in 2016. The generosity of the CA is more limited: around EUR 515 per month in 2017, with no variation in terms of the level of needs.

Over the years 2005-2016, CA expenditure increased in real terms by around 25% (Table 2): this growth was particularly strong before the crisis, but it continued at a slower pace even after the onset of the crisis and the austerity plans.

Where the real cuts took place was within public funding for LTC services for the elderly: -25.1% between 2005 and 2016.

Therefore, compared with the years before the crisis, the LTC system for the elderly appears nowadays even more cash-based than in the past. These cash benefits are provided once health care authorities have certified the disability intensity of the beneficiaries concerned, but without any further accountability required of beneficiaries: frail elderly people can use their monthly allowance without the need to justify how it is used.

[1] Data were retrieved from the INPS website (www.inps.it) statistical database (*banche dati statistiche*).

Neither access to, nor the amount of, social transfers related to the CA scheme is means-tested. The CA is provided only on the basis of disability intensity.

The second institutional pillar is constituted by home and residential care services, provided by municipalities (for the social care part) and regions (for the health care/nursing-related part). There are two main types of home care provision: support for daily living tasks (cooking, cleaning, etc.) and nursing activities. Residential care is mostly provided through nursing homes. There has been in recent years a broader diffusion of day centres. Overall, public expenditure in 2016 on LTC residential and home care services for the elderly (by both municipalities and health care authorities) was equal to EUR 8.6 billion. Most of the expenditure on LTC services for the elderly comes from the NHS (around 69% of total LTC services expenditure in 2016). Admission is based on needs but also on income levels: co-payments can be a relevant part. The criteria for access to residential and home care are quite differentiated within the country, depending on the region and the municipality of residence, as well as on the criteria for co-payment.

Apart from these two main pillars, care leave plays an important role[2]. The Italian care leave system is relatively generous and developed. It offers a combination of both short-term leave for urgent cases and longer leave provisions (Laws No 104/1992, 388/2000 and 183/2010; and all the legislative changes later made to these three laws).

Care leave, which is fully compensated and receives pension coverage, is granted: only for public and private employees who have to care for severely disabled relatives or children; according to the principle of the 'sole carer', which means that no more than one worker in a household has the right to care leave as a carer for a severely disabled person: 3 working days of paid leave (at 100% of the last salary) per month; and up to 2 years of paid leave (at 100% of the last salary, but within an annual ceiling – EUR 47,446 in 2016).

Table 3 offers an overall view on the coverage rate offered by the Italian LTC system. Whereas a relatively large part of the elderly population is covered by the main cash transfer programme (the CA), the coverage rate of services is much lower: around 2.2% of the elderly can access residential facilities and around 5-6% home care (it is not possible to simply add the coverage rates of social home care and nursing home care because there is some overlap between beneficiaries of the two programmes).

Tables 4 and 5 help to frame the Italian professional services coverage rate in a comparative perspective: Italy is shown to remain largely behind the average western European situation (EU-15) both for residential and home care.

In 2017, EUR 500 million was allocated to a national fund for people with LTC needs, which increased by 67% between 2008 and 2017. This fund (created by Law No 296/2006) constitutes the main national instrument for sustaining the development of LTC social services, almost entirely managed by regional authorities. The fund has been characterised by instability[3], and by its relatively limited resources given the fact that more than 20% of the Italian population is over 65. The fund can be used with a relative degree of discretion by regional authorities in relation to what type of provision they want to develop.

Separately from the fund, specific resources were provided to develop care services for dependent people in southern regions (Campania, Puglia, Calabria and Sicilia). This was achieved through a reprogramming of the 2007-2013 EU funds (initiated under a

[2] Further information can be found in the ESPN Thematic Report on work-life balance measures for persons of working age with dependent relatives - Italy (February 2016).

[3] For example, the fund was nullified in 2012. An agreement between central government and the regions (February 2017) included a reduction in the fund in 2017 (from EUR 500 million to EUR 450 million). Through a subsequent agreement (March 2017), the regions committed themselves to restore the original amount of the fund using their own financial resources.

cohesion action plan from December 2011 onwards) for a total of EUR 269.5 million (EUR 130 million in 2013 and EUR 139.5 million in 2014).

In particular, the ministerial decree for resource allocation to the fund for 2017 defined the following priorities that regional and local governments should apply:

- the strengthening of home care services, combined with respite care provision;
- a focus on interventions related to very severe disabilities (at least 40% of the resources transferred to regions should be used for needs – such as, for example, amyotrophic lateral sclerosis – that require help for the whole day);
- the strengthening of the integration between social and health care, to be achieved through: the development of coordinated and unique professional services in order to access LTC provision; better joint planning of activities between health authorities and local authorities' social services departments; and a stronger connection between hospital and home care, especially for hospital discharges;
- the implementation of a national information system on LTC (sistema informativo non autosufficienza – Sina);
- the strengthening of services for all those individuals with disabilities who, on becoming older, cannot rely anymore on their parents (the so-called 'dopo di noi' – 'what happens after us' (meaning the parents and the relatives of the person with disability - issue);
- the strengthening of provision fostering independent living for individuals with severe disabilities.

The recent Budget law for 2018 maintained the same amount of resources for the fund. Moreover, the latest Budget law introduced a formal recognition of the importance of informal care givers. It also recognises the need to support economically families in this role, although not specifying the amount of resources that will be devoted to such goal.

Another important legislative innovation is represented by the 'national plan for chronic care' (*piano nazionale cronicità*), which was signed and agreed at the Permanent State-Regions Conference in July 2016. The new plan fosters new investment and innovation in primary care, continuous care assistance and home care; and it promotes the introduction of personalised care plans and chronic care models.

There are no official data available in relation to the labour force employed in this sector. The most recent data are the ones produced by OECD, referring to the mid-2000s. Table 6 attempts a first estimation, which should be considered an attempt to offer an idea on the size of phenomenon observed. It can be estimated that around 1.1 million workers are employed in the LTC sector for the elderly (equal to around 5% of total employment). The vast majority work as private care workers, frequently with a migrant background and hired (often irregularly) directly by households (Pasquinelli, 2013): around 830,000 employees find themselves in such a condition (often having an irregular labour contract). The vast majority of those who work in professional services are employed in residential facilities. Given the fact that most workers are employed by households – in many cases with irregular contracts (in terms of working hours declared, working schedules, etc.), labour conditions in the sector are often not particularly good (Pasquinelli, 2013).

2 Analysis of the main long-term care challenges in the country and the way in which they are tackled

There at least seven sets of challenges facing the Italian LTC system that need to be addressed:

a) the regulation and functioning of the main cash programme (the CA);

b) the investment needed in residential care;

c) the strengthening of home care services;

d) the regulation of migrant care work and employment conditions in the sector;

e) the reconciliation of work and care activities for the children and relatives of frail elderly people;

f) the presence of marked social inequalities in access to formal LTC services;

g) the institutional difficulties in the governance model of the LTC system between the national and regional/local level;

h) the lack of developed quality-measurement indicators.

As can be seen from the list above and Table 1 (discussed in the previous section), financial sustainability issues are not a priority, given the relatively limited level of expenditure on LTC and the fact that projections show a limited expenditure growth over the next 15 years.

The first set of challenges deals with the functioning and regulation of the CA. There is an absence of any accountability requirements on beneficiaries, which leads frequently to this cash transfer being spent in an irregular way in the private care labour market (Pavolini et al., 2016). Another shortcoming of the functioning of the CA is the fact that benefits are provided on the basis of a flat rate: there is no differentiation according to how severe the disability is (unlike in most other EU countries: for example, Germany – which has a three-level system, France, the United Kingdom and Spain).

A second set of challenges concerns residential care. Any serious 'ageing in place' strategy needs a strong residential care pillar. As shown previously (Table 4), the diffusion of beds in residential LTC facilities in Italy is much lower than that in the rest of western Europe: in 2015 there were fewer than 2 beds for every 100 individuals aged at least 65 in Italy compared with 5.0 in western Europe. Not only is there a lower diffusion of residential care, there is also a problem of the characteristics of this type of supply: for example, there is a very limited diffusion in Italy of housing facilities for elderly people who are still able to partially manage by themselves (e.g. flats with home automation) and who do not yet need either residential homes or nursing homes.

A third set of challenges relates to the situation in home care services. Although home care provision has improved over time, it is still characterised by a lower coverage in Italy (the share of LTC recipients living at home was 5.5% in 2015 in Italy in comparison with 8.2% in the EU-15) (Table 5). The fact that residential care coverage is relatively low also creates more tensions in public home care provision: it means that in Italy many (severe) cases, which elsewhere would/could be treated through different forms of residential care (last stages of Alzheimer's or other forms of dementia, etc.), are left at home (also respite care facilities are scarcely available in the country). This means that a large proportion of the elderly in need of care at home have a quite complex health status. Home care has a medium level of coverage, if compared with western European standards; on the other hand, the number of hours of home care for nursing services (i.e. the most widespread service) per capita per year is equal to 17. Therefore, if we analyse not simply the coverage level but the (hourly) intensity of public home care, the help provided is quite scarce and limited over time.

A fourth challenge is represented by the fact that Italy has one of the highest (if not the highest) levels of diffusion of migrant care workers, often with irregular contracts (Ranci and Pavolini, 2013). This is related to several factors: the limited coverage provided through residential care; the presence of a home care system with a medium level of coverage, but with a low intensity of care provided; and the relatively vast access to a cash benefit (the CA), which covers more than 13% of the 65+ age group, and which is neither means-tested nor subject to accountability on how it is spent. As a result, such a system is not able to sustain LTC needs, and in particular the needs of low-income households, in terms of affordability, accessibility and the quality of services. The level of the CA, at around EUR 515 per month for each beneficiary, means that it is only enough to pay a salary to a migrant care worker if household incomes are adequate. Otherwise it is not enough for low-income households to access the market by themselves. The result is that informal care (when present and available) is the main source of LTC for low-income households with a frail elderly person, given the difficulty of accessing formal public services (especially residential ones). Overall, the majority of workers in the field have irregular contracts and the quality of their employment conditions is low: Ranci (2008) calculated that at the end of the last decade at least half of migrant care workers had irregular contracts, and they were often living in the same house as the dependent person they were caring for – therefore in practice on call throughout the day and night. A decade later there are no particular reasons to think that the situation has definitely improved (Pavolini et al. 2016).

A fifth challenge deals with the reconciliation between care and work for the children and other relatives of frail elderly people. Mainly because of a generally limited availability of services, the Italian LTC system also has a negative impact on carers' participation in the labour market and on the reconciliation between work and family life. Naldini, Pavolini and Solera (2016) show that around 14% of mid-life working women in Italy with caring responsibilities have reduced or given up labour-market participation due to reasons related to coping with informal care for their elderly parents. This percentage is around 5% in Scandinavian countries and around 8% in western European continental ones (e.g. France, Belgium and Germany).

A sixth challenge relates to inequalities in access to (public) LTC services. The mix of policy instruments is not able to meet the LTC needs of individuals and families. Resources held by households are decreasing. The share of very old elderly people (80+) among those with LTC needs is increasing. The traditional approach – based on public cash allowances combined with a reliance on both within-household informal care and migrant care (often working in a grey market) – is showing its shortcomings, and social inequalities are becoming increasingly important and problematic. In particular, social inequalities take two forms: class/income inequality; and territorial inequality.

Albertini and Pavolini (2016), analysing four European LTC systems (Denmark, France, Germany and Italy), showed that care systems based on service provision grant higher access to formal care and display lower inequalities. Moreover, countries where cash-for-care programmes and family responsibilities are more relevant register inequalities in access to formal care: given its institutional design based more on cash allowances (the CA) than services, Italy is, among the four countries considered in the study, the one that shows the highest level of inequality among frail elderly individuals in accessing formal care. Consideration must be also be given to the interplay between health care and LTC. The elderly population has been severely hit during recent years by the austerity measures also adopted in health care. Table 7 reports the same type of data about self-reported unmet needs for medical examinations for reasons related to costs, distance or waiting times by income quintile, focusing only on individuals aged 65 or over. In 2016 6.6% of 65+ individuals reported unmet medical needs, and of those in the lowest and second-lowest income quintiles 12.3% and 8.7% respectively declared access problems: percentages more than twice as high as those registered in the EU-27. The situation worsened after the onset of the crisis and the implementation of austerity plans, but difficulty in accessing medical care was already a structural facet of the Italian LTC and health care system, especially among the lowest income quintiles.

Frail elderly Italians have problems of access to LTC services not only in relation to income/class, but also in relation to where they live (Table 8). The coverage of residential and home care services in southern Italy is (at least) half that registered in central and northern Italy. If we consider the data contained in Table 8, we can conclude that the coverage rate of LTC services in central and northern Italy reaches a level more similar to the average in western European countries, whereas the coverage rate for southern Italy is extremely low.

Overall a more robust system of more complete home care services and residential care would be required to match the needs of the frailest (especially those with limited informal care support or with such a complicated health status that it is not feasible to maintain them at home). Otherwise, the Italian LTC system risks becoming more and more unequal in terms of capacity to gain access to formal (public and private) care.

Reforms in this policy field should aim at redistributing more resources: the main debate around LTC in the last few years has concentrated around the possible introduction of income criteria (means testing) in relation to access to the CA. Such a choice seems to be necessary, and it could allow part of the resources currently spent on higher-income beneficiaries to be redistributed to lower-income beneficiaries or to strengthen home and residential services.

The new regulation of co-payments, introduced in 2015, has improved the selection criteria for access to many social services (including home care and residential care for LTC beneficiaries). The expected result should be lower co-payments for low-income households and individuals, and an increased cost burden for wealthier ones. LTC beneficiaries, especially those with a low income, should benefit from the reform in relation to their access to home and residential care. However, this reform has shortcomings; the principal one being that the ISEE (equivalent economic situation indicator) is not applicable to the CA.

A seventh important challenge is related to the institutional design of LTC governance in Italy. After the 2001 constitutional reform, which introduced federalist-like arrangements in the Italian system, social and health care services have become a policy area where national governments can only partially intervene and in most cases through a complex process of negotiations and agreements with regional governments. Such institutional arrangements make it harder to introduce relatively homogeneous policies at the regional level and, given the strong differences already present between northern and southern Italy (see Table 8), the risk is that the gap between these two areas of the country could persist in the future even in the medium term.

A last challenge is that no national system has been developed in order to measure how quality in LTC is ensured: there are quality standards developed partially at the national level, but mostly set (following partially different rules and regulations) at the regional level, as the outcome of the decentralisation reforms just described above. There is no national agency responsible for checking that they are respected; this work is delegated to regions, which have different capacities to monitor LTC service quality (Pavolini et al., 2016).

3 Analysis of the indicators available in the country for measuring long-term care

Overall, the type and characteristics of indicators available in the country for LTC are not totally satisfactory.

Box 1 lists the main indicators available at the national level on a regular basis for studying LTC public provision. Most of the indicators referred to have been used in the present report. They offer information on home care, residential care and the CA programme. In particular, they provide information on the number of beneficiaries, coverage rates and, when available, expenditure.

The shortcomings of these data are the following.

a) The timing of data production and delivery: most indicators are not updated frequently and they often offer a picture which dates 3-4 years back (the data on the CA and related expenditure is less affected by this shortcoming).

b) The data often provide information on coverage, but less so on other important dimensions of LTC provision (waiting lists and times, intensity of care, and the number and professional qualifications of workers employed).

c) There are no regular data on private (migrant) care workers, who play an extremely important role in the Italian LTC system.

d) Data on LTC quality, affordability and access are scarce and can be obtained only through proxies, such as the ones used in the present report (e.g. share of elderly people who declare unmet medical needs by income quintile).

The Italian government is working on how to improve the indicators available. In relation to nursing home care it is developing a new database (SIAD), which will be able to provide on a regular basis more precise information (in terms of LTC needs, intensity of care, etc.). Moreover, in a recent Bill (DPCM n° 194/2017) the government has provided more precise information on data collection specifically on LTC.

Annex:Tables

Table 1: LTC public expenditure on elderly people (65+) as a share of GDP (%): projections (2016-2030)

2005	2011	2016	2020	2025	2030	Variation of LTC total expenditure in real terms 2005-2016 (%)	Variation of LTC per elderly person expenditure in real terms 2005-2016 (%)
1.07	1.28	1.13	1.24	1.27-1.28*	1.31-1.39*	+3.4	-12.6

** Expenditure range estimated adopting different scenarios.*

Source: MEF-RGS (2017); Pavolini et al. (2016).

Table 2: LTC public expenditure on elderly people (65+) by type of public provider in Italy: a comparison over time (2005-2016)

Public provider:	2005	2016	Variation of LTC expenditure in real terms 2005-2016 (%)
NHS	43.4%	31.0%	-25.1
Local authorities	10.5%	14.2%	+41,4
Companion allowance	46.1%	54.9%	+24.5
Total	100.0%	100.0%	+3.4

Source: MEF-RGS (2017); Pavolini et al. (2016).

Table 3: Coverage rate of LTC provision for elderly people (65+) by type of provision in Italy (share of the elderly population - %)

Type	2016 (or most recent year) (%)
Residential care (2014)*	2.2
Social home care from local authorities (2013)**	1.2
Nursing home care (2013) (FTE)***	4.8
Companion allowance (2016)****	13.5

*Source: * Own elaboration on Istat (2016); ** own elaboration on Istat (2015); *** own elaboration on Health Ministry (2016); **** own elaboration on INPS online database.*

Table 4: Beds in residential long-term care facilities over time: Italy in a comparative perspective (per 100 people above 65 years old) (2000-2015)

	2000	2015
EU-15	4.6	5.0
Italy	1.2	1.9

Source: Based on OECD Health Statistics online database (2018).

Table 5: LTC recipients at home over time: Italy in a comparative perspective (per 100 people above 65 years old) (2000-2015)

	2000	2015
EU-15	6.6	8.2
Italy	1.9	5.5

Source: Based on OECD Health Statistics online database (2018).

Table 6: The LTC labour force: a first estimation

Type	N° of workers
Residential care (2013)*[4]	230,731
Social home care from local authorities (2015) (FTE)**[5]	21,980
Nursing home care (2013) (FTE)***[6]	7,821
Private care workers (2013)****	830,000
Total	1,060,731 + 29,801 (FTE)
Estimation of share of total employment	5.0%

*Source: * Own elaboration on Istat (2016); ** own elaboration on Istat (2017); *** own elaboration on Health Ministry (2016); **** Pasquinelli (2013).*

[4] Istat (2016) provides data only on the overall workforce employed in residential facilities for different kinds of beneficiaries (children, people with disabilities, frail elderly, etc.). Given the fact that around 76% of all beneficiaries are elderly people, the estimation reported in the table is calculated simply by taking 76% of the overall labour force.

[5] Istat (2017) provides data only on the total expenditure on social home care for the elderly provided by local authorities. Given the fact that around 80% of hours provided for home care are contracted out by local authorities to social cooperatives, we have taken into consideration the average cost of labour in the collective agreements for social cooperatives and have calculated the average yearly cost for a full-time equivalent (FTE) worker in social home care for the elderly. The estimation is the result of such average yearly cost per FTE worker and the total amount spent by local authorities.

[6] The Ministry of Health (2016) provides data only on the total number of elderly people receiving nursing home care and the number of hours provided on average to each beneficiary. We have calculated the total amount of hours provided to all elderly beneficiaries in a year. The estimation is the result of such total amount divided by the number of hours of work provided on average by a FTE nurse in Italy (data obtained from microdata of the Eurostat labour force survey).

Table 7: Self-reported unmet needs for medical examination for reasons related to costs, distance or waiting times by income quintile: individuals aged 65 or over (%)

		2007	2015
Total	EU-27	4.4	3.5
	Italy	5.7	6.6
First quintile of equivalised income	EU-27	6.4	5.5
	Italy	9.6	12.7
Second quintile of equivalised income	EU-27	4.8	4.2
	Italy	7.0	8.7
Third quintile of equivalised income	EU-27	3.6	3.6
	Italy	3.7	7.2
Fourth quintile of equivalised income	EU-27	3.4	2.3
	Italy	3.9	4.3
Fifth quintile of equivalised income	EU-27	1.7	1.4
	Italy	1.7	1.3

Source: Based on Eurostat EU-SILC online database (2018).

Table 8: Public LTC provision for the elderly in Italy: the north-south divide (coverage rates as a share of the elderly population – %)

Type	Central and northern Italy	southern Italy
Residential care (2013)*	3.0	1.2
Social home care from local authorities (2013)**	1.3	1.0
Nursing home care (2013) (FTE)***	5.7	3.0

Source: * Istat (2016); ** Istat (2015); *** Health Ministry (2016).

Box 1: Main indicators available in order to study LTC in Italy

Type of LTC provision	Information on	Source	Timing of data production	Last available data
Home care	Social home care	Istat *Rilevazione sugli interventi e i servizi sociali dei Comuni singoli o associati* [Study on local authorities' social care provision]	Yearly	2013*; 2015**
	Nursing home care	Ministry of Health *Annuario Statistico del Servizio Sanitario Nationale* [Statistical Yearbook of the NHS]	Yearly	2013
		Ministry of Health *Flusso SIAD del nuovo sistema informativo sanitaria* [New SIAD database on health care]	Yearly	Still under implementation
Residential care		Istat *I presidi residenziali socio-assistenziali e socio-sanitari* [Nursing and residential homes]	Yearly	2014
Cash transfers	Companion allowance	INPS *Rapporto Annuale INPS* [INPS Annual Report]	Yeary	2017
		INPS *Prestazioni a invalidi civili* [Online database on social transfers to individual with disabilities] https://www.inps.it/webidentity/banchedatistatistiche/menu/pensioni/invciv.html	Continous update	2017
LTC expenditure		Ministry of Finance (MEF-RGS) *Le tendenze di medio-lungo periodo del sistema pensionistico e socio-sanitario* [Medium-long term trends in pensions, healthcare and LTC]	Yearly	2017

* Data on coverage; ** data on expenditure.

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