Towards a Structured and Systemic Integration of Home Care for the Non-Self-Sufficient in Italy

Towards a Structured and Systemic Integration of Home Care for the Non-Self-Sufficient in Italy

OECD
BETTER POLICIES FOR BETTER LIVES

This document was produced with the financial assistance of the European Union. The views expressed herein can in no way be taken to reflect the official opinion of the European Union.

Please cite this publication as:
OECD (2025), *Towards a Structured and Systemic Integration of Home Care for the Non-Self-Sufficient in Italy*, OECD Publishing, Paris, https://doi.org/10.1787/a204ba8c-en.

ISBN 978-92-64-90719-5 (print)
ISBN 978-92-64-78269-3 (PDF)
ISBN 978-92-64-88373-4 (HTML)

Photo credits: Cover © SeventyFour/Shutterstock.com.

Corrigenda to OECD publications may be found at: https://www.oecd.org/en/publications/support/corrigenda.html.

Foreword

Why is it important to develop an integrated care system for non-self-sufficient persons? What governance model can foster co-ordination between the different levels of government and between the public, the non-for-profit and the private sector in Italy? And what obstacles complicate, at the local level, the co-ordination between the various figures involved in assistance activities? What steps should be taken to structure information systems and service models integrated between the health and social spheres? Which practices are considered most relevant and innovative internationally?

This report aims to provide some answers to these questions and to the main issues posed by population ageing, with a look at the Italian situation. In Italy, and in OECD countries at large, integration policies are becoming increasingly important due to the intersection of the demographic and epidemiological transitions. Advances in medicine, various public health interventions and improved socio-economic conditions are leading, especially in high-income countries, to a significant increase in life expectancy, accompanied by a decline in infectious diseases and the prevalence of chronic degenerative diseases. During this same period, important demographic changes have also taken place, resulting in Italy in what is now known as the “demographic winter”. The coming decades are expected to be characterised by a strong birth rate decline, a reduction in the resident population, marked ageing of the population and further fragmentation of households – with uneven dynamics between inland and metropolitan areas, given the processes of urbanisation and depopulation.

Care needs will be influenced by the increase in multimorbidity, and an associated rise in conditions of non-self-sufficiency, or disability, and to features linked to social fragility or marginalisation. The multidimensional nature of complex health needs, the reduced capacity of households, the marked inequalities, and the spread of in-work poverty, forcefully pose new challenges to the resilience of home-based care settings, and to the feasibility that they will be able to address the needs of a substantial number of elderly and non-self-sufficient persons.

The complexity of the needs of people requiring home care and the problems faced by their carers call for a co-ordinated, and person-centred approach that overcomes the traditional divisions between the health and social sectors. The implementation of a new model of integrated home care services will require overhauling the assumptions that characterise the current situation: personal care supported mainly by the ties of still large and not very dispersed families; and decent levels of economic support guaranteed by work, savings and assets. This important issue is at the centre of the concerns of policymakers, users, and those working in health and social realities in many OECD countries.

The main objectives of this report are therefore to understand the challenges and potential associated with the integration of home care services for people who are not self-sufficient, and to promote progress in policies for the integration of health and social care – ensuring that integrated care systems are people-centred and sustainable in the long term.

The report adopts a multidisciplinary approach to explore the main dynamics of the sector, identify good practices in Italy and abroad, and highlight key innovations and areas for improvement. Particular attention is paid to the regional and local dimension, given the increasing decentralisation of Italy’s healthcare

system over the past two decades. The analysis combines a review of existing policies and practices with an analysis of national and international data, complemented by new and unpublished data from two OECD surveys conducted in 2024-2025 – one targeting Italian regions and autonomous provinces, and the other covering 14 local areas. Comparative experiences from other OECD countries provide further insights into different models of social and health integration and the lessons they may offer for Italy.

A home care system that can effectively respond to the health demand of non-self-sufficient elderly persons, and their families, must reasonably address at the same time the three dimensions of care, assistance and protection without avoiding the resulting complexity. It also requires multi-level governance; service design tools; synergies among public, private and family workforce; and technological and digital innovation; and needs to have, at the centre, the non-self-sufficient elderly and the peculiar characteristics of their households and their specific living arrangements. The system's financing capacities play on the possibility of a stronger co-ordination of resources committed to chronicity with resources committed to non-self-sufficiency and social inclusion.

The analysis of these specific features of the Italian context, together with an examination of common international practices, has highlighted the "co-ordination" model as a relevant model for social and health integration in the Italian system. This model provides for a plurality of levels that are co-ordinated through common standards and tools, as opposed to alternative approaches such as "full integration" (total centralisation of functions and resources) or "linkage" (isolated agreements or initiatives that do not change the existing institutional structure).

Acknowledgements

The action has received funding from the European Union via the Technical Support Instrument and is implemented by the OECD, in cooperation with the Reform and Investment Task Force of the European Commission. The deliverables of this action are available on to a dedicated webpage: https://www.oecd.org/en/about/programmes/sg-reform/towards-person-centered-integrated-care-in-italy.html.

The opinions expressed and arguments employed herein do not necessarily reflect the official views of the OECD member countries or the European Union.

Authors acknowledge the essential support and active collaboration of the Italian Ministry of Health, the Ministry of Labour and Social Policy, the National Institute of Health, the National Agency for Regional Healthcare Services, and the International Health Brick Programme. The authors would also like to thank the many persons and institutions (regions and autonomous provinces, local health units, municipal authorities, third sector and private entities and academic researchers) who contributed to this work through interviews, the provision of documentation, the responses to questionnaires, and the participation to focus groups.

Table of contents

FIGURES

TABLES

Executive summary

Italy has one of the oldest populations in the EU and OECD. At the beginning of 2025, people aged 65 and over accounted for 24.7% of the population, while those aged 80 and over represented 4.1%. By 2050, these shares are projected to rise to 37% and 15%, respectively – the second highest in the world after Korea. Functional limitations are widespread among other people in Italy: 13.7% report difficulties with basic daily activities and 15.9% with more complex instrumental activities.

Despite rising needs, services for dependent older people in Italy remain fragmented. Responsibilities are divided across health and social care, levels of government and multiple providers, resulting in uneven access and outcomes. Support may take the form of cash transfers, residential or semi-residential services, home care, and informal family care. The most common cash transfer is the National Social Security Institute (INPS) support allowance for certified disability, supplemented in some municipalities by additional transfers with varying rules for access and use. Semi-residential and residential facilities provide day or round-the-clock care, with significant regional variation in access, service offerings and costs. At home, Integrated Home Care (ADI) mainly delivers nursing care, while Social Home Care (SAD) provides social benefits, often delivered by the third sector.

The growth in chronic conditions has heightened the need for an integrated system of care for non-self-sufficient persons. In Italy, integration between health and social services is widely recognised as central to reducing fragmentation and improving co-ordination. Governance of social and healthcare services for non-self-sufficient individuals is highly decentralised, with a multi-level governance approach spanning national, regional and local levels.

Several reforms have been launched in Italy to improve the governance of home care services. Decree 77/2022 defines models and standards for territorial assistance in the National Health Service. The National Plan for Non-Self-Sufficiency 2022-2024, for the first time, defines Essential Levels of Social Benefits, mandating guaranteed home care, relief and support for non-self-sufficient older people. Other significant initiatives regarding long-term care include Law No. 227/2021, “Delegation to the Government on Disability”, Law No. 33/2023, “Delegation to the Government on Policies for the Elderly,” and Legislative Decree No. 29/2024, adopted in implementation of these delegations, as well as the 2024 update of the National Chronic Disease Plan. Law No. 33/2023 – and its implementing decree – aims to build a system of integrated social, healthcare, and socio-healthcare services to ensure better and more comprehensive care for individuals. Furthermore, the aforementioned decree established the Interministerial Committee for Policies for the Elderly (CIPA), with the aim of strengthening the co-ordination of measures for the elderly and identifying planning and co-ordination tools such as Territorial Activity Programs, Area Plans, and Program Agreements, which are increasingly used. The National Recovery and Resilience Plan approved by the European Commission on 22 April 2021, also includes two key components for improving the integration of social and health services: component 2 of Mission 5, which enhances the entire social dimension of healthcare policies for older people; and component 1 of Mission 6, which envisages the implementation of interventions to develop local networks, facilities, and telemedicine for local healthcare..

Consultations with policymakers, professionals and service providers in Italy confirm the urgency of further policy reform. Common challenges include fragmentation of responsibilities, underinvestment in home and

community care, wide territorial disparities, staff shortages, financial pressures and weak information systems. Stakeholders emphasised the need for a clear governance framework, stronger support for informal carers, improved workforce training and reliable data to monitor needs and outcomes. While recognising regional autonomy, many underlined that a national framework is essential to reduce inequalities and guarantee minimum levels of care across the country.

Many other OECD countries face similar challenges in long-term care. Case studies from Japan, England (United Kingdom), Denmark, Australia and the Basque Country (Spain) illustrate strategies for integration. Most cases follow a *co-ordination* model, with mechanisms to link health and social services while maintaining separate structures. Comparative analysis highlights six key building blocks for integration: institutional arrangements, single access and standardised assessment, financial integration, governance with spending levers, multidisciplinary teams, interoperable data systems and recognition of informal support. Countries are also investing in community networks, volunteer programmes and caregiver recognition to reduce the burden on families. Staff shortages remain a common barrier, underlining the need for training and investment.

Also for Italy, *co-ordination* appears the most feasible approach for integration – as opposed to *full integration* (total centralisation of functions and resources) or *linkage* (isolated agreements or initiatives that do not change the existing institutional structure). Such co-ordination model would involve recomposing medical/nursing case, personal care and assistance functions through joint planning and delivery, while leaving their institutional ownership unchanged. This would rely on unified governance across national, regional and local levels and operate around three interrelated functions: the integrated care pathway, the mix of measures and providers, and the mobilisation of resources. The integrated care pathway requires a single access and assessment system, shared permanently between health and social services, with personalised care plans combining medical, nursing, rehabilitation, social and family support measures. Delivery would need to evolve from fragmented sectoral services to co-ordinated packages managed by multidisciplinary teams, engaging public, private and community providers. Finally, financing would need to shift towards integrated allocations combining health and social resources, complemented by family contributions and community networks.

Various actions can enable such integration:

- Creating a supportive legal and institutional framework: Establishing clear roles across levels of government, fostering collaboration among stakeholders, and empowering qualified multidisciplinary teams.
- Promoting community action: Recognising the role of civil society and private actors in delivering social innovation and strengthening community-based support.
- Ensuring timely and robust evaluation of the implementation of integrated care through the systematic collection and analysis of both process and outcome indicators.
- Encouraging the use of cost-effective health technologies: Deploying assistive tools, telemedicine and digital solutions to support independence, continuity of care and healthy ageing.
- Strengthening workforce skills, competencies and knowledge for effective integrated, person-centred care.

1 The demographic and epidemiological context and the supply of home care

This chapter explores the demographic and epidemiological context of non-self-sufficiency in Italy and the supply of home care. It first outlines the scale of population ageing and functional limitations, highlighting the growing prevalence of chronic conditions. The chapter then reviews the range of support and services available for non-self-sufficient persons, distinguishing between medical/nursing care, personal care, and assistance as framed by existing regulations. Attention is given both to the formal organisation of services and to their provision in practice. The analysis shows that social and healthcare services only partially meet the demand for long-term care. Finally, the chapter discusses the limitations of Italy's data and monitoring systems, which constrain the capacity to assess needs and outcomes.

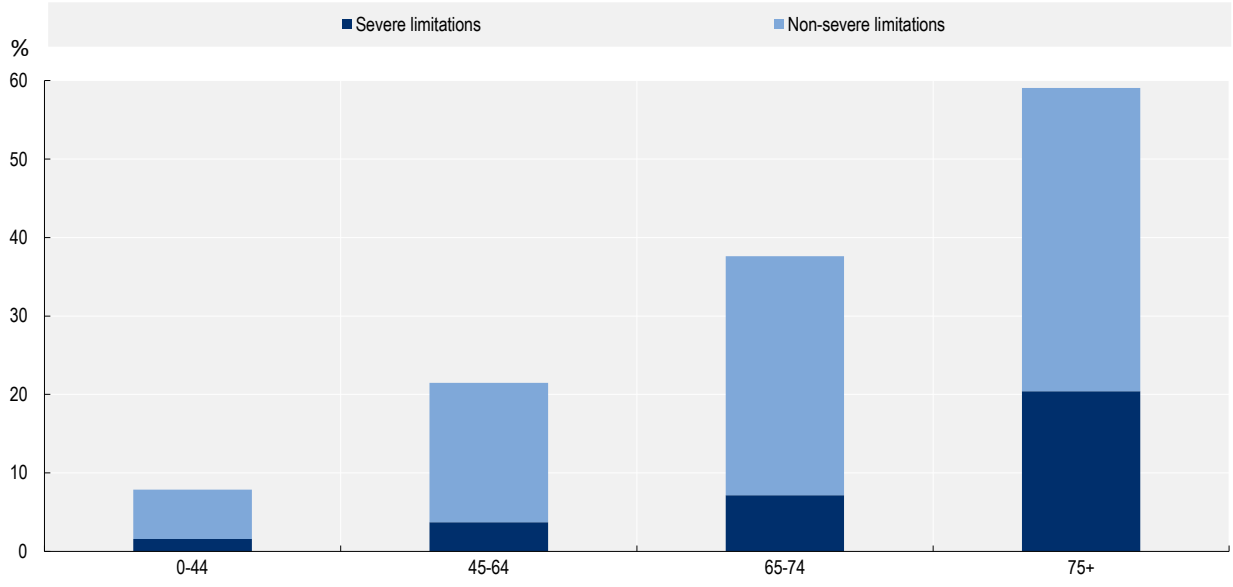
1.1. The numbers behind non-self-sufficiency in Italy

At the beginning of 2025, the population aged 65 and over and aged 80 and over in Italy represented 24.7% and 4.1% of the population, respectively. The population aged 65 and over will reach 37% of the total population in 2050, the second highest share in the world after South Korea, while the population aged 80 and over will represent 15% of the population (United Nations, Department of Economic and Social Affairs, Population Division, 2024[1]).

In 2021, 5% and 16.4% of the population reported severe and non-severe limitations in their usual activities, respectively. Based on this result, 12 767 000 Italians living in their own homes have limitations in performing ordinary activities due to health problems. The presence of limitations varies greatly between different age groups. While 7.9% of people under the age of 45 report limitations (severe and non-severe), the percentage increases significantly with age, reaching 59.1% in the over-75 age group (Figure 1.1) (ISTAT, 2023[2]). This figure may represent an underestimation of the actual need for services, as it is based exclusively on information reported by people living in their own homes who participated in the survey. It should also be noted that the 2021 population census found that 4.1 million people aged 65 and over were living alone, an increase of almost 600 000 compared to 2011 (ISTAT, 2025[3]).

Figure 1.1. Almost 60% of the population aged 75 and over declare that they have limitations in their usual activities

People with severe and non-severe limitations in their usual activities (as a percentage), by age, 2021



Source: ISTAT (2023[2]), Disabilità in cifre.

Given the high concentration of persons with limitations in their usual activities among the elderly population, an in-depth analysis of the elderly population can provide a more detailed picture of care needs in Italy. The PASSI d'Argento survey by the Istituto Superiore di Sanità (ISS) reports data on the state of health and independence of the population aged 65 and over.[1] The data for the two-year period 2023-2024 show that 13.7% of the population aged 65 and over have at least one limitation in Activities of Daily Living (ADLs), i.e. in performing the basic functions of daily life such as eating, dressing, washing, moving from one room to another, being continent, using services to do one's needs. Moreover, 15.9% of the population aged 65 or over have at least one limitation in Instrumental Activities of Daily Living (IADL), i.e. in complex

functions such as preparing meals, carrying out housework, taking medication, getting around, managing one's finances or using a telephone. Once again, the data show a significant increase in limitations as age increases. Among persons aged 85 years and over, 41% and 33%, respectively, require support in performing at least one ADL and IADL. The distribution of the non-self-sufficient population varies across the country, with a higher rate of persons with limitations in the south and islands and a lower rate in the northern regions.

1.2. Support and services available for non-self-sufficient persons

1.2.1. The organisation of services in accordance with the regulations

Non-self-sufficient persons in Italy may receive medical/nursing care, personal care and assistance in the form of money transfers, formal services in residential or semi-residential facilities, formal services provided at home and informal support from family members, friends or personal caregivers.

Among money transfers, the most widespread is the attendance allowance provided by the National Social Security Institute (INPS) to those with a certified 100% disability. The allowance amounts to EUR 515 per month and no income criteria are required to access it. In some cases, there are also monetary transfers provided at municipal level (i.e. care allowances or vouchers), whose access criteria, amount and usage constraints vary between municipalities.

Semi-residential and residential services offer respectively daytime and 24-hour care services to non-self-sufficient persons. The conditions of access, the services offered and the costs of these services vary between regions.

Finally, non-self-sufficient persons can access home services, as defined by Legislative Decree No 299/1999, which include:

- **Care services with high health integration, provided at home**, i.e. those activities characterised by particular therapeutic relevance and intensity of the health component and mainly relating to the areas of maternal and childcare, the elderly, handicap, psychiatric pathologies and alcohol, drug and medicines addictions, pathologies due to HIV infections and terminal pathologies, inability or disability resulting from chronic degenerative pathologies.
- **Healthcare services of social relevance provided at home**, i.e. activities aimed at health promotion and the prevention, detection, removal and containment of degenerative or disabling outcomes of congenital and acquired pathologies. These activities contribute, taking into account environmental components, to participation in social life and personal expression.
- Certain **health-related social services provided at home**, i.e. social system activities that aim to support the person in need, with problems of disability or marginalisation that affect the state of health, including home care services for the activities of daily living, such as eating, washing and dressing (ADL) and home care services in the instrumental activities of daily living, such as cooking, shopping and managing finances (IADL).

Medical/nursing care

The main reference for Integrated Home Care (ADI) is Article 22 of the Prime Ministerial Decree "Nuovi LEA" (New Essential Levels of Care) of 2017, which regulates home care as a response to the needs of people who are not self-sufficient and in fragile conditions. This article relates to the provision of home healthcare services, mainly nursing and rehabilitation, in accordance with the clinical conduct of the general practitioner.

Integration refers to the processes of interaction between different healthcare professionals (originally the family doctor with the district nurse). The number of professionals involved has progressively widened and qualified, including specialised figures such as rehabilitation therapists or geriatricians. Home care is accessed in all cases after a multidimensional assessment of needs and the drawing up of an Individual Care Project.

The integration of different levels of ADI with the opportunities offered by telemedicine and teleassistance is becoming increasingly important, as is interaction with specialist services in the local area, including through teleconsultation, and interaction with assistance and protection activities.

There are various healthcare activities carried out at home that are highly complex in terms of organisation but are not focussed on home care services because they originated as "*hospital therapies carried out at home*". This is a healthcare sector that has been around for many decades and is evolving in leaps and bounds, keeping pace with advances in healthcare technology, physics and engineering, and remote management, surveillance and monitoring capabilities. Sometimes these home therapies also overlap with home care services, depending on the progression of the disease and the level of independence of the individuals and their families.

From a regulatory standpoint, there is still no stable and recognised activity for *long-term home care* for elderly people who are not self-sufficient. The Prime Ministerial Decree "Nuovi LEA" (New Essential Levels of Care) regulates four levels of home care based on the complexity of healthcare needs and the intensity of care required. Probably the most suitable type of care for the healthcare system would be Level 3 ADI, i.e. *continuous care and planned interventions, also characterised by the need to provide support to the family and/or carer*. However, in the vast majority of cases, no actual provision is made for activating professional nursing care or professional personal care assistance services (50% of which are paid for by the health service), that play an essential role in long-term care. Added to this is the total "episodic fragmentation" of interactions with social home care activities provided by municipal administrations, which, at national level, continue to show low, fragile and ad hoc levels of integration (with local exceptions).

Personal care

In the case of elderly people who are not self-sufficient, home care involves assisting people who have multiple, often chronic, conditions and reduced ability to perform activities of daily living (ADL) independently. This is the key issue that needs to be addressed in order to develop any realistic prospects for long-term home care. In the case of elderly people who are not self-sufficient, home care needs to be understood in terms comparable to what Article 30 of the 2017 "New LEA" Decree defines as long-term residential social and health care for non-self-sufficient individuals.

Assistance with activities of daily living is an essential element that enables elderly people who are not self-sufficient to remain at home and receive the care they need. Like care services, assistance activities can vary in intensity and complexity, as well as over time due to various factors such as the progression of illness, living conditions, and the capabilities of the family, friends, and community network. It should also be emphasised that it is possible to respond to the various intensities and modes of personal assistance with both professional and non-professional activities, depending on the different levels of assistance required. In this regard, it should be noted that Article 29 of the aforementioned Legislative Decree 29/2024 provides for the development of specific national guidelines for the operational integration of social and health interventions provided for in-home care and assistance services and for the adoption of a continuous and multidimensional approach to caring for older adults, including those who are not self-sufficient, and their families, including through digital tools. This document aims to establish a model aimed at promoting integrated health, social, and social interventions integrated into the local network through shared management.

Assistance

The fundamental public function of “Social protection” is the responsibility of the municipality, while the regions have organisational and planning powers, and the state has powers over the Essential Levels of Social Services (LEPS) and their financing and planning. The function is regulated, implemented and financed by each municipality and may be exercised individually or in association with other local authorities. The Social Territorial Area (ATS) is the portion of the territory in which the exercise of the function is planned through the Area Plan, and in most cases its perimeter includes several local administrations (approximately 7 896 municipalities – approximately 610 ATS). The ATS is also responsible for the following functions:

- co-ordination and governance of the integrated system of social interventions and services;
- planning and scheduling interventions based on a needs analysis;
- provision of interventions and services;
- personnel management in the various forms of association adopted.

Article 19 of Ministerial Decree 95/2012, converted by Law 135/2012, identifies the fundamental functions of municipalities pursuant to Articles 117 and 118 of the Constitution. In particular, Article 19 specifies as a fundamental function of municipalities the “planning and management of the local social services system and the provision of related services to citizens”.

This provision is the focal point of the implementation of the function. As a rule, access to municipal social services is conditional on both means testing (ISEE) and an assessment of the need for protection, assistance, support and social assistance, based on the circumstances of the individual, their family and their formal and informal support networks. The “protective” nature of the public social assistance function is expressed precisely in this access mechanism, which focusses public action on individuals and families in greatest difficulty in order to help them regain a degree of autonomy in relation to economic, social, employment, housing, training and educational inequalities, combined with individual functional and bio-psycho-social characteristics. For elderly people who are not self-sufficient, their own social vulnerability or that of their family unit can significantly compromise the possibility of providing appropriate and effective home care.

The Ministerial Decree “System for monitoring essential service levels” provided for in Article 23 of Legislative Decree 29/2024 defines the monitoring system and its operating methods, as well as the specific indicators for verifying the implementation status of the provision of the Essential Levels of Social Services (LEPS). Specifically, monitoring the implementation status of the LEPS, as identified in Article 1, paragraphs 162, letters a), b), and c), 163, and 164 of Law No. 234 of 30 December 2021, focusses on the following areas of intervention:

- social home care and integrated social assistance, including health services
- social relief services
- social support services
- financial contributions (to supplement the attendance allowance).

1.2.2. Service provision in practice

There is a high need for social and health services throughout the country that the available formal social and healthcare services cannot fully meet. The limited availability of data adds a further potential barrier to the relevance of the services offered.

Social and healthcare services only partially meet the demand

Although almost all people aged 65 and over with at least one limitation in ADL and IADL state that they receive help (99.3% and 98% respectively), most of them receive informal assistance from family members, acquaintances, friends or personal caregivers (Table 1.1).

Table 1.1. Informal services are the main form of care for elderly people with limitations that prevent them from carrying out usual activities (i.e. not self-sufficient)

Percentage of elderly individuals with one or more limitations in ADL and IADL receiving formal and informal care services, 2023-2024

Type of care received	Elderly with at least one limitation in ADL	Elderly with at least one limitation in IADL
Family members	95.4%	94.5%
Acquaintances, friends	12.2%	15.0%
Voluntary associations	2.4%	1.2%
Person identified and paid on their own (e.g. caregiver)	37.0%	23.6%
Home care by public service providers e.g. Local Health Authority, municipality	11.8%	2.8%
Assistance at day centre	2.4%	0.4%
Financial contributions (e.g. care allowance, attendance allowance)	21.6%	6.6%

Note: The sum of the elderly with at least one limitation in ADL who access the services listed is greater than 100% because the services are not mutually exclusive (e.g. a non-self-sufficient person may access care services at home and receive informal assistance from family members and personal caregivers for a fee).
Source: Istituto Superiore di Sanità (2025[4]), Passi d'argento, https://www.epicentro.iss.it/passi-argento/dati/fragili.

In 2023, the Ministry of Health recorded more than 1.6 million cases treated in integrated Home Care (ADI), three-quarters of which were related to elderly people (65+).[2]

The intensity of ADI services often makes it impossible to provide adequate support to non-self-sufficient persons. According to the data published by the Ministry of Health in 2023 each non-self-sufficient elderly person assisted through ADI received 14 hours of care per year, on average, 9 of which are provided by nurses, 3 by rehabilitation therapists and 2 by other professionals. These hours correspond to 9 visits – on average – per case treated, to which must be added 2 visits by medical personnel.[3]

Access to Home Care Services (SAD) offered by municipalities is even more limited than that of ADI. At the national level, in 2022, 5% and 1.4% of people with disabilities received social care home services and home care integrated with health services, respectively. Among people aged 65 and over, 1% and 0.5% received social care home assistance services and home care integrated with health services, respectively (ISTAT, 2020[5]). To make up for this shortage of public support for non-self-sufficient persons, in Italy there were more than 1.1 million personal caregivers (regular and non-regular) in 2021, according to estimates (CERGAS Bocconi, 2023[6]).

In 2024, the current expenditure for healthcare of the population was EUR 185.1 billion, of which 74.3% was financed by the public administration and 22.3% by direct household expenditure (ISTAT, 2025[7]). Only 2.5% of this expenditure – amounting to EUR 4.6 billion – related to home care for treatment and rehabilitation and long-term home care. Ninety-one per cent of the expenditure on home care is financed by public administration and 6% represents direct expenditure by households.

In 2022, municipalities spent EUR 281.2 and EUR 61.3 billion on social home-based social care services and home-based social care integrated with health services, respectively. These amounts correspond to

3.2% and 0.7% of the total annual expenditure of the municipalities. The average annual expenditure per service user was EUR 2 096 and EUR 793, respectively (ISTAT, 2025[8]).

The data and monitoring system has shortcomings

While there are data on non-self-sufficiency and on persons assisted through Integrated Home Care (ADI) or through Home Care Services (SAD), there is no database that specifically correlates non-self-sufficient persons assisted through ADI and/or SAD. This information gap is a significant obstacle to effective planning and evaluation of care policies for the non-self-sufficient population.

Moreover, the available data tend to focus mainly on the coverage of services, rather than on the intensity or quality and appropriateness of care. Information is often obtained through ad hoc surveys, which may be sample-based and require significant latency and processing times. This practice limits their usefulness for the planning and evaluation of services. In addition, the current data collection and monitoring system offers a performance-focussed perspective, without providing an integrated view of the care pathway. All this highlights the need to strengthen and modernise the data and monitoring system so that it can better inform policies and strategies in the field of elderly care.

References

CERGAS Bocconi (2023), *Il personale come fattore critico di qualità per il settore Long Term Care*, https://cergas.unibocconi.eu/sites/default/files/media/attach/Def_5%20Rapporto%20OLTC.pdf?VersionId=nBCtXf8Sb8l.5ue0Ksy5vUcrNiVTCJvl (accessed on 2 November 2023). [6]

ISTAT (2025), *Conti della sanità*. [7]

ISTAT (2025), *Rapporto annuale 2025. La situazione del Paese*. [3]

ISTAT (2025), *Spesa per servizi dei comuni*. [8]

ISTAT (2023), *Disabilità in cifre*, https://disabilitaincifre.istat.it/dawinciMD.jsp?a1=u2i4W000GaG&a2=__&n=$$$1$$$$$$$&o=5L&p=0&sp=null&l=0&exp=0 (accessed on 2023). [2]

ISTAT (2020), *Interventi e servizi sociali dei comuni*, http://dati.istat.it/viewhtml.aspx?il=blank&vh=0000&vf=0&vcq=1100&graph=0&view-metadata=1&lang=it&QueryId=22823&metadata=DCIS_SPESESERSOC1. [5]

Istituto Superiore di Sanità (2025), *Passi d'argento*, https://www.epicentro.iss.it/passi-argento/dati/fragili. [4]

United Nations, Department of Economic and Social Affairs, Population Division (2024), *World Population Prospects 2024*. [1]

Notes

[1] The analysis excludes the institutionalised population, i.e. elderly persons hospitalised or residing in Residential Care Homes (*Residenza Sanitaria Assistenziale* – RSA), Residential Social Care Homes (*Residenza Sociosanitaria Assistenziale* – RSSA) or Nursing Homes.

[2] The figure refers to the entire population aged 65 and over, with and without limitations in self-sufficiency.

[3] These visits do not contribute to the count of the average number of hours per person assisted.

2 The integration analysis model

This chapter sets out an analytical model for assessing integration. It begins by reviewing various models of integration, from basic co-ordination to full institutional merger. It then introduces the framework applied in this report, which combines three perspectives. First, it identifies the main policy areas relevant for integration: governance, workforce, information systems and care delivery. Second, it considers the dimensions of integration – institutional, planning, professional, managerial and community – through which these areas can be organised. Third, it anchors the analysis in home-based interventions and services, distinguishing between medical/nursing care, personal care and assistance. Together, these perspectives provide a structured tool to assess the Italian system and compare it with international experiences.

The significant growth in the prevalence of chronic conditions among the population has increased the need for an integrated system of care for non-self-sufficient persons. In the Italian national debate, the concept of integration between the health system and social services represents the key to policies capable of reorganising existing services, reducing fragmentation and the lack of co-ordination. A greater awareness of the influence of social factors on health has led to the identification of social and health integration as the tool for implementing a renewed approach to care capable of responding to the multidimensional and complex needs of the non-self-sufficient population.

At the international level, there are multiple definitions and models of "integrated care". The World Health Organization defines it as 'an approach aimed at strengthening health systems by placing the needs of the person at the centre through the provision of quality services throughout the life course, designed on the basis of the multidimensional needs of the population and delivered by multidisciplinary teams'. Several countries have developed public health and chronic care management models aimed at improving the quality of care services and the well-being of the population. The evidence on the positive impact of such integrated care models in terms of improving access to services and user satisfaction is growing in strength and number. In addition, some experiences show that integrated care makes it possible to improve the appropriateness of interventions, reduce recourse to hospitalisation and preserve the autonomy of the person, ensuring their overall well-being.

2.1. Various integration models

In recent years, the integration of public services – and of health and social services in particular – has become a policy priority in many OECD countries. Different models are emerging, ranging from partially integrated approaches to fully integrated solutions.

The literature indicates that linking or "networking" services to improve access and user experience can generate significant efficiency and effectiveness gains, especially for people with multiple and complex needs. The high specialisation of services can make it difficult to achieve the combination and sequencing of services best suited to the complex needs of users.

The idea of integrating services to overcome fragmentation originated mainly in the health sector, but models and definitions are now also being applied to social systems, to borderline areas between health and social care, but also to further areas such as education and employment services (OECD, 2023[1]).

Integration models within and between systems are often multidimensional and include various elements – such as case management, integrated care pathways, changes in working practices, and changes in organisational, governance and financial systems. The OECD report *Integrating Social Services for Vulnerable Groups* (OECD, 2015[2]) distinguishes between horizontal integration – the most common in Europe, bringing together actors from different sectors or entities to respond to the needs of users – and vertical integration, which aims to combine governance and financing across multiple service levels (from intergovernmental co-operation to co-ordination between residential, home and community-based services at the micro level). In the specific case of the elderly, it refers to Leutz's model (1999[3]), which distinguishes between:

- Full integration: Pooling of organisational and financial resources from different sectors, within a single structure or through contractual agreements, with shared objectives.
- Co-ordination: Explicit structures to facilitate care delivery between distinct sectors, e.g. through discharge planning, case management or information sharing.
- Linkage: Minimal integration between separate health and social services, each with its own responsibilities, funding and rules.

These models are comparable to "*ricongiungimento*", "*ricomposizione*" and "*rammendo*", respectively, under Caiolfa's interpretation (2022[4]).

2.2. The model of analysis

Putting people at the centre of care requires offering a range of services that are aligned with individual needs, and ensuring smooth transitions between institutional, community and home-based settings. Long-term care services which are well integrated with healthcare not only improve quality of life and health outcomes, but also enhance cost-effectiveness and help to reduce pressure on hospitals and other health facilities.

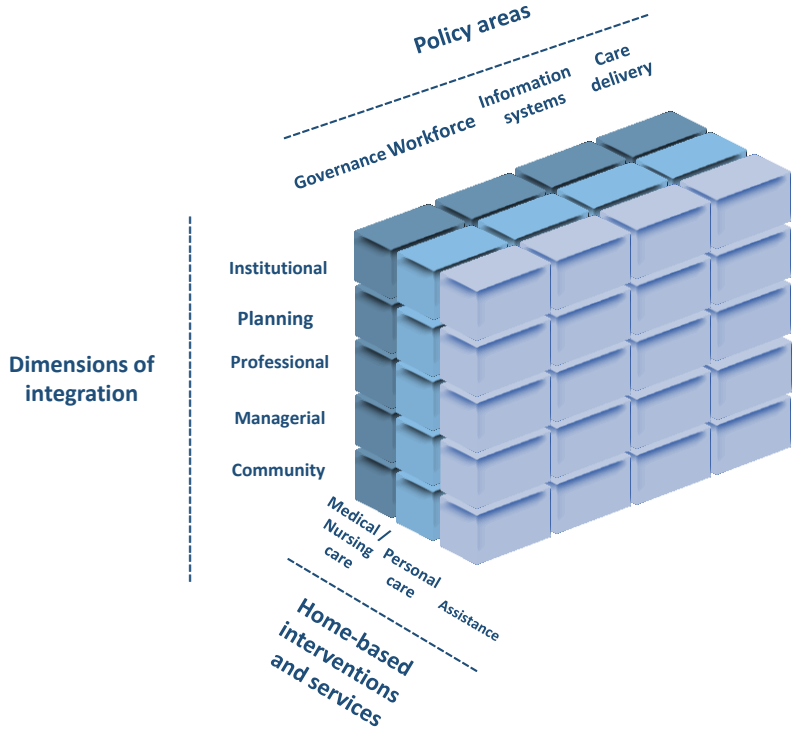
This project focusses specifically on the integration of home-care social and health services for non-dependent elderly persons. Home care is one component of a broader continuum of integrated care, which also encompasses hospital, residential and semi-residential services, and specialised care.

The integration analysis model used in this project is based on a framework wherein three groups of elements intersect:

- The available home care support and services
- The policy areas
- The dimensions of integration.

Together, these three groups of elements form an analytical and constructive framework capable of outlining the prospects for the creation of an innovative territorial welfare system (Figure 2.1).

Figure 2.1. The model for analysing the degree of home care integration



2.2.1. Policy areas

Given the complexity of the topic, it was decided to structure the analysis around four policy areas: governance, workforce, data and information systems, and service delivery. Each of these areas represents an essential component in the mosaic of practices, policies and services that make up the universe known as “integrated care”.

An effective governance model for health and social integration must be based on close co-operation between the various institutional levels, with the aim of ensuring unified planning and management of health and social services. The guiding principle in this area is the creation of integrated multi-level governance that allows for effective and synergic management of resources at local and national levels, overcoming the current fragmentation. The proposed actions include the formalisation of the collaboration between Health Districts and Social Territorial Areas, through the joint drafting of Territorial Activity Programmes (PAT) and Area Plans (PdZ). This favours the alignment of planning and the implementation of an integrated approach to home services as well.

Social and health integration cannot be realised without an adequately trained and valued workforce. The guiding principle in this area is the creation of an interdisciplinary working environment, which recognises the importance of both the formal and informal care sector. One of the most important challenges for health and social integration is continuous training for the different actors involved, including nurses, social workers and family caregivers. The key proposal is the establishment of common and compulsory training courses for multidisciplinary teams, which strengthen the transversal skills needed to work in an integrated setting. Training must also include the use of technological and digital tools, so as to facilitate the sharing of information between the various professionals. Moreover, it is crucial to enhance the contribution of informal carers (such as family caregivers) by offering them training and care support. It is precisely with this in mind that Legislative Decree 29/2024 provides for the adoption of specific guidelines to define uniform methods for implementing training programmes. Regions can use these guidelines, within their own autonomy, to achieve uniform training standards throughout the country. The implementation of this regulatory provision aims to improve, including through the grading of needs, and standardise the training offering for care professions, as well as define the procedures for obtaining the professional qualification of family assistant.

Effective social and health integration requires interoperable information systems that allow information to be shared between the various actors involved. The guiding principle in this area is the interoperability of health and social information systems, which makes it possible to monitor needs and interventions in real time, reducing duplication of effort and improving the quality of care. Currently, separate information systems exist in Italy for the management of health and social services, making data sharing complex. The central proposal is the development of an integrated platform of existing information systems, ensuring access to data by all professionals involved in the care pathway. Such a platform must be accompanied by clear regulations on data protection and access to information to guarantee the security and privacy of users. In this regard, it should be noted that the guiding criteria for the implementation of Law No. 33 of 23 March 2023, include “strengthening the integration and interoperability of the information systems of the competent bodies and administrations within the framework of existing programmes to enhance infrastructure and IT networks, also by leveraging citizen-generated data and evidence, as well as data resulting from surveys, studies, and research conducted by third sector entities.” This principle has been incorporated into Legislative Decree no. 29/2024, which provides that “the Ministry of Labor and Social Policies, the Ministry of Health, the Delegated Political Authority for Disability, INPS, the regions and autonomous provinces, municipalities, and ATSs shall promote the interoperability of their IT systems, in compliance with the guidelines on the technical interoperability of public administrations adopted by the Agency for Digital Italy (AGID) and the guidelines defined by the National Agency for Digital Health (ASD).” This aims to facilitate the simplification and integration of procedures for assessing and evaluating the

condition of non-self-sufficient elderly persons, which is further implemented under Article 28, paragraph 5, of the aforementioned Legislative Decree 29/2024, which establishes the procedures for sharing databases containing information or findings that, for any reason, enter into the basic assessment and evaluation process, as well as the collection of data, communications, and information related to its conclusion.

The provision of home services for non-self-sufficient persons must follow a well-defined pathway providing integrated, continuous and personalised care. The guiding principle in this area is the creation of an integrated care pathway combining all the necessary health and social services, with a multidimensional assessment of the patient's needs. Proposed actions include the establishment of a Single Point of Access (PUA) in each territory to facilitate the orientation and care of non-self-sufficient persons. PUAs must be able to manage the initial assessment and refer patients to the competent multidisciplinary teams, which will be responsible for drawing up and monitoring the Individualised Care Proejct (PAI). The PAI must be updated regularly according to the evolution of the patient's condition, thus ensuring that care is always appropriate to the specific needs.

2.2.2. Dimensions of integration

The fundamental public functions of "Healthcare" and "Social Care" are characterised by deep constitutive asymmetries that condition their possibilities for integration, a structural condition with which the countless local experiences based on the meeting of spontaneous good will are confronted. The decisive point is the transformation of these voluntarist encounters into integration arrangements that are instead permanent, recognisable, consistent and widespread throughout the country. With respect to the basic elements that characterise these asymmetries, it is possible to identify dimensions on which to pivot in order to attempt to realign the interactions between health and social care, trying to make them stable and continuous:

- Institutional: Structured forms of involvement and co-decision making of regional, corporate, municipal institutional levels.
- Planning and management: Unitary planning tools for the social and healthcare areas; forms of sharing management functions.
- Organisational and management: Shared and common organisational systems between health and social services; production of services with health and social components; forms of resource sharing.
- Multi-professional: Integrated care processes with common tools and organisational methods.
- Community: Participative modalities in the social and health area; activation of community networks of proximity; use of the institutions of "Shared Administration".

The constitutional reform of 2001 requires that the exercise of fundamental functions be divided according to the vertical structure of administrative powers at the state, regional and municipal levels. This is in turn decisive for integration, considering that healthcare is a regional responsibility and social assistance is a municipal responsibility, while the state is responsible for defining minimum healthcare and social service levels. For these reasons, it is only possible to propose a systemic and structured vision of integration within a multi-level institutional logic that finds its operational basis in co-ordinated territorial action between the Health Districts and the Social Territorial Areas.

2.2.3. Home care

The analysis of the integration of social and health care for elderly people who are not self-sufficient requires consideration of the three fundamental dimensions of medical/nursing care, personal care and assistance. These dimensions represent distinct functions, which can be traced back to different regulatory and institutional areas, but are deeply interdependent in the concrete configuration of needs and care

pathways. Medical/nursing car refers mainly to home-based health services, predominantly nursing and rehabilitation; personal care includes support (in various forms and intensities) for activities of daily living, necessary to ensure that people can remain in their own homes; assistance concerns the needs for protection, support for instrumental activities of daily living and social support, which are fundamental to ensuring equity and effectiveness in the provision of services (see the previous chapter for a description of the Italian system). The adoption of an integrated perspective makes it possible to grasp the multidimensional nature of non-self-sufficiency and to assess the capacity to activate co-ordinated responses.

References

Caiolfa, M. (2022), *Il Sistema Nazionale Anziani: unagovernance multilivello per la nonautosufficienza*. [4]

Leutz, W. (1999), "Five Laws for Integrating Medical and Social Services: Lessons from the United States and the United Kingdom", *The Milbank Quarterly*, Vol. 77/1, pp. 77-110, https://doi.org/10.1111/1468-0009.00125. [3]

OECD (2023), "Integrating local services for individuals in vulnerable situations", *OECD Local Economic and Employment Development (LEED) Papers*, No. 2023/08, OECD Publishing, Paris, https://doi.org/10.1787/1596644b-en. [1]

OECD (2015), *Integrating Social Services for Vulnerable Groups: Bridging Sectors for Better Service Delivery*, OECD Publishing, Paris, https://doi.org/10.1787/9789264233775-en. [2]

3 International experiences of social and healthcare integration

This chapter reviews international experiences of social and healthcare integration. It first outlines the regulatory and policy frameworks for services for non-self-sufficient individuals across OECD countries. It then examines governance models that promote closer alignment between health and social care. A set of case studies – Japan, England (United Kingdom), Denmark, Australia and the Basque Country (Spain) – provides concrete examples of different integration approaches, covering governance arrangements, interventions and providers, information systems and interoperability, available resources, and transferability. The chapter concludes by identifying key characteristics of successful integration and drawing lessons of potential relevance for Italy.

The integration of social and healthcare services for people who are not self-sufficient is a complex issue that is currently central to many OECD countries and European Union policies. Numerous regulations and reforms have been introduced at international level in recent decades to extend coverage, improve quality, ensure sustainability and promote the integration of services for people who are not self-sufficient. Although these interventions share similar objectives, their characteristics depend on various factors, such as available resources, the target population, the models adopted, the objectives defined and local conditions. To fully understand the challenges and opportunities of social and healthcare integration in Italy, it may be useful to look at international experiences and understand their context, measures, challenges and successes.

3.1. Services for non-self-sufficient individuals: International regulatory and policy framework

At the international level, access to Long-Term Care (LTC) is recognised as an essential component of social protection and universal health systems (ILO, 2022[1]; WHO, 2015[2]). Consistent with this, in the context of the 2030 Agenda for Sustainable Development, Target 3.8 aims to ensure universal health coverage, including essential care services, while Target 5.4 promotes the recognition of unpaid care work and the development of accessible public care services (United Nations, 2015[3]). At the same time, there is still no internationally agreed definition of non-self-sufficient persons.

Within the UN framework, the Convention on the Rights of Persons with Disabilities obliges States to provide home and community support measures for elderly people who are not self-sufficient (United Nations, 2006[4]). The UN Decade of Healthy Ageing 2021-2030, promoted by the UN and the World Health Organization (WHO), calls for integrated LTC systems based on multidimensional needs assessment, personalised interventions and the involvement of family and community networks (WHO, 2020[5]). In this context, the Integrated Care for Older People (ICOPE) model, developed by the WHO, provides an evidence-based operational approach to delivering integrated care at the primary and community levels, including co-ordinated action plans between health and social services and support for caregivers (WHO, 2017[6]; 2019[7]).

On the social protection front, the International Labour Organization included LTC among the basic social rights in its Recommendation No. 202 (ILO, 2012[8]). The *Care at work* report notes significant gaps in terms of accessibility, quality of services and working conditions of care staff, calling for adequate public investment and the setting of minimum standards of coverage and quality (ILO, 2022[1]).

In the context of the European Union (EU), the Social Rights Pillar states in its Principle 18 the right to quality LTC services and sustainable financial conditions for users, in particular home care and community-based services (European Commission, 2017[9]). As care is the responsibility of the Member States, the EU supports them through legislation such as the Work-Life Balance Directive, and with guidance, funding, monitoring and analysis. The European Care Strategy sets out a vision for transforming care in order to ensure quality, affordable and accessible services and to improve the situation for both recipients and carers professionally or informally (European Commission, 2022[10]). At the same time, the EU Council Recommendation on LTC services recommends that Member States set high quality standards for all LTC facilities and ensure fair working conditions for healthcare workers, including wages, by promoting social dialogue and collective bargaining (Council of the European Union, 2022[11]). To address skills needs and labour shortages, Member States should also improve initial and continuing education and training, build career paths through reskilling and upskilling, establish pathways to regular employment status for undeclared LTC workers, explore legal migration pathways for LTC workers, and make the profession attractive to both men and women. Instruments such as the European Semester and the Recovery and Resilience Plans (NextGenerationEU) complement these principles, acting as levers for investment and reform in the sector (European Commission, n.d.[12]).

3.2. Towards greater integration of social and healthcare services: Governance models in OECD countries

Many OECD countries face common challenges: fragmentation of services, limited home coverage, shortage of trained staff and financial sustainability issues. People with limited self-sufficiency receive a mix of mainly healthcare and mainly social services, and their provision is often poorly integrated. The governance of these services is therefore often divided between the Ministry of Health and the Ministry of Social Affairs, and responsibility is often shared between central government and local authorities. Local authorities also often play the leading role in service delivery (OECD, 2022[13]). The important role of the informal sector (i.e. family carers and personal caregivers) and the poor integration of information systems are additional challenges shared by many OECD countries.

A growing number of OECD countries are implementing measures to improve the integration of social and healthcare services. Finland, the United Kingdom, Slovenia and Spain, for example, are currently undergoing a long process of reforming their health and social services. Greater integration of social and health services requires improvements in integration at the political, institutional, organisational, functional and operational/care levels. Some of the most common measures in OECD countries include:

- **A single ministry or department for healthcare and social policies**. In 2023, 11 OECD countries had a ministry or department responsible for health and social policies. In other countries, however, responsibilities are separated, with the aim of ensuring that each sector receives specific attention. In these cases, strong inter-ministerial co-ordination mechanisms are essential to ensure policy coherence and effectiveness.
- **A single public body and pooled funding for services for people who are not self-sufficient:** In some countries, responsibility for social and health services for older people, people with disabilities or people who are not self-sufficient is centralised in a single body. For example, since 2020, France has given an increasing role to the National Solidarity Fund for Autonomy (CNSA). Traditionally responsible for financing services for people with disabilities, the agency will be responsible for services for the elderly and people with disabilities by 2030. In this model, the various funding streams are transformed into a pooled funding system – a key tool for promoting the integration of LTC.
- **Intergovernmental bodies for co-ordination between national and local actors in LTC services**. In Spain, for example, the Territorial Council of the Public System for Autonomy and Dependency Assistance brings together the state and the regions; in France, the "Conference of Funders" discusses measures and resources for non-self-sufficient people over 60; in Finland, there are plans to establish 21 "well-being districts", funded by the central government, which will be responsible for social and health services previously managed by municipalities.
- **Co-ordination and communication systems between actors involved in service planning and management**. Other OECD countries have set up co-ordination systems (e.g. intergovernmental committees, regular meetings) to improve integration and co-operation between service providers. In several Nordic countries, central government and local authorities meet regularly to discuss measures concerning services and any difficulties to be addressed.
- **Integration between the formal sector and family caregivers, personal caregivers, and foreign workers**. Currently, most OECD countries have support mechanisms for family caregivers and informal carers. About two-thirds of OECD countries provide leave for caregiving, although it is not always paid, while training opportunities are often limited and offered online by the third sector. Some countries, including Canada, Germany, Israel and Spain, have mechanisms in place to facilitate the regularisation of informal migrant caregivers (European Commission, 2022[14]).
- **Improving the integration of health and social information systems.** In Finland, for example, the national statistics institute is creating a single data register for services provided, using the

Kanta model, https://www.kanta.fi/en/professionals, facilitated by the existence of a single Ministry for Health and Social Affairs.

- **Strengthening the healthcare and support workforce**: For example, in the United Kingdom, the "People at the Heart of Care" plan provides for 50 000 additional nurses in the National Health Service (NHS) and at least GBP 500 million for adult care reform. Health Education England is leading the 15-year planning process, with a focus on initial and continuing training for cross-sector roles and the introduction of an "Integrated Skills Passport" to facilitate the transfer of skills and knowledge between health and care (Department of Health and Social Care, 2022[15]).
- **Quality frameworks.** Several countries are updating their quality frameworks with the aim of promoting uniform standards and continuous improvement in social and long-term care services. France, for example, introduced a single national framework for over 40 000 facilities in 2022. The expansion of the role of public, non-profit and for-profit providers makes quality standards and monitoring mechanisms increasingly relevant, despite the limited availability of up-to-date data (OECD, 2022[13]).

Governance systems also require the involvement and co-ordination of a range of actors and different entities at the local level, including the various bodies that constitute and promote **social innovation** (see Box 3.1).

Box 3.1. Social innovation supporting social and healthcare integration

Social innovation can make a valuable contribution to improving the integration of health and social services, especially in the care of non-self-sufficient elderly people. These are new initiatives, often tested at local level, which arise from collaboration between different actors – public institutions, third sector organisations, volunteers and citizens – to respond to complex needs that are not fully covered by traditional systems. Various examples show the potential of social innovation to build more people-centred, flexible and sustainable care systems based on collaboration between different actors.

The OECD report Starting, Scaling and Sustaining Social Innovation shows how these initiatives develop through three phases: starting, when a problem is addressed in a new way by those close to the local area, often with limited resources but great flexibility; scaling, in which effective solutions are adopted by other areas, supported by alliances with public administrations or integrated into national policies; and sustaining, which requires stability over time, including long-term funding, the ability to adapt to change and tools to assess impact.

Various projects show how social innovation can strengthen integrated care for older people. In **Poland**, for example, a project supported by the European Social Fund has developed an integrated model of long-term care for people with chronic diseases in rural areas affected by depopulation and weak family networks. In **Sweden** (Västernorrland), the IMPROVE (*Involving the community to co-produce public services*) project used a living lab approach to co-design sustainable home care solutions in remote areas, including technologies such as incontinence sensors and night-time monitoring cameras. The transnational project SI4CARE (*Social Innovation for integrated healthcare of ageing population in ADRION Regions*) in the countries of the **Adriatic-Ionian region** aims to strengthen co-operation between different levels of the healthcare sector to promote social innovation in care services for older people. The initiative involves public and private actors to improve the capacity to develop policies, co-ordinate strategies and offer integrated and innovative services.

Source: OECD (2025[16]), *Starting, Scaling and Sustaining Social Innovation: Evidence and Impact of the European Social Fund*, https://doi.org/10.1787/ec1dfb67-en, and OECD (2024[17]), "Assessing the framework conditions for social innovation in rural areas, https://doi.org/10.1787/74367d76-en.

3.3. A look at social and healthcare integration in some OECD countries

The transformation of care systems for non-self-sufficient older people is a challenge for many OECD countries, which must reconcile demographic ageing, the sustainability of services and the growing demand for home care. In this context, five case studies – Japan, England, Denmark, Australia and the Basque Country (Spain) – explore different solutions for promoting effective integration between health, social, housing and community support services, and provide insights that could be transferred to Italy.

3.3.1. Japan: The community-based integrated care system

With the proportion of people aged 65 and over set to rise to 34.8% by 2040, Japan is at the forefront of adapting care systems to demographic ageing. In 1973, Japan introduced free healthcare for older people. However, the increase in hospital admissions of older people with social needs prompted the government to launch a ten-year strategy for promoting the health and well-being of older people in the early 1990s, known as the *Gold Plan*. This was followed by the *New Gold Plan* and, in 2000, the Long-Term Care Insurance (LTCI) Act, designed to ensure more sustainable financing of LTC (Szczepura et al., 2023[18]). The LTCI supported the extensive development of home and community care, with a 203% increase in utilisation in the first decade (Tamiya et al., 2011[19]).

In 2012, the Community-based Integrated Care System was introduced as an extension of the LTCI to integrate healthcare, long-term care, preventive care, daily living support and housing solutions (OECD, 2018[20]). The model, inspired by the Health and Welfare Centres already tested in isolated areas, aims to promote ageing "at home" by reducing dependence on hospital or institutional care (Szczepura et al., 2023[18]; Hatano et al., 2017[21]).

The governance model

The Japanese model of integrated care is based on multi-level governance with a strong focus on the local area. At the local level, there are Comprehensive Community Support Centres (CCSCs) in every municipality, which are designed to be a single point of access to services for older people and their families. In larger centres, the service may be divided into several locations.

CCSCs act as local hubs for the assessment, planning and co-ordination of health, social and housing services available in the community; they also lighten the co-ordination burden that would otherwise fall on individual professionals and facilities. Each centre is run by a multidisciplinary team of public health nurses, social workers and long-term care specialists.

The clinical co-ordination function is entrusted to the Care Manager, a central figure in the system. The Care Manager – who must have a national qualification in healthcare, medicine or social work and at least five years' experience – assesses the level of certified need, draws up an Integrated Care Project and accompanies the user in accessing services (Szczepura et al., 2023[18]).

Each Centre is supported by appropriate housing solutions and community-based ageing support services, with a focus on health promotion, prevention, rehabilitation and recovery support. The Centres also offer guidance on housing and long-term care, excluding nursing homes.

Interventions and providers

The Japanese model has been described as an example of "integrated care neighbourhoods", in which services are organised to provide an integrated and accessible response to the complex needs of the elderly population at the local level (Szczepura et al., 2023[18]). The model is based on person-centred care rooted in the community. The Individualised Care Plan may include preventive measures, primary care,

home care, rehabilitation, support for daily activities, adapted housing solutions and the promotion of social interaction.

Interventions are provided by accredited public and private entities. Access to services is regulated by the LTCI system, which determines the level of care needed through a standardised 74-item questionnaire, a home visit and a medical report (Tamiya et al., 2011[19]). Elderly people who are not eligible for LTCI benefits can access preventive services.

A distinctive feature of the Japanese system is its multi-level structure, based on four interdependent pillars (Datta et al., 2025[22]):

- Self-help (*Ji-jo*): Promotes individual and family autonomy through educational initiatives, health check-ups, lifelong learning and voluntary activities for healthy older people.
- Mutual assistance (*Go-jo*): Values informal support and volunteering, including with institutional participation; municipalities finance volunteer training and Social Welfare Councils (local co-ordination bodies responsible for promoting social well-being in communities) co-ordinate activities, facilitating integration with formal services.
- Social solidarity (*Kyo-jo*): This is the backbone of the insurance system: all citizens over the age of 40 pay premiums for LTCI and certified older people are entitled to services. Co-operatives and solidarity organisations also operate at the local level.
- Public support (*Ko-jo*): This includes mandatory public services financed by tax revenue, service regulation, and economic and housing support programmes for low-income older people.

This arrangement allows for a flexible and adaptable response to the complex needs of the elderly population, combining national consistency and local implementation. The system encourages ageing in the community, reduces pressure on hospitals and residential facilities, improves quality of life, and makes care more financially sustainable, thanks to potentially lower costs compared to exclusively formal models. (Datta et al., 2025[22]).

Information systems and interoperability

Japan is investing structurally in technological innovation to support the transformation of its care system. A new academic discipline, *Care Science*, complementary to medicine and nursing, has been introduced to promote the development of assistive technologies, including robotics, sensors and artificial intelligence.

In 2021, the Japanese Ministry of Health established the LIFE (Long-Term Care Information System for Evidence) information system, which aims to support scientific evidence and the measurement of care outcomes, as well as to promote the digital transformation of the sector by encouraging the adoption of new organisational models and service delivery methods (Szczepura et al., 2023[18]).

Resources

The Japanese LTCI system has established specific insurance for non-self-sufficiency. Funding is based on a combination of insurance contributions and general taxation, with approximately half of the funds coming from individual insurance premiums and the other half covered by municipal and national taxes (Datta et al., 2025[22]). Residents over the age of 40 pay compulsory insurance premiums; from the age of 65, they are entitled to LTCI benefits based on their certified level of need.

The user's contribution to the cost is on average 10% of the value of the service (Datta et al., 2025[22]), but there are support measures for people on lower incomes. A separate insurance fund is available for people with disabilities between the ages of 40 and 65. In addition, municipal governments finance complementary measures to promote health, prevent frailty, provide social housing and develop community networks, often in partnership with organised voluntary organisations (Szczepura et al., 2023[18]).

The *Care Managers* play a central role in resource management: they define the care plan within the limits set by the insurance system, monitoring the efficient use of available services.

Transferability

The Japanese model shows that maintaining quality of life in old age requires integrated measures combining healthcare and long-term care, support for daily living and economic protection. The transferability of this model requires functional multi-level governance, an integrated information system, a stable financing framework and adequate availability and co-ordination of qualified personnel. The Japanese experience shows that integration is not only a question of organisational structure, but also of professional culture and civic participation. The creation of local networks, the involvement of community actors and a person-centred approach are essential elements for effective integration (Sano et al., 2023[23]).

The widespread presence of community support centres is a key element in identifying local needs and resources and connecting older residents with appropriate medical and social services. Replicability depends on the ability to integrate formal services and community resources within a territorial framework. The system is also based on a balance between public intervention, self-help and mutual support, easing pressure on public services and strengthening community resilience (Datta et al., 2025[22]).

3.3.2. England: Integrated Care Systems – ICS

In England, the issue of integrating health and social care for older people has undergone a long evolution. After the creation of the National Health Service (NHS) in 1948, which guaranteed free healthcare for all, social care for older people who were not self-sufficient remained separate and subject to economic eligibility criteria. It was not until the 2000s that a reform process was launched to overcome this fragmentation, supported, for example, by the 2006 White Paper “Our Health, Our Care, Our Say”, which sought greater integration of services for older people.

In recent decades, health policies in the United Kingdom have repeatedly reaffirmed their commitment to shifting the provision of care from hospitals to settings closer to the community and people’s homes. Among the most significant measures are the 2014 NHS Five Year Forward View and the 2019 NHS Long Term Plan, together with the 2014 Care Act and related regulations and guidelines.

With the entry into force of the Health and Care Act in 2022, 42 Integrated Care Systems (ICS) were formally established in England with the aim of overcoming historical, cultural, legal and financial barriers to integration and improving the living conditions of people living in their respective areas. One of the main aims of these local partnerships is to facilitate the transition from hospital care to forms of care and support closer to people’s homes and communities. (Szczepura et al., 2023[18]; Age UK, 2024[24]).

The governance model

In each of the 42 geographic areas of the ICS, NHS bodies and local authorities are organised into two bodies (NHS England, n.d.[25]; National Audit Office, 2022[26]):

- the *Integrated Care Board* (ICB), an NHS body whose members are appointed by hospital trusts, primary care providers and local authorities. The ICB receives funding from NHS England to plan and purchase health services in the area covered by the integrated system. Each ICB manages the health budget and works with local providers (hospitals, general practitioners, etc.).
- the *Integrated Care Partnership* (ICP), a joint committee set up by the ICB together with local authorities, with the possibility of including other stakeholders, such as third sector organisations. The ICP is responsible for developing an Integrated Care Strategy that sets out how to meet the

health and care needs of the local population. The ICB, local authorities and NHS England are required to take this strategy into account when planning and delivering services.

Interventions and providers

Local authorities are responsible for social care, public health and other services crucial to well-being (housing, education, transport, leisure). When planning their activities, they must take into account the strategy developed by the ICP.

The ICS model promotes a multidisciplinary approach to caring for frail older people. Teams include nurses, social workers, volunteers and other professionals, and operate both in the home and in residential facilities. Services also include the Social Prescribing Link Worker, a role introduced to facilitate access to non-clinical services provided by volunteers and the community, often to address social issues. Although not exclusively aimed at the elderly population, this professional figure represents a cost-effective solution to the fact that around a quarter of visits to general practitioners are motivated by social issues – access to services, housing or employment problems, guidance on welfare services – which require skills and advice other than strictly clinical ones (Szczepura et al., 2023[18]). Analysis of some local experiences has also shown that integration between nurses and social workers has led to a reduction in hospitalisations.

Information systems and interoperability

England has invested heavily in the digitisation of health and social care services. The *Plan for digital health and social care* published by NHS England in 2022 provides for the complete digitisation of health and care records in the 42 ICSs and the extension of broadband to all care homes to facilitate remote care. The Care Quality Commission has launched a new strategy to improve service monitoring through digital data collection. At the same time, the National Institute for Health and Care Excellence (NICE) is developing a database for digital technologies and artificial intelligence in the social sector (Szczepura et al., 2023[18]).

Analyses of data use within ICSs reveal considerable heterogeneity in terms of the maturity of digital infrastructures, organisational capacity and data usage patterns. Only a few systems have advanced technologies and are able to use data effectively for individual care and population health management. Technological development is often not accompanied by an adequate evolution of organisational culture and staff skills, making targeted training and refresher courses necessary. Recruiting and retaining professionals with digital skills remains a significant challenge. Many ICSs also report difficulties in balancing daily operational needs with a more strategic use of data, calling for greater clarity on long-term national priorities in this area. Although there is consensus on the importance of involving patients and citizens in decisions regarding the use of data, different views remain on who should take responsibility for this. Finally, those consulted in the context of the analysis recognise ample opportunities for improvement, emphasising the importance of collaborative action between ICSs and more structured dialogue with national decision makers to strengthen the systemic use of health data (Understanding Patient Data, 2024[27]).

Resources

ICSs are mainly funded through funds allocated by NHS England, which receives resources from the Department of Health and Social Care (DHSC). The DHSC also provides a direct contribution to local authorities for public health services. NHS England distributes funds to ICBs according to a formula that takes into account factors such as population size and health needs. ICBs manage the budget by purchasing services or delegating funds (National Audit Office, 2022[26]). In addition to regular funding, ICSs may receive additional funding for integration projects from NHS England, DHSC or local authorities. To support the delivery of integrated care, many ICSs use pooled budgets with local authorities.

Transferability

The English experience shows a system undergoing progressive transformation towards the structural and operational integration of services for older people. NHS England (n.d.[25]) mentions as the main features of the model the promotion of integrated services across sectors, partnerships between the NHS and local authorities, unified staff management, a focus on prevention, decentralisation at local level, the activation of multidisciplinary local teams, collaboration between providers and support for the social and economic development of communities. The evidence gathered suggests benefits in terms of perceived quality and reduction in avoidable hospitalisations. However, inconsistencies between ICSs, shortcomings in staff training, limited formalisation of protection, and the need for investment in data interoperability represent significant challenges. The transferability of the model requires strong central co-ordination, dedicated resources, and the promotion of a collaborative culture across the country (Szczepura et al., 2023[18]). Multi-level governance is one of the most complex but also strategic aspects of ensuring consistency between national choices and adaptation to local needs, which is crucial for the sustainability of the ICS model.

3.3.3. Denmark: Pilot projects for interdisciplinary collaboration at local level

The Danish healthcare system, based on general taxation and universal access, guarantees high-quality care, with high patient satisfaction and few unmet needs. Governance is structured on three levels: the state, responsible for strategic direction; the regions, which manage specialist healthcare services; and the municipalities, responsible for social care, home care, care for the elderly, prevention and rehabilitation. Integration between these levels remains a key challenge. To strengthen it, 21 Health Clusters were established in 2021-2022, each centred around a large hospital, to co-ordinate regional and municipal responsibilities, promote coherent care pathways and overcome fragmentation. The Clusters bring together policymakers and health managers to define shared strategies at the regional level. (OECD, 2024[28]).

Alongside these national initiatives, several local projects have sought to improve integration, including one launched in six municipalities to strengthen interdisciplinary collaboration between health and social services. Following the Summit on Older People organised in 2020 by the Danish Ministry of Health, the municipalities of Faxe, Hedensted, Haderslev, Copenhagen, Ringsted and Rudersdal launched projects aimed at reorienting care services for older people based on the specific needs of their local areas. The initiatives were implemented as part of *Fremfærd Sundhed og Ældre*, an institutional collaboration that aims to strengthen the municipal labour market's capacity to fulfil its welfare responsibilities, with a particular focus on long-term care.

A committee of experts, composed of trade union representatives, local authorities and municipal administrations, established a joint development space. This space allowed managers and operators from the six municipalities to co-design new approaches to elderly care, drawing on both local experience and the principles of the Dutch *Buurtzorg* model (see Box 3.2). The initiative was made possible thanks to dedicated funding provided by *Fremfærd Sundhed og Ældre*.

Box 3.2. The Buurtzorg model (Netherlands)

The Buurtzorg model, developed in the Netherlands since 2006, is based on self-managed nursing teams that provide holistic and personalised care at community level. Each team, consisting of up to 12 nurses and care workers, looks after 40 to 50 patients in their neighbourhood. The teams are responsible for organising their work, managing tasks and decision making, actively collaborating with GPs, therapists and other local professionals, and building their own network of users through word of mouth and referrals. Buurtzorg supports the teams' operations through an IT platform to reduce administrative burdens, increase productivity and improve the quality of care. Through the platform, teams access information on performance, interventions and results, promoting mutual learning.

Over time, the model has evolved in different directions. Buurtzorg+ has strengthened prevention and collaboration between nurses and therapists. BuurtzorgT has extended the self-management approach to psychiatric care, promoting equality between staff and users, the use of digital tools for joint learning and greater autonomy for users in managing their own care pathways.

Source: OECD (2024[28]), *Good practices in delivering integrated care: Examples from the Netherlands, Denmark, France and Ontario, Canada;* www.buurtzorg.com/about-us/buurtzorgmodel; and www.buurtzorg.com/innovation/buurtzorg-te.

Each municipality participated in the development of the projects with a group of ten managers and operators, ensuring the involvement of key professionals and decision makers for the implementation of the projects. The experiences share an approach based on interdisciplinary collaboration: small permanent groups composed of therapists, nurses and social and health workers meet every morning to plan their work and co-operate throughout the day, with the aim of ensuring better co-ordinated care that is more focussed on the individual needs of citizens. The organisation of activities varies between municipalities. In Faxe, for example, a new role of professional co-ordinator has been introduced, a social or health worker responsible for facilitating interdisciplinary meetings and promoting closer collaboration. The municipality of Hedensted, on the other hand, is creating joint physical facilities for home care and nursing. Groups of six to eight social and healthcare workers share a small number of home visit routes and plan their own shifts within the framework set by management. Some municipalities have involved staff in daily planning, organising care pathways and shifts; others have adopted tools inspired by the Buurtzorg model, such as dashboards for monitoring indicators such as care times, absences, continuity and rehabilitation outcomes.

The initiative was evaluated, highlighting how the organisation into small teams facilitated continuity in relations with citizens and was associated with lower absenteeism rates than other working groups. Operators recognised that the transition to new organisational forms takes time; planning and management functions remain necessary but take different forms, mainly geared towards supporting "bottom-up" decisions. The recommendations emphasise the importance of continuing to strengthen stable teams, composed of different professionals and equipped with an adequate level of operational autonomy.

The replicability of the model requires a public administration with strong organisational capacity at the local level.

3.3.4. Australia: The new Support at Home program

Australia is reforming its care system for older people to strengthen the integration of health and social services, with a particular focus on home care, in response to the recommendations of the Royal Commission into Aged Care Quality and Safety. The Support at Home program, due to start in November 2025, is the government's main initiative in this area. The central objective of the reform is to ensure that older people who are not self-sufficient can remain in their own homes for as long as possible,

receiving integrated support tailored to their health, functional and social needs. The reform aims to ensure fair prices, a greater focus on early intervention and higher levels of care for people with complex needs (Australian Government, 2025[29]).

In parallel, the Australian Government has developed the *National Carer Strategy 2024-2034* and the accompanying *Action Plan 2024-2027*, which are highly relevant in this context. These initiatives promote better recognition of carers, emphasise the importance and of unpaid carers in the provision of care to older persons, and include measures to strengthen training and support for family caregivers, improve data on informal care to inform policy, and create opportunities for better work – caregiving balance (Australian Government, 2024[30]; 2024[31]).

The governance model

The reform is part of the new legal framework set out in the *Aged Care Act 2024*, https://www.legislation.gov.au/C2024A00104/latest/text, the federal government's legislation on care for the elderly. The Act introduces a rights-based legal framework and strengthens the responsibilities of service providers in terms of transparency and quality. It will come into force on 1 November 2025, coinciding with the launch of the *Support at Home*, https://www.health.gov.au/our-work/support-at-home program.

Consolidation of existing programmes

The Support at Home programme will gradually absorb three existing home care schemes:

- *Home Care Packages (HCP) Program*: Provides packages of support at four different funding levels. It ensures personalised home care to enable older people to remain in their own homes for as long as possible, delaying the need for residential care. It offers a co-ordinated mix of services, including support with domestic tasks, aids and equipment (such as walking frames), minor home modifications, personal care and clinical care, including nursing and rehabilitation services. The approach is based on consumer-directed care, ensuring that interventions are aligned with the person's needs and goals. The programme will be replaced on 1 November 2025 (Government of Australia, 2025[32]).
- *Short-Term Restorative Care (STRC) Programme*: Offers temporary, intensive support for up to eight weeks, with the aim of preventing or delaying admission to residential facilities. The intervention focusses on functional recovery through a multidisciplinary approach, combining social and health support with a view to rehabilitation. The programme will be replaced on 1 November 2025 (Australian Government, 2025[33]).
- *Commonwealth Home Support Programme (CHSP):* For relatively independent older people who need limited help with daily activities, the CHSP provides essential services such as cleaning, meals, transport and social support. It will remain in place until at least July 2027, allowing for a smooth transition to the new scheme for providers and users (Australian Government, 2024[34]).

The gradual replacement of these three programmes aims to simplify access to services, reduce overlaps and promote greater integration between the health, functional and social aspects of home care. To this end, the Australian Government's Department of Health, Disability and Ageing has allocated resources to support providers and stakeholders during the transition to the new Support at Home program.

Planned interventions and providers

The Support at Home programme aims to ensure better access for older people to services, aids, equipment and home modifications to help them stay healthy, active and socially connected to their communities. It offers three dedicated pathways: the Restorative Care Pathway, which provides multidisciplinary rehabilitation interventions to strengthen independence; the AT-HM scheme, which

provides access to aids and home modifications based on assessed needs; and the End-of-Life Pathway, which provides more funding to access in-home aged care services in last three months of life (Australian Government, 2025[35]).

The services are divided into three areas: clinical supports (nursing care, allied health and therapeutic services, nutrition, care management and restorative care management), independence support (personal care, social support and community engagement, therapeutic services for independent living, respite, transport, assistive technology and home modifications), and everyday living assistance (domestic assistance, meals, home maintenance and repairs) (Australian Government, 2025[36]).

Each participant will receive a personalised package of services provided by a single provider, who will be responsible for the overall delivery of services.

When the Support at Home programme comes into effect, the *Single Assessment System for aged care,* https://www.health.gov.au/our-work/single-assessment-system, will already be operational. This is a unique assessment system for determining the needs of older people and their eligibility for the programme. Once the assessment is complete, the person will receive an individual support plan to share with their service provider. The plan will contain a summary of the elderly person's care needs and personal goals; a classification of needs, associated with a recurring quarterly budget; and/or approval for short-term interventions.

Resources

The Support at Home programme is financed through a mixed system based on public contributions and user contributions, in accordance with principles of fairness and sustainability. The government will fully fund clinical services (e.g. nursing care and physiotherapy), while moderate contributions will be required for services related to independence (e.g. personal care, aids and home adaptations) and higher contributions for services related to daily living (e.g. cleaning and gardening). Rates will be set per unit of service and will vary according to the type of service provided. Individual contributions will also be adjusted according to income. To protect those receiving long-term care, there will be a cumulative cap of AUD 130 000 (EUR 72 152) on individual contributions. From 2026, a pilot scheme for pooled funding for collective settings (e.g. retirement villages) will also be launched, in which users will be able to access flexible services by sharing their individual resources.

Transferability

The introduction of a single assessment system, the aggregation of multiple programmes into a single modular structure, and the presence of a co-ordinating provider for each user are key tools for ensuring integration, efficiency, and personalisation. However, challenges remain related to the shortage of qualified personnel, the ability of providers to adapt to new requirements, and the risk of regional inequalities in implementation. The success of the reform will also depend on the ability to integrate digital tools and common information systems to facilitate quality monitoring and information sharing.

The new model emphasises the importance of continuity and consistency in care. In addition, the role of local providers, including non-profit organisations and social enterprises, is enhanced. They will continue to be accredited and funded according to standardised and transparent criteria.

3.3.5. Basque Country, Spain: The 2021-2024 strategy for social and health care

In Spain, long-term care follows a multi-level structure: the central government defines the general principles, while the autonomous communities, such as the Basque Country, have extensive powers in the planning, management and financing of social and health services. All autonomous communities, albeit to

varying degrees, rely on the participation of private operators for the construction or management of health and social infrastructure (Díaz-Tendero and Ruano, 2024[37]).

In the Basque Country, social and healthcare assistance is supported by a regulatory framework consisting of three main laws: Law 27/1983, which governs institutional relations in the autonomous community; Law 8/1997 on healthcare organisation, supplemented by Decree 100/2018 on integrated healthcare organisations; and Law 12/2008 on social services, with Decree 185/2015 regulating criteria, requirements and procedures for accessing the Basque social services system.

Framework agreements have been in place since 1996 to ensure that social and healthcare needs are met. Over time, various strategies have been developed to support the integration of social and health care (2013-2016; 2017-2020; 2021-2024). The 2025-2028 strategy is currently being developed.

The governance model

Social and health care involves various actors at different levels of governance:

- The Basque Government, whose responsibilities range from social and health policy planning to the planning and provision of health, social and care services.
- The provincial governments (Álava, Bizkaia and Gipuzkoa), whose responsibilities mainly focus on social policies and the provision of care services.
- The 252 Basque local councils, which are the main gateway to social and primary care services.

The Basque Country's 2021-2024 social and healthcare strategy outlines the integrated governance model. It provides for an inter-institutional, multi-level and multidisciplinary framework for interaction between the main institutions and organisations involved in the management and delivery of social and healthcare services. It defines multidisciplinary and inter-institutional decision making bodies and functional co-ordination bodies for health and social services.

One of the tools developed by the Basque Government are the social and health co-ordination protocols – guidelines that describe and aim to simplify the collaborative relationships and activities of the institutions and organisations involved in the governance and delivery of social and healthcare services. The protocols are to be reviewed periodically and reports documenting the status of implementation of social and health co-ordination procedures are to be drawn up regularly. Among the difficulties encountered in the management and evaluation of the protocols are the lack of defined criteria for the validity and revision of the protocols, the poor alignment between protocols in different local contexts, and the lack of involvement of social service managers in the integration process in some local contexts (OECD, 2024[38]).

Interventions and providers

In the Basque Country, social and health care is based on strategies that aim to provide co-ordinated and holistic responses to the social and health needs of the population (not exclusively for older people). Experience from previous strategic programmes indicates that effective co-ordination at the micro level requires flexible teams that are rooted in the community and based on relationships of mutual trust. This vision has proved particularly relevant in complex contexts such as those that have emerged after the COVID-19 pandemic, where co-ordination between different levels of care is essential.

Social and healthcare teams may include primary and/or secondary care professionals, depending on the care pathway required. The 2021-2024 strategy has two main strands: strengthening primary social and health care, as the gateway to the system, through dedicated teams working in co-ordination with other levels of care when necessary; and developing specific interventions for target groups, with an emphasis on early intervention.

The action plan provides for the creation of a map of social and healthcare contacts, including those in the local area; the drafting of a conceptual guide to consolidate the functions of primary social and healthcare assistance; the mapping and analysis of existing protocols and procedures in the various historical areas; experimentation with pilot projects for team co-ordination; the presentation to interest groups and the development of shared proposals; and the dissemination and implementation of interventions (Basque Government, 2021[39]).

Information systems and interoperability

One of the pillars of the Basque Country's 2021-2024 social and healthcare strategy is the development of interoperability between social and healthcare information systems, with the dual objective of guaranteeing citizens the right to interact with the administration electronically in administrative procedures and adapting existing information systems to an integrated and co-ordinated working model between social and healthcare professionals. To achieve this, the strategy provides for the standardisation of content and messages, the development of interoperable platforms, the design of tools for joint case management and the systematic evaluation of data exchange services (Basque Government, 2021[39]).

Resources

The 2021-2024 strategy provides for the definition of a shared and stable public funding framework to support the social and health services listed in the regional catalogue in a co-ordinated manner, clarifying the methods and proportions of public funding by the institutions involved (Basque Government, provinces and local authorities).

Launched with the 2017-2020 Strategic Priorities and consolidated in the 2021-2024 Strategy, the project provides for the development of a shared financing model, the definition and signing of inter-institutional agreements for the allocation of costs, and the establishment of a joint executive committee responsible for planning and monitoring investments in social and health services, including criteria, frequency and review mechanisms (Basque Government, 2021[39]).

Transferability

The experience of the Basque Country offers important insights for the construction of an integrated model based on a territorial approach. In particular, it is worth noting the consistency between the multi-level governance structure and the adoption of concrete operational tools, such as inter-institutional protocols, mixed social and health teams and the progressive interoperability of information systems. The holistic and flexible approach could also be useful in Italy, where the fragmentation of responsibilities between the state, regions and municipalities often hinders continuous and integrated care. Potentially transferable elements include the formalisation of co-ordination roles at the local level; shared mapping of professionals and resources; and the definition of a stable framework for public co-financing between institutional levels.

3.3.6. Conclusions

The five case studies (Japan, England, Denmark, Australia, Basque Country) show how other systems are advancing in the integration of social and health care. A comparative analysis identifies key elements such as institutional configuration, single access and standardised assessment, financial integration, multi-level governance and integrated planning, local teams and human resources, information infrastructure and monitoring, and social capital and informal support, with insights for the Italian case.

- **Institutional setup**. Using the methodology proposed by Caiolfa (2022[40]) to categorise the integration models identified in the case studies, the most common model among the systems analysed is that of co-ordination, as in Japan, England and the Basque Country. Australia is an example of full integration: with the Aged Care Act 2024, the Support at Home programme will replace three separate schemes and will be regulated, funded and monitored at federal level.

- **Single access and standardised assessment.** Establishing a single point of access, equipped with a nationally or regionally recognised multidimensional assessment procedure, can help ensure equity in care provision. In Japan's Comprehensive Community Support Centres, a questionnaire with 74 indicators translates needs into an insurance level with a spending ceiling; in Australia, the Single Assessment System will link the assessment to the quarterly budget associated with each user; in the English ICS, the local hub summarises health and social criteria. The Basque Country is setting up district-based social and health service centres, while in Denmark there are still multiple entry points, reflecting the experimental nature of the initiatives.
- **Financial integration.** In the cases analysed, one integration objective is to convert multiple sources into a single economic endowment that can be spent on modular service packages. Japan achieves this convergence through the LTCI; Australia will adopt, with Support at Home, a federal tariff with graduated co-payments accompanied by a lifetime spending cap; in England, pooled budgets allow NHS and municipal resources to be combined within the ICS; in the Basque Country, a three-level commission redistributes contributions from the region, provinces and municipalities into a shared fund. A clear definition of the integrated package allows users to know their economic rights and encourages managers to provide continuous and efficient care.
- **Multi-level governance and integrated planning.** Integration is consolidated when there is a body with planning and financial leverage powers. In the English ICS, the Board controls health funds and the Partnership approves local strategy; in Japan, the CCSCs are unique access points for different services; the Basque Strategy provides for inter-institutional round tables with a three-year review of protocols. These mechanisms create accountability and reduce the risk of fragmentation – a major challenge for Italy (Maino, Betti and De Tommaso, 2022[41]).
- **Local teams and human resources.** In all five cases, operational responsibility is delegated to multidisciplinary teams with managerial autonomy. For example, Japan entrusts co-ordination to regulated care managers who define individual plans, while in Denmark small self-managed teams plan shifts and visits; in the Basque Country, a mixed team reports to district social and healthcare co-ordinators. However, critical issues remain regarding staff availability, indicating that integrated functions require investment in training and study programmes dedicated to LTC.
- **Information infrastructure and monitoring.** The case studies associate operational integration with significant investment in information systems. Japan has launched the LIFE database, which collects process and outcome indicators across the entire LTCI in a uniform manner; England has planned a single clinical and social record within the ICS for 2026; in the Basque Country, an interoperable platform has been developed between health registries and social files. These initiatives contribute to transparency on costs and outcomes and allow for comparison of the performance of different units.
- **Social capital and informal support.** Systems with advanced levels of integration assign a formal role to community networks. Japan includes self-help and mutual aid as complementary pillars to insurance coverage; the English ICS funds Social Prescribing Link Workers to connect social needs and civic resources; in the Basque Country, structured volunteer programmes are part of social and health protocols, while Denmark is experimenting with forms of community housing with strong local participation. These measures address two critical issues for Italy: the growing burden on family caregivers and the still patchy co-operation with the third sector. By integrating the informal dimension into governance – with recognition of roles, training and targeted funding – the systems analysed ease the pressure on public services, strengthen territorial resilience and support continuity of care.

Various insights can be drawn for Italy. In the Italian context, co-ordination appears to be the most compatible strategy, allowing common standards and local autonomy to be combined. Furthermore, the experience of the five systems analysed confirms that social and health integration works when a number of elements converge, such as a single point of access with standardised assessment, a financial endowment that unifies sources, governance with spending levers, integration committees with decision

making powers, multidisciplinary local teams, training that strengthens the autonomy and skills of local teams, an interoperable information infrastructure and publicly accessible datasets on care outcomes, as well as tools that institutionalise informal support.

References

Age UK (2024), *The State of Health and Care of Older People in England 2024*, https://www.ageuk.org.uk/siteassets/documents/reports-and-publications/reports-and-briefings/health--wellbeing/state-of-health-and-care/state_of_health_and_social_care_24.pdf. [24]

Australian Government (2025), *About the Short-Term Restorative Care (STRC) Programme*, https://www.health.gov.au/our-work/short-term-restorative-care-strc-programme/about-the-short-term-restorative-care-strc-programme. [33]

Australian Government (2025), *Support at Home program*, https://www.health.gov.au/our-work/support-at-home. [29]

Australian Government (2025), *Support at Home program - A guide for older people in Australia, families and carers*, https://proveda.com.au/wp-content/uploads/2025/04/support-at-home-program-booklet-for-older-people-families-and-carers-compressed.pdf. [35]

Australian Government (2025), *Support at Home service list*, https://www.health.gov.au/resources/publications/support-at-home-service-list. [36]

Australian Government (2024), *About the Commonwealth Home Support Programme (CHSP)*, https://www.health.gov.au/our-work/chsp/about. [34]

Australian Government (2024), *National Carer Strategy 2024–2034*, https://www.health.gov.au/resources/publications/national-carer-strategy-2024-2034?language=en. [30]

Australian Government (2024), *National Carer Strategy Action Plan 2024–2027*, https://www.health.gov.au/sites/default/files/2025-07/national-carer-strategy-action-plan-2024-2027_0.pdf. [31]

Basque Government (2021), *Estrategia de Atención Sociosanitaria de Euskadi 2021-2024*, https://arretasoziosanitarioa.euskadi.eus/contenidos/documentacion/doc_sosa_soziosanitario_estrat/es_def/adjuntos/estrategia_sociosanitaria_es_web.pdf. [39]

Caiolfa, M. (2022), *Il Sistema Nazionale Anziani: unagovernance multilivello per la nonautosufficienza*. [40]

Council of the European Union (2022), *Council Recommendation on access to affordable high-quality long-term care, 2022/C 466/01*, https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:32022H2438. [11]

Datta, M. et al. (2025), "Overhauling US Long-Term Services and Supports: Looking Toward Japan", *Journal of Applied Gerontology*, https://doi.org/10.1177/07334648251348004. [22]

Department of Health and Social Care (2022), *Joining up care for people, places and populations*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1055687/joining-up-care-for-people-places-and-populations-web-accessible.pdf. [15]

Díaz-Tendero, A. and J. Ruano (2024), "Long-Term Care Policies in Spain: Welfare State and Resilience in the European Context", *Economies*, Vol. 12/12, p. 347, https://doi.org/10.3390/economies12120347. [37]

European Commission (2022), *A European Care Strategy for caregivers and care receivers, COM(2022) 440 final*, https://ec.europa.eu/social/main.jsp?catId=1570&langId=en. [10]

European Commission (2022), *Spain: Government adapts immigration law to include migrant workers in the labour market*, https://ec.europa.eu/migrant-integration/news/spain-government-adapts-immigration-law-include-migrant-workers-labour-market_en (accessed on 2 November 2023). [14]

European Commission (2017), *European Pillar of Social Rights*, https://commission.europa.eu/strategy-and-policy/priorities-2019-2024/economy-works-people/jobs-growth-and-investment/europe. [9]

European Commission (n.d.), *Recovery and Resilience Scoreboard*, https://ec.europa.eu/economy_finance/recovery-and-resilience-scoreboard/index.html. [12]

Government of Australia (2025), *Home Care Packages Program*, https://www.health.gov.au/our-work/hcp. [32]

Hatano, Y. et al. (2017), "The Vanguard of Community-based Integrated Care in Japan: The Effect of a Rural Town on National Policy", *International Journal of Integrated Care*, Vol. 17/2, https://doi.org/10.5334/ijic.2451. [21]

ILO (2022), *Care at work: Investing in care leave and services for a more gender equal world*, https://www.ilo.org/global/publications/books/WCMS_838653/lang--en/index.htm. [1]

ILO (2012), *R202 – Social Protection Floors Recommendation, No. 202*, https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:3065524. [8]

Maino, F., M. Betti and C. De Tommaso (2022), *Allineare gli interventi sulla non autosufficienza al contesto europeo*, Percorsi di secondo welfare, http://www.secondowelfare.it/primo-welfare/allineare-gli-interventi-sulla-non-autosufficienza-al-contesto-europeo/. [41]

National Audit Office (2022), *Introducing Integrated Care Systems: joining up local services to improve health outcomes*, https://www.nao.org.uk/wp-content/uploads/2022/10/Integrated-Care-Systems-Funding-and-accountability-for-local-health-and-care.pdf. [26]

NHS England (n.d.), *What are integrated care systems?*, https://www.england.nhs.uk/integratedcare/. [25]

OECD (2025), *Starting, Scaling and Sustaining Social Innovation: Evidence and Impact of the European Social Fund*, Local Economic and Employment Development (LEED), OECD Publishing, Paris, https://doi.org/10.1787/ec1dfb67-en. [16]

OECD (2024), "Assessing the framework conditions for social innovation in rural areas", *OECD Local Economic and Employment Development (LEED) Papers*, No. 2024/4, OECD Publishing, Paris, https://doi.org/10.1787/74367d76-en. [17]

OECD (2024), *Good practices in delivering integrated care: Examples from the Netherlands, Denmark, France and Ontario, Canada*, https://www.oecd.org/content/dam/oecd/en/about/programmes/dg-reform/ireland/Good%20practices%20in%20delivering%20integrated%20care%20%E2%80%93%20examples%20from%20the%20Netherlands,%20Denmark,%20France%20and%20Ontario,%20Canada%20(Output%204).pdf. [28]

OECD (2024), *Una proposta di modello di intervento per promuovere l'integrazione degli interventi sanitari e sociali a domicilio per persone non autosufficienti - Output 4*, https://www.oecd.org/content/dam/oecd/en/about/programmes/dg-reform/italy-inps/OECD_integrated%20care%20in%20Italy_report%20Output%204_ITA.pdf. [38]

OECD (2022), *Integrating Services for Older People in Lithuania*, OECD Publishing, Paris, https://doi.org/10.1787/c74c44be-en. [13]

OECD (2018), *Japan: Promoting Inclusive Growth for an Ageing Society*, Better Policies, OECD Publishing, Paris, https://doi.org/10.1787/9789264299207-en. [20]

Sano, J. et al. (2023), "An overview of systems for providing integrated and comprehensive care for older people in Japan", *Archives of Public Health*, Vol. 81/1, https://doi.org/10.1186/s13690-023-01076-5. [23]

Szczepura, A. et al. (2023), "Integrated Long-Term Care 'Neighbourhoods' to Support Older Populations: Evolving Strategies in Japan and England", *International Journal of Environmental Research and Public Health*, Vol. 20/14, p. 6352, https://doi.org/10.3390/ijerph20146352. [18]

Tamiya, N. et al. (2011), "Population ageing and wellbeing: lessons from Japan's long-term care insurance policy", *The Lancet*, Vol. 378/9797, pp. 1183-1192, https://doi.org/10.1016/s0140-6736(11)61176-8. [19]

Understanding Patient Data (2024), *New research: The use of data in Integrated Care Systems (ICSs)*, https://understandingpatientdata.org.uk/news/new-research-use-data-integrated-care-systems-icss. [27]

United Nations (2015), *Transforming our world: the 2030 Agenda for Sustainable Development*, https://sdgs.un.org/2030agenda. [3]

United Nations (2006), *Convention on the Rights of Persons with Disabilities, United Nations*, https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities. [4]

WHO (2020), *Decade of Healthy Ageing: Baseline Report*, https://www.decadeofhealthyageing.org/. [5]

WHO (2019), *Integrated care for older people: guidance for person-centred assessment and pathways in primary care*, https://www.who.int/publications/i/item/9789241513500. [7]

WHO (2017), *Integrated care for older people: Guidelines on community-level interventions to manage declines in intrinsic capacity*, https://www.who.int/ageing/health-systems/icope. [6]

WHO (2015), *World report on ageing and health*, https://www.who.int/publications/i/item/9789241565042. [2]

4 Social and healthcare integration at regional and local level in Italy

This chapter analyses social and healthcare integration at regional and local level in Italy. It reviews governance arrangements for services for non-self-sufficient individuals and explores integration at the professional level. The chapter also examines interoperability of information systems and the use of tools for integrated service delivery. Evidence from surveys and focus groups provides insights into how professionals in Italy perceive integration on the ground, highlighting both progress made and persistent challenges.

This chapter draws heavily on a survey conducted by the OECD from January to April 2024. This survey covered all Italian regions and autonomous provinces to assess the current level of integration of home-based health and social services for people who are not self-sufficient.

The chapter also presents insights based on information gathered through a questionnaire administered to professionals working in the local area.

4.1. The governance of social and healthcare services for non-self-sufficient individuals

In Italy, the governance of social and healthcare services for non-self-sufficient individuals is highly decentralised, developing across different levels of government: national, regional/autonomous province, and local (multi-level governance). As in most OECD countries, regions and local authorities have taken on an increasing role in the governance of services in Italy since the 1970s. Furthermore, due to its ability to understand and respond to the complex needs of the dependent population, civil society in general, and the third sector in particular, has taken on a crucial role in the governance of services in recent years (participatory governance).

Several initiatives have also been launched in Italy to promote an integrated multilevel governance system with integrated planning; Improve the governance of home care services. At the national level, with the enactment of Legislative Decree 29/2024, the Interministerial Committee for Policies for the Elderly (CIPA) was recently established (Article 3 of Legislative Decree 29/2024). Its task is to ensure the co-ordination and integrated planning of national policies for the elderly, with particular attention to frail and non-self-sufficient individuals. Furthermore, at the local level, the role of ATS and health districts has been strengthened, which, with a view to socio-health integration, ensure the “integrated” provision of services to recipients. The National Plan for Non-Self-Sufficiency 2022-2024 also includes measures to promote social and healthcare integration at the governance level. At the same time, the use of tools for the organisation and co-ordination of health and social activities at the local level is becoming increasingly widespread, including regional Territorial Activity Programmes, Local Area Plans based on Social Territorial Areas and Programme Agreements for co-ordination between different levels of government. Following the reform of the Third Sector Code in 2017, this is increasingly at the centre of shared administration initiatives with the public sector in the form of co-planning and co-design.

Almost all of the regions and autonomous provinces that completed the OECD questionnaire (17 out of 18) report that they have their own governance tools to improve the integration of care services. In particular, 12 regions have promoted social and healthcare integration through specific investments and projects, and seven have launched co-planning initiatives with the Third Sector.

Despite these experiments, more than half of the sample (11 out of 18) report that, even in terms of governance, the level of integration between the two types of home care currently existing in Italy – Integrated Home Care (ADI) and Home Care Services (SAD) – could be greatly improved. This assessment is supported, in particular, by the difficulties in integrating the planned intervention models, co-ordinating the provision of mainly nursing and social inclusion support services attributable to ADI and SAD, respectively, and encouraging interprofessional collaboration.

4.2. Social and healthcare integration at the professional level

Full social and healthcare integration cannot be achieved without greater co-ordination between those directly involved in care activities. On the one hand, it requires greater integration between the roles and responsibilities of health, social, and social-healthcare professionals in the formal sector. On the other hand, there is an increasingly urgent need for full recognition of the role of family carers and personal and

family caregivers who make up the informal sector. They play an essential role in linking the provision of existing services with the needs of dependent persons and account for a large proportion of the care provided in Italy.

In Italy, the obstacles to social and healthcare integration at the professional level are of various kinds. At the legal level, the fundamental principles of protection of the professionalism and dignity of workers do not allow for the extension of the duties provided for in contracts. In terms of training, the prevailing system in tertiary education and in continuing training takes a sectoral approach that places limited value on multi-disciplinarity. Further barriers relate to the shortage of labour in both the health and social sectors, which reduces the pool of potential users of integrated training initiatives.

The OECD survey reveals that most regions and autonomous provinces grant the right to request an assessment and to participate in the assessment itself to a variety of professionals (in some contexts, these two phases involve up to 8 and 11 actors, respectively). Furthermore, in almost all the responding regions and autonomous provinces (16), opportunities for discussion between the professionals involved in the assessment are provided.

On the other hand, professional integration is less evident in the service delivery phase, as shown not only by the high number of respondents who consider the level of integration between Integrated Home Care (ADI) and Home Care Services (SAD) to be insufficient, but also by the low number of regions (6) that use case managers to promote an integrated approach to care. International practices on territorial and multidisciplinary teams, and on their co-ordination, have demonstrated the effectiveness and efficiency of integrated models.

Most Italian regions and autonomous provinces also have their own legislation that provides for and/or defines the role of personal or family caregivers. Given the high prevalence of irregular work (between 52% and 76% of personal/family caregivers work irregularly, according to various estimates) and the difficulties in monitoring the quality of care provided, some regions have adopted measures to promote the regular employment of caregivers, including tax incentives, financial contributions and the creation of regional registers. These initiatives could be reinforced by recently introduced national policies to promote and standardise the training of personal/family carers and their regular employment.

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

Adopting policies to support family caregivers is essential to ensure the well-being of these essential roles in the care of non-self-sufficient people and to improve the quality of life of all those concerned.

4.3. Interoperability of information systems

The availability of data in the healthcare and social sectors is essential for the effective design and monitoring of public policies in these areas. A key tool for full integration is the interoperability of the respective information systems. Efficient management of health and social data can enable health, social, and social-healthcare professionals to plan interventions in a fully informed manner. Furthermore, the presence of interoperable information systems can increase the equity of the care system, the quality of interventions and patient participation in the planning of interventions. In Italy, this objective is initially limited by the considerable divergence between the level of digitisation of social and health information systems.

In the social sector, the Unified Social Services Information System (*Sistema Informativo Unitario dei Servizi Sociali* – SIUSS), introduced at national level in 2017, is an information resource with great potential

for collecting data on social services, offering policymakers a tool to support the planning, monitoring and evaluation of social policies.

However, its use is hampered by the limited transmission of data by municipalities, many of which have not yet adopted digital solutions, resulting in a fragmented information landscape. At regional and local level, the OECD survey also reveals the existence of an innovative digital tool for managing and storing information on social services: the *Cartella Sociale Informatizzata* (CSI, Computerised Social File), which is already operational or about to be activated in 15 of the 18 regions and autonomous provinces that responded. However, the implementation of the CSI is fragmented at the territorial level, even within individual regions. Among the main obstacles to its full implementation are the lack of adequate technical and IT tools and privacy issues.

In the healthcare sector, the digitisation of information systems appears to be more advanced and less fragmented. Several tools have been introduced since the 1990s. These include the Home Care Monitoring Information System (SIAD), which allows the collection of data on health and social care provided by the National Health Service in the context of home care. The Electronic Health Record (FSE), established in 2015, also allows both professionals and patients to easily access health data. Among the regions responding to the survey, nine indicate that issues related to privacy, resistance from healthcare professionals and a lack of specific training are hindering the full implementation of the FSE at the regional level. The use of the FSE will be promoted throughout the country by the Steering Committee for the New Health Information System (NSIS), which sets the strategic objectives and new functionalities of the FSE.

The shortcomings in the digitisation of health and social information systems are accompanied by a limited level of interoperability between them, both at national and regional level. The survey indicates that only three regions are currently preparing an integrated information system for Integrated Home Care (ADI) and Home Care Services (SAD); here too, the main obstacles encountered are related to privacy and the lack of adequate technical and IT tools. Some recent national initiatives aimed at promoting data interoperability, in particular the establishment of the National Digital Data Platform (PDND), may encourage the emergence of new regional and local experiences in the social and healthcare sector.

4.4. Tools for integrated delivery

The co-ordination of intervention methods in the care of non-self-sufficient individuals is the last of the pillars of social and healthcare integration described in this report. As already mentioned, Italy has two different home care services based on the cultural model of reference and the nature of the services offered: Integrated Home Care (ADI), which falls under the responsibility of the National Health Service, and Home Care Services (SAD), which is a social service provided by municipalities.

Because of these differences, most regions think the level of integration between these two service delivery models could be improved significantly.

The preliminary dashboard below (Figure 4.1), based on a set of 34 indicators broken down into four policy areas, gives a fairly accurate estimate of the level of integration achieved in the 18 regions and autonomous provinces that took part in the survey. Dark red indicates a very limited degree of integration, while the gradual shift towards green indicates an increasingly advanced and comprehensive model of integrated social and health services.

Figure 4.1. Levels of integration vary considerably between regions and autonomous provinces

Source: OECD, based on surveys of regions and autonomous provinces.

4.5. In-depth analysis: How professionals perceive integration at local level

As part of the pilot phase of the project, professionals' views on the level of integration maturity were analysed. The main sources of information were focus groups, conducted in 14 local areas, and the "Scirocco" questionnaire (see Box 4.1) on the level of integration maturity.

4.5.1. Answers to the "Scirocco" questionnaire

The "Scirocco" questionnaire, administered online between 9 December 2024 and 11 February 2025, received a total of 500 responses, allowing for the analysis of 12 aspects of integration – from governance to process co-ordination and funding (see Box 4.1).

Box 4.1. The "Scirocco" questionnaire

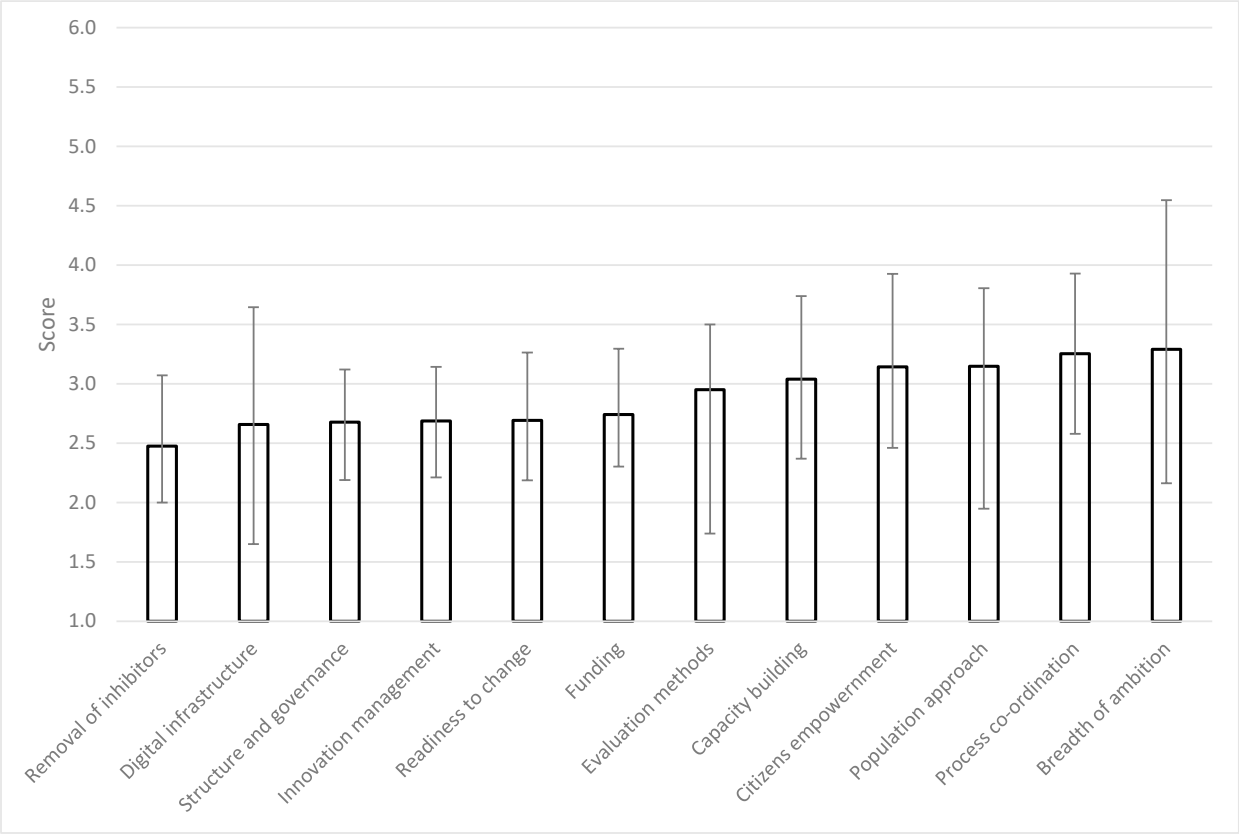
The questionnaire was developed through the activities of the SCIROCCO Exchange project funded by the Health Programme of the European Union (www.sciroccoexchange.com).The questionnaire assesses the maturity of integrated care and identifies areas for improvement and barriers to integration through 12 questions:

- **Readiness to change**: Is there recognition of the need to create new roles, new work processes and practices, and new systems to support information exchange and team collaboration?
- **Structure and governance**: Is there an adequate multi-level, multi-stakeholder governance structure in place?
- **Digital infrastructure**: Is there an integrated and interoperable information system?
- **Process co-ordination**: Is there a systematic approach to defining integrated care pathways?
- **Funding**: Is there secure, multi-year funding and/or reimbursement mechanisms accessible to all stakeholders to ensure the sustainability of interventions and services?
- **Removal of inhibitors**: Have obstacles to change – such as legal issues, resistance to change from individuals or professional groups, cultural barriers to the use of technology, perverse financial mechanisms, lack of skills – been removed?
- **Population approach**: Is the stratification of the population based on needs fully implemented?
- **Citizen empowerment**: Are citizens involved in decision making processes relating to interventions to maintain and improve their health, and are they also included in decisions concerning service delivery and policy choices?
- **Evaluation methods**: Is the approach to evaluation systematic and does it represent a complete cycle?
- **Breadth of ambition**: Is there full integration between social services and health services?
- **Innovation management**: Is innovation recognised, evaluated and, where possible, extended to benefit the whole system?
- **Capacity building**: Is there a person-centred integrated care delivery system in place that involves reflection and continuous improvement of the workforce?

Source: AReSS Puglia, Regional Strategic Agency for Health and Social Services (n.d.[1]).

Figure 4.2 shows the average score and variability by pilot area for each of the 12 aspects of the assessment. Specifically, all aspects received an average score of less than 3.5, which is the average value on the assessment scale (scores vary from 1 to 6). "Process co-ordination" and "Breadth of ambition" are the two aspects that received the highest average scores (3.3). The degree of integration is considered lower for "Removal of inhibitors" (2.5) and "Digital infrastructure" (2.7). The "Breadth of ambition" score shows the highest variability between geographic areas, while the "Structure and governance" and "Innovation management" scores show the lowest variability between geographic areas.

Figure 4.2. Average score by aspect of integration



Note: In addition to the average value, the variability of scores between geographic areas is also reported.
Source: Scirocco questionnaire, see Box 4.1.

Figure 4.3 describes the average scores for each assessment aspect by geographic area. Operators in Trento Sud consistently awarded scores above the average, while operators in Conversano and Merano awarded scores below the average for all 12 aspects of integration.

Figure 4.4 shows the average scores by professional category (500 responses). Community nurses and professionals in "other professional categories" (e.g. gerontologists, educators) who responded to the questionnaire gave a higher than average score to all 12 aspects of integration. Social healthcare workers and social workers consistently gave scores below the average.

Figure 4.3. Average score by pilot area

Pilot geographical area	Readiness for change	Structure and governance	Digital infrastructure	Process coordination	Financing	Removal of obstacles	Approach to the population	Citizen empowerment	Methods of evaluation	Breadth of ambition	Innovaton management	Building and strengthening skills	Number of responses	% responses over total
Chiavarese-Tigullio-Tigullio Occidentale	3.1	3	3.6	3.5	3.3	2.5	3.5	3.4	3.2	4.3	3.1	3.3	31	6.3
Conversano	2.3	2.2	2.4	2.6	2.4	2.2	2.6	2.5	2.4	2.2	2.3	2.9	37	7.6
Empolese-Valdarno-Valdelsa	3	3.1	3	3.6	2.6	2.8	3.2	3.5	3.5	3.6	3.1	3.3	33	6.7
Lugo di Romagna	2.9	3	3.1	3.7	2.7	2.6	3.8	3.1	3.2	3.4	2.8	3.1	87	17.8
Merano circondario	2.4	2.4	1.7	2.6	2.3	2	1.9	2.8	1.7	2.2	2.2	2.4	19	3.9
Piacenza città	2.2	2.3	1.8	3	3.3	2.5	3.4	3.9	3.4	3.7	2.7	3.3	27	5.5
Portogruaro	2.5	2.7	3	3.2	2.6	2.5	2.8	2.6	2.7	3	2.5	2.6	72	14.7
Trento sud	3.3	3.1	3	3.9	3.2	3.1	3.7	3.8	3.4	4.5	3.1	3.7	42	8.6
Val Badia	2.9	2.6	1.7	3.1	2.9	2.5	3.4	3.7	2.5	2.8	2.3	3	20	4.1
Valle del Serchio	2.8	2.8	2.9	3.2	2.6	2.4	3.3	2.8	3.5	3.8	2.9	3	16	3.3
Vicenza	2.4	2.4	3	3.4	2.3	2.4	3	2.5	2.9	2.8	2.5	2.7	106	21.6
Total	**2.7**	**2.7**	**2.7**	**3.3**	**2.7**	**2.5**	**3.1**	**3.1**	**2.9**	**3.3**	**2.7**	**3**	**490**	**100**

Note: Colour scale, where dark green indicates significantly above average and red indicates significantly below average.
Casentino, Cerignola and Lecce were excluded from the analysis by pilot area because the number of responses was less than 10. Therefore, the analysis by pilot area is based on 490 responses.
Source: Scirocco questionnaire, see Box 4.1.

Figure 4.4. Average score by professional category

Professional role	Readiness for change	Structure and governance	Digital infrastructure	Process coordination	Financing	Removal of obstacles	Approach to the population	Citizen empowerment	Methods of evaluation	Breadth of ambition	Innovation management	Building and strengthening skills	Number of responses	% responses over total
Social assistant	2.7	2.6	2.5	3	2.5	2.3	3.1	2.9	2.9	3.2	2.4	2.8	128	25.6
Community nurse	2.9	2.9	2.9	3.6	2.8	2.7	3.4	3.2	3.1	3.4	3	3.3	171	34.2
General practitioner	2.4	2.4	3.2	3.6	2.2	2.4	3	2.4	2.8	2.8	2.3	2.5	64	12.8
Operatore socio sanitario	2.2	2.3	2.4	2.8	2.7	2.4	2.8	2.8	2.7	2.6	2.3	2.9	43	8.6
Other professional role	2.9	3	3.3	3.5	2.9	2.5	3.2	3.2	3.1	3.5	2.8	3.1	94	18.8
Total	2.7	2.7	2.8	3.4	2.7	2.5	3.2	3	3	3.2	2.7	3	500	100

Note: Colour scale, where dark green indicates significantly above average and red indicates significantly below average.
The category “Altro ruolo professionale” (“Other professional categories”) includes gerontologists (N=11), educators (N=7), physiotherapists (N=7) and administrators (N=6).
Source: Scirocco questionnaire, see Box 4.1.

4.5.2. Focus groups at local level

To further analyse the information gathered and understand the specificities and complexities of social and healthcare integration in Italian regions, 14 focus groups were conducted in five regions and two autonomous provinces between February and March 2025. A total of 191 professionals from social and healthcare services participated (further details are provided in Annex 4.A).

The focus group meetings, each lasting four hours, were conducted in the pilot areas using the integration analysis model presented in a previous chapter of this report as a reference and were divided into three main thematic sessions: structural and systemic integration; the characteristics that define their innovative scope; and the role of community welfare:

- **Structural and systemic integration** – i.e. the transition from integration understood as the simple juxtaposition of healthcare and social services in relation to individual complex cases, to integration as a permanent and pre-organised link for a unified response to complex health needs (multiple chronic conditions, non-self-sufficiency and disability, frailty and social marginalisation): the focus group stressed a clear need to move beyond the fragmented, service-based approach to care, which focusses on the episodic management of individual cases, and to favour organisational models capable of responding in a unified and continuous manner to the complex needs of non-self-sufficient older people. This transition requires a review of existing organisational structures, which are still characterised by a silo mentality. Participants highlighted the absence of a catalyst to promote integrated action between health, social and healthcare services, without which professionals often continue to operate in parallel chains. Some organisations, such as the ATS in Lugo di Romagna and the Empolese-Valdelsa Health Authority, have developed "natively integrated" organisational structures, supported by shared governance tools, which are promising practices towards more advanced models of integrated care.
- **Characteristics that define their innovative scope** – i.e. home care settings, the high complexity of health needs, and the need for continuous and long-term action: these three characteristics pose serious challenges for existing organisational structures, which are often still based on service-oriented responses that are fragmented by sector and limited in duration – reason why home-based activities have always been the least developed area of action. Faced with a complex demand, it is not possible to provide partial answers: it is necessary to develop Individualised Care Projects (PAIs) capable of coherently recomposing the results of multidimensional assessments, overcoming the current fragmentation and integrating health, social and protective interventions. It is therefore essential to have a solid and widespread territorial infrastructure that connects the home care chain with chronic care and proximity services, and that allows for the articulation of a continuum of care based on three key components: proactive healthcare, integrated assistance and protection of social vulnerabilities. This approach requires specific organisational tools, such as multi-professional micro-teams, joint home visits, standardised assessment forms and integrated care programmes, as well as strong interpersonal skills with individuals, families and caregivers. Relevant examples of this come from the districts of Vicenza and Lecce, where models have been developed that go beyond the mere juxtaposition of services and offer integrated responses to the entire family unit through a dual capacity: the development by public health and social services of a broad and engaging relationship with the person, the caregiver and any family assistant; and the creation of an advanced accreditation system capable of responding appropriately to the entire range of a PAIs that addresses care, assistance and protection.
- **Community welfare** – i.e. the context of complex healthcare and social networks, public and private, formal and informal, limited or widespread, capable of contributing to the development of healthcare responses within the territory in question: these responses are based not only on meeting healthcare needs, but also on support and interaction between the various organised entities within a local community, enhancing and qualifying their different roles, skills, functions and

capabilities. Building community welfare requires intentional and proactive action to build stable networks and promote a sense of belonging as a source of shared well-being among institutions, public and private organisations, individuals and families, including through shared administration tools such as co-planning and co-design. Home care, by its very nature, develops within family and community contexts, whose balance directly influences the possibility of providing adequate and continuous assistance. In addition to working with families, working with community organisations is an integral and constitutive part of the home setting and, even if some sectors receive help from volunteers, building permanent networks with third sector organisations remains a challenge. For this reason, it is necessary to invest in professionals capable of acting as a bridge between the public system and civil society organisations, supporting the transition from informal neighbourhood relationships to structured and purposeful networks. Experience gained in areas such as Chiavari, Rovereto and Val Badia demonstrates the possibility of promoting greater integration between public services and active communities, for example through the figure of the family and community nurse or the creation of “permanent solidarity tables” with a social welfare and educational focus.

Furthermore, common and cross-cutting elements emerged in all 14 focus groups, albeit with varying degrees of intensity, which deserve attention when formulating responses to needs:

- The need to **codify, institutionalise and transform into an operational tool** what has been built up in daily practice, thanks to initiatives based mainly on the goodwill and willingness of health and social workers to collaborate and share experiences.
- The **lack of or difficulty of using IT tools**, which hinders both the necessary exchange of information and the implementation of truly integrated and comprehensive care for the person.
- A **significant use of human and economic resources**, despite only managing to involve a limited number of recipients, and despite the high quality and value of the interventions carried out.
- **Difficulties in dialogue and interaction** between the various actors involved, which compromises the overall effectiveness of the interventions.
- Critical issues related to the **recruitment of staff** and the **lack of adequate training** for operators: labour demand in the LTC sector is growing, but the sector struggles to respond due to unattractive working conditions, low wages, precarious contracts and limited opportunities for training and professional development, which hinder recruitment, retention and the quality of care. Added to this is the scarcity of structured opportunities for discussion, which further limits the development of shared skills and the construction of a common approach.

References

AReSS Puglia, Regional Strategic Agency for Health and Social Services (n.d.), *Scirocco Exchange*, https://aress.regione.puglia.it/aree-tematiche/sanita-integrata-e-digitale/scirocco-exchange. [1]

Annex 4.A. Information on focus groups

Fourteen focus groups were conducted in five regions and two autonomous provinces in February-March 2025, with a total of 191 professionals participating, including social and healthcare workers, local administrators, representatives of patient organisations and other relevant stakeholders. The date, location and number of participants in each focus group are presented in in Figure 4.5.

The guided focus group discussions focussed on aspects such as structural and organisational barriers; existing facilitators; experiences of success and failure; concrete proposals for improving care integration; the implementation of new needs-based assessment tools; the promotion of interoperability of information systems; and the development of skills and capacities for integrated care.

Figure 4.5. Date, location and number of participants in the focus groups

Region-Autonomous Province	Azienda	Distretti/Ambiti territoriali	Focus group - venue	Focus group - date	Number of participants
Provincia Autonoma Bolzano	Azienda Sanitaria dell'Alto Adige	San Martino in Badia	Piccolino (BZ)	18 February 2025	14
		Merano-Circondario	Merano (BZ)	19 February 2025	13
Emilia-Romagna	AUSL Romagna	Lugo	Lugo (RA)	28 February 2025	11
	AUSL Piacenza	Piacenza	Piacenza	27 February 2025	13
Puglia	ASL Lecce	ATS/DSS di Lecce	Lecce	10 March 2025	9
	ASL Foggia	ATS/DSS di Cerignola	Cerignola (FG)	11 March 2025	15
	ASL Bari	ATS/DSS di Conversano	Conversano (BA)	12 March 2025	14
Liguria	ASL 4 Liguria	Distretto 14 Tigullio occidentale	Chiavari (GE)	27 March 2025	21
		Distretto 15 Chiavarese			
		Distretto 16 Tigullio			
Provincia Autonoma Trento	Azienda Provinciale per i Servizi Sanitari PAT	Distretto Sanitario Sud	Rovereto (TN)	17 February 2025	14
Toscana	Azienda USL Toscana Centro	Società della Salute Empolese-Valdarno-Valdelsa	Empoli	25 March 2025	16
	Azienda USL Toscana Nord-Ovest	Zona Distretto Valle del Serchio	Bagni di Lucca (LU)	24 March 2025	13
	Azienda USL Toscana Sud-Est	Zona Distretto Casentino	Bibbiena (AR)	26 March 2025	15
Veneto	Azienda ULSS 8 Berica	ATS 6 Vicenza	Vicenza	19 March 2025	13
	Azienda ULSS 4 Veneto Orientale	ATS 10 Portogruaro	San Donà di Piave	20 March 2025	10
				Total number of partecipants	191

The population – total and over the age of 65 – and the type of municipalities involved – Centres versus Internal Areas – in the pilot areas are shown in Figure 4.6.

Figure 4.6. Population structure of the pilot areas of the project

Region-Autonomous province	Azienda	Districts/Territories	Total population	Population 65 + (%)	% popolation "Centres"	% popolation "Internal
Provincia Autonoma Bolzano	Azienda Sanitaria dell'Alto Adige	San Martino in Badia	11,262	18%	0.00	1.00
		Merano-Circondario	58,264	21%	0.00	1.00
		Total PAB Pilot	**69,526**	**20%**		
		% Pilot	13%			
Emilia-Romagna	AUSL Romagna	Lugo	101,501	26%	1.00	0.00
	AUSL Piacenza	Piacenza	103,121	23%	1.00	0.00
		Emilia-Romagna Pilot	**204,622**	**24%**		
		% Pilot	5%			
Puglia	ASL Lecce	ATS/DSS di Lecce	176,109	23%	1.00	0.00
	ASL Foggia	ATS/DSS di Cerignola	94,753	17%	0.28	0.72
	ASL Bari	ATS/DSS di Conversano	91,119	23%	0.00	1.00
		Totale Puglia Pilot	**361,981**	**21%**		
		% Pilot	9%			
Liguria	ASL 4 Liguria	Distretto 14 Tigullio occidentale	40,612	29%	0.91	0.09
		Distretto 15 Chiavarese	69,336	28%		
		Distretto 16 Tigullio	30,903	29%		
		Totale Liguria Pilot	**140,851**	**28%**		
		% Pilot	9%			
Provincia Autonoma Trento	Azienda Provinciale per i Servizi Sanitari PAT	Distretto Sanitario Sud	49,409	22%	0.00	1.00
		Total PAT Pilot	**49,409**	**22%**		
		% Pilot	9%			
Toscana	Azienda USL Toscana Centro	Società della Salute Empolese-Valdarno-Valdelsa	241,196	23%	0.90	0.10
	Azienda USL Toscana Nord-Ovest	Zona Distretto Valle del Serchio	36,598	28%	0.00	1.00
	Azienda USL Toscana Sud-Est	Zona Distretto Casentino	33,601	27%	0.09	0.91
		Totale Toscana Pilot	**311,395**	**24%**		
		% Pilot	8%			
Veneto	Azienda ULSS 8 Berica	ATS 6 Vicenza	314,078	22%	0.92	0.08
	Azienda ULSS 4 Veneto Orientale	ATS 10 Portogruaro	225,966	24%	0.31	0.69
		Total Veneto Pilot	**540,044**	**23%**		
		% Pilot	11%			

Note: *Provincia autonoma* (Autonomous Province).

5 A possible cycle for integrated home care

This chapter presents a possible cycle for integrated home care in Italy. It sets out an integrated care pathway based on unified access, assessment and personalised care planning, stressing the importance of co-ordination across health, social and family support and of keeping the individual at the centre. It then examines the mix of interventions and providers needed to deliver comprehensive responses, and the mobilisation of public and private resources to sustain home care. Finally, the chapter identifies key enabling factors for integration, including a supportive legal and institutional framework, stronger social economy ecosystems, robust monitoring and information systems, the use of cost-effective health technologies, and investment in strengthening workforce skills, competencies and knowledge for effective integrated care.

5.1. A possible integrated home care cycle for Italy

A home care system capable of offering a realistic and effective response to the health needs of non-self-sufficient elderly people and their families must simultaneously address the three dimensions of care, assistance and protection without shying away from the complexity that this entails.

For healthcare, there is the fundamental issue of "long-term" home care, a setting that is addressed in residential and semi-residential care through the so-called "long-term care" referred to in Article 30 of the 2017 Prime Ministerial Decree "Nuovi LEA" (New Essential Levels of Care). Healthcare organisations are increasingly accustomed to operating through the provision of individual services, intended for use by individual persons, administered within a specific period determined by precise elements of temporal appropriateness and duration. Outside this model (individual services, for individual use, with predetermined administration), current healthcare organisations are finding it increasingly difficult to understand, organise and manage the set of interactions necessary to deliver interlinked services guided by multidimensional care processes. While this difficulty is clearly evident in fully managed healthcare settings (hospitals, outpatient clinics, residential facilities), it is even more pronounced in home care settings, where the complexity of multidimensional care processes is compounded by the individual capabilities of the person being cared for, their family situation and their living and housing conditions. These complexities cannot be confined to care slots with a predefined term of effectiveness and appropriateness in the "long term" and are characterised by "clinical instability and symptoms that are difficult to control, requiring continuity of care and planned interventions", as stated in paragraph 3, letter d) of the 2017 Prime Ministerial Decree "Nuovi LEA" (New Essential Levels of Care).

In the social sphere, the fundamental question arises of the actual "consistency and extent of protection" provided by municipal organisations to disadvantaged individuals and families receiving home care. The content of the fundamental public function of "Social Assistance" consists in "the planning and management of the local social services system and the provision of related services to citizens, in accordance with the provisions of Article 118, paragraph 4, of the Constitution". The focal point of service provision is conditioned both by means testing (ISEE) and by the assessment of the needs for protection, assistance, support and social assistance arising from the conditions of the person, their family and their formal and informal networks of reference. The "protective" nature of the public function of social assistance is expressed precisely in this access filter, which focusses public action on individuals and families in greatest difficulty in order to help them regain a degree of autonomy in relation to economic, social, employment, housing, training and educational inequalities, combined with individual functional and bio-psycho-social characteristics. However, the current response capacity of municipal social services is limited, as is the capacity for action of the Home Care Service. In this regard, it is worth noting that Legislative Decree 29/2024 addressed the issue of semi-residential care, which, from a social welfare perspective, aims to combat social isolation and the deterioration of the personal conditions of older people.

The lack of systemic and structural co-ordination between ADI and SAD has always been considered the factor responsible for the historical fragility of home care services dedicated to complex and multidimensional needs, but perhaps other factors of equal importance within health and social organisations need to be added.

- the tendency of healthcare organisations to provide home care rather than home assistance services, which are moreover standardised and prepackaged in terms of both content and duration, even for non-self-sufficient elderly people.
- the limited scope and extent of protective assistance provided by municipalities to socially vulnerable or marginalised individuals and households, which is currently too limited to support the progressive increase in inequalities and the advance of poverty.

However, the central issue for a long-term home care proposal is that of personal care. Situated between healthcare and social protection (assistance), this dimension is in fact almost entirely delegated to the

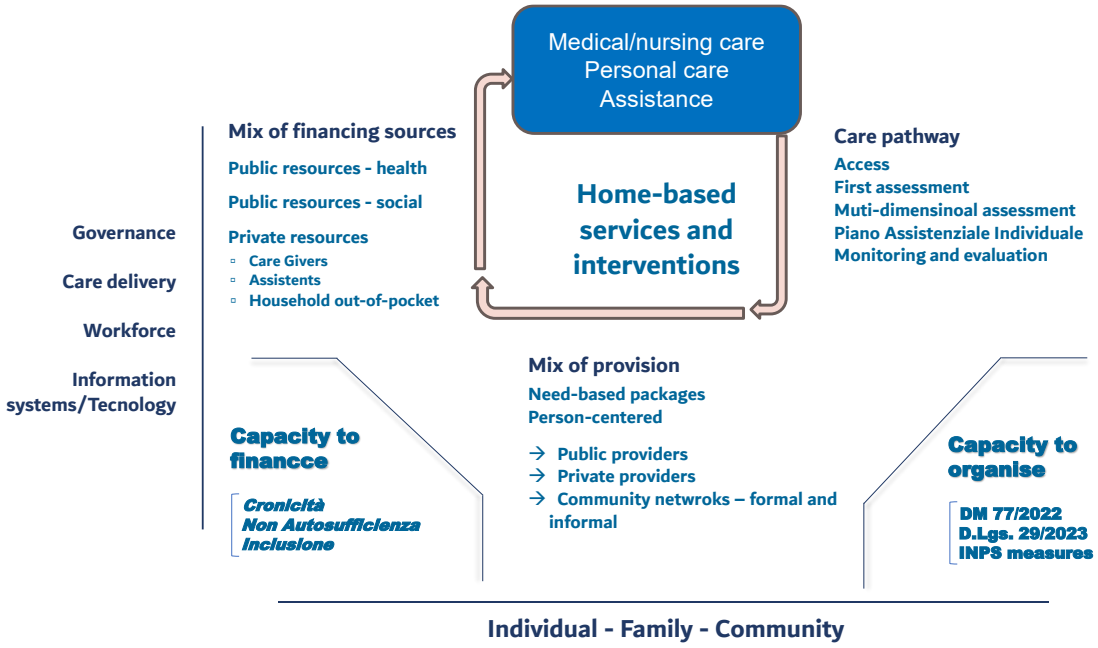
internal resilience of families and private economic resources, except for the Accompanying Allowance and other forms of cash transfers. However, these allowances and cash transfers are not co-ordinated, integrated or finalised in the typical daily care routine of a non-self-sufficient individual living at home. This is by no means a trivial task, as it is essential to organise it both in terms of the specific needs of the individual and the family with regard to the performance of ordinary daily tasks, and in terms of access to the complex organisational network outside the home that is essential for the treatment of diseases, the promotion of health, the preservation of residual individual autonomy, and the relief and support of individuals and families.

One viable option is to recompose, or reunify, social (protection), healthcare (treatment) and welfare functions, leaving their current ownership unchanged. This approach involves the joint performance of both planning activities (integrated planning) and delivery activities (unified territorial organisation) through unified governance bodies that include the various stakeholders at the state, regional and local levels (multi-level governance) (Caiolfa, 2022[1]). The cycle proposed for the overall home care system reflects this approach and is based on three macro-functions that must be interrelated (Figure 5.1):

- the integrated care pathway
- the mix of measures and providers
- the range of activated and achievable resources.

Population stratification – following the models and standards for community care defined by Ministerial Decree 77/2022 – is crucial for organising individual care systems based on their level of health and social care needs. Stratification systems have a significant strength in that they can be defined at multiple levels of healthcare planning – national, regional, and corporate – to best adapt to the diverse characteristics of a region's care demand. These stratification tools can be complemented by systems for classifying the degree of non-self-sufficiency,[1] useful for differentiating and scaling interventions to support a cycle of integrated home care.

Figure 5.1. A possible integrated home care cycle



5.1.1. The integrated care pathway

It is considered essential to build a unified territorial system of services, access, and multidimensional assessments, permanently shared by healthcare and social services. This approach requires not only systematic and structural interaction between the two organisations, but also a greater awareness of the integration needed within the healthcare system, to overcome traditional and newly established corporate silos, and in the social sector, to co-ordinate the various municipal administrations that constitute a territorial area. With reference to the reforms introduced by component 2 of mission 5 (social dimension of healthcare policies for the elderly) and component 1 of mission 6 of the National Plan for the Prevention and Rehabilitation (PNNR) (interventions for the development of proximity networks, facilities, and telemedicine for local healthcare), the integrated care model process can be divided into the following phases:

- Request/report and access to the Single Access Point (PUA) front office
- Pre-assessment and identification of simple and complex social and healthcare needs (PUA front office)
- Multidimensional assessment for complex needs that are both social and healthcare and fall within classes 4, 5, and 6 of the risk stratification system (Multidimensional Assessment Unit at PUA back office)
- Formulation of the PAI (health, social, and welfare) and, where indicated, the health budget (UVM at PUA back office), with identification of the institutional case manager
- Provision or implementation of integrated care
- Monitoring of integrated care.

To achieve comprehensive management of complex healthcare needs, the PUA is not just a physical location but represents a set of shared health and social resources and tools. In the Community House, it is a single and integrated access service – also through the Local Operations Center – that provides reception, orientation, information, support, simple problem solving, and assessment of complex cases. In addition to the establishment of a multi-professional assessment team, the innovations brought about by ongoing reforms make it essential to establish a highly codified organisational relationship with the community homes' internal team, the organisational structure that can conduct in-home assessments and organise the related integrated responses. To this end, within the PUA, it is necessary to establish a qualified micro-team, made up of a nurse, social worker, and doctor, who will serve as a stable point of contact for assessing needs both in the Community House and at home. In the home setting, the integrated social and healthcare model consolidates the interventions, services, and any monetary transfers related to health, welfare, and social protection services and measures under state, regional, or local jurisdiction into a single Individual Care Plan (PAI). The reorganisation implemented by the PAI aims to make the set of interventions, measures, and services appropriate and effective with respect to the health and social care needs of the individual and their family unit, as identified and assessed by the Unified Multidimensional Evaluation system. To this end, the PAI pursues the reorganisation, co-ordination, and contextual delivery of all planned interventions, according to the methods and timeframes defined and shared with the individual, caregivers, and family members, where indicated. All these activities must be consolidated in the same home setting and co-ordinated into a single ongoing program. Until now, home care has been primarily considered a form of care useful for reducing hospital burden, in the case of planned discharges or in-home hospital therapies, supplemented by short-term nursing and rehabilitation activities. The ongoing demographic transition requires us to reconsider the home setting as a much broader and more generalised approach, capable of addressing the complex care burden that will increasingly burden individuals and families. It is therefore essential to adopt a different approach to constructing the home setting, considering it the natural and customary place of care and assistance. This shift requires designing home care according to the actual and specific characteristics of the individual involved, the living environment in which they live, and their family unit with their social support network.

5.1.2. The mix of measures and providers

If, as part of a care pathway, a Care Plan has been developed that effectively addresses the complex health needs of a non-self-sufficient elderly person, how can a programme of interventions be organised to accommodate this complex level of care, assistance, and protection? Answering this first organisational question means simultaneously addressing the organisation of interventions into service packages, the mix of services potentially included in these packages – which address chronic diseases and conditions, care and ADLs, protection and social vulnerability – their gradation based on the assessed intensity, and their essential customisation. The second question to be addressed concerns the possible avenues for organising the provision of all complex home-based responses in a given area; that is, all the interventions contained in all the home-based PAIs developed in a given area, during a given financial year. This poses the key to the essential evolution of current delivery systems, which are excessively focussed on the production of divisional services and activities. The mix of interventions required to develop multidimensional responses, leading to the creation of truly multidimensional PAIs, requires a consequent evolution in the relationships between public organisations, private organisations, and local and community network organisations, as well as the related accreditation methods. Reorganising current healthcare, assistance, and social services into a unified service capable of fully implementing the PAI and serving as a true global reference point for individuals receiving home care and their families requires the development of innovative forms of home-based social and health care. These forms of care combine ADI interventions with SAD interventions, integrate them with care activities initiated by individuals and their families, unify the methods of activating and using specialised services – including through digital healthcare – and provide a single platform for accessing assistive devices, as well as national, regional, and local support and assistance activities. These innovative organisational forms should be able to co-ordinate, according to a complementary approach, direct public activities, services of accredited private organisations, and co-planning with third sector entities.

5.1.3. The range of activated and achievable resources

The shift in perspective resulting from the new and necessary relationship between the complex demand for health and the corresponding complex response, which must also be implemented in the home setting, is leading the system to approach the issue of funding and resource allocation differently. If the home setting for non-self-sufficient older adults is in any case linked to chronic conditions, complex interventions, and a long-term perspective, it is therefore inevitable to consider an integrated construction of related funding. There are two directions for change: achieving constant co-ordination between public health (corporate) and social (municipal) resources, including through joint planning between the health district and the social territorial area; building joint health and social allocations based on long-term care and PAI, which are therefore not closed and open to each individual intervention – or weekly intervention cycles – but remain open, accommodating nursing, rehabilitation, specialist, care, guardianship, support, and promotion interventions from time to time. Similarly, after seeking ongoing co-ordination between healthcare and social resources and allocations, the crucial step comes into play involving private resources – those of the individual and their family, and those of their friendship network and living environment. It seems difficult to seek a truly multidimensional approach to home care without addressing this, perhaps the most challenging step. The point is that, net of protective activities aimed at families experiencing social vulnerability, ADL assistance is almost entirely covered by the support and caregiving capabilities of families – through the direct activities of caregivers or family assistants, supported in part by INPS (National Institute of Social Security) or regional or local financial transfers. Obviously, without assistance with activities of daily living, no home care programme for dependent elderly people can sustain itself. This opens up two main perspectives regarding the ability of public organisations to understand the real dynamics of current home care. The first perspective concerns the possibility of envisioning a much more advanced public procurement system than the current one – sectoral and divisional – capable of also impacting the healthcare dimension by engaging families' direct and indirect resources in an innovative

and advanced form of accreditation, which also includes specialised and care services and can be funded through the co-payment of family resources. The second perspective concerns the development of the so-called Care and Assistance Budget, which calls for the co-ordinated, and contextual use of all public and private resources for individuals and their families, as well as a propensity for the active involvement of local and community networks, including through the institutions of Shared Administration (co-programming and co-design).

5.2. Factors enabling integration

Although there is extensive literature on the subject, and integrated care can reduce the length of hospital stays, emergency room visits, and admissions to nursing homes, evidence of its impact remains limited. This is partly due to the difficulty of interpreting and generalising evidence from local (micro-level) interventions, given the wide variability in the meaning and application of the term “integrated care” across OECD countries. However, there is a growing body of knowledge on the factors enabling integrated care.

5.2.1. Creating a supportive legal and institutional framework

The development of an effective integrated care system requires a collaborative and cohesive approach between different levels of government and stakeholders. To achieve this, it is essential to define a clear and shared legal and institutional framework based on common values and mutual respect for roles and responsibilities.

A key element of this framework is the establishment of qualified local teams, bringing together different professionals to drive meaningful change and innovation. It is also necessary to invest in building strong and reliable relationships between professionals, management, policymakers, patient representatives and the community.

Open communication and transparent, consensus-based decision making enable common ground to be identified, leading to effective and informed choices. By adopting these principles and working together towards a shared vision, stakeholders can promote a cycle of integrated home care that optimises outcomes for patients, delivers high-quality care and support, and ensures the well-being of the entire community.

5.2.2. Promoting community action

Recognising the role of civil society and all stakeholders – public and private – in addressing the economic and social challenges facing communities can facilitate the creation of social economy ecosystems, conceived as a set of actions aimed at promoting, growing and developing social innovation, including through improved relations between the various actors involved. Approaches to maximise the involvement of local communities – including those most at risk of poor health – may improve health and well-being and reduce health inequalities.

5.2.3. Ensuring timely and robust evaluation of the implementation of integrated care

The availability of monitoring and evaluation tools and processes foster a culture of openness, transparency, continuous professional development and improvement in service delivery. To strengthen the evidence base and legitimacy of integrated care, timely and robust evaluations – including on the quality and level of care co-ordination and possibly built into routine data collection – are needed.

A well-functioning information and communication technology system is a prerequisite for better collaboration, effective communication and streamlined care processes. However, in many areas, privacy legislation will need to be revised to allow for interoperability and data exchange between operators.

The development of shared information infrastructure is the most promising long-term prospect. This approach ensures that systems meet the specific needs of the workforce and patients, do not increase the administrative burden, and facilitate professional work rather than hindering it.

5.2.4. Encouraging the use of cost-effective health technologies

Common assistive technologies that improve vision, hearing, mobility, safety and communication are essential for promoting functional activities and movement.

Wearable devices and telemedicine enable the monitoring of a wide range of chronic conditions, allowing for the detection of serious problems, better patient adherence to treatment guidelines and a reduction in the risk of intensive care and long-term care.

Healthy ageing can be facilitated by technologies that enable people to live safely and independently in the community, thereby delaying the need for and demand for informal and formal long-term care services.

5.2.5. Strengthening workforce skills, competencies and knowledge for effective, person-centred integrated care

Three key components can promote effective integrated working: effective, integrated professional, organisational and clinical governance; the right workforce skills, competencies and knowledge, such as health system knowledge, transversal skills (e.g. problem solving, adaptability, mentoring), and IT-related skills; and effective working practices within the team, including a strong understanding of roles, responsibilities, key processes and objectives of the team. Those three dimensions are mutually supporting and need to be in place for the workforce to make meaningful steps towards sustainable and impactful integrated care delivery.

The development of new professional skills and roles, such as advanced nursing roles and case managers, can promote a more competent and collaborative workforce that is better equipped to manage the complex needs of individuals who are not self-sufficient and create better integration between the healthcare and social sectors.

Integrated learning – around communication, teamwork, collaborative practice – should become a core part of lifelong learning of all health and social care professionals. After an initial introduction to integrated care in undergraduate education, health and social care professionals' skills and knowledge should be further developed in postgraduate education and throughout continuing professional development.

References

Caiolfa, M. (2022), *Il Sistema Nazionale Anziani: unagovernance multilivello per la nonautosufficienza*. [1]

Llena-Nozal, A., A. and K. Killmeier (2025), *Needs assessment and eligibility criteria in long-term care: How access is managed across OECD countries*, https://doi.org/10.1787/461811c4-en. [2]

Notes

[1] As an example, in France people are assigned to six categories by assessing their degree of loss of autonomy. Only four out of six categories grant entitlement to benefits. Individuals in categories 5 and 6 are considered autonomous enough to live without formal support; however, they have options to receive support at home with certain household tasks such as cleaning, preparing meals, doing laundry or shopping if they have limited financial capacity to pay for these services themselves (Llena-Nozal, and Killmeier, 2025[2]).

Towards a Structured and Systemic Integration of Home Care for the Non-Self-Sufficient in Italy

The complexity of the needs of people requiring home care and the problems faced by their carers call for a co-ordinated, person-centred and long-term sustainable approach that overcomes the traditional divisions between the health and social sectors. The main objectives of this report are to understand the challenges and potential associated with the integration of home care services for people who are not self-sufficient, and to promote progress in policies for the integration of health and social care. The report adopts a multidisciplinary approach to explore the main dynamics of the sectors, identify good practices in Italy and abroad, and highlight key innovations and areas for improvement. Particular attention is paid to the regional and local dimension, given the increasing decentralisation of Italy's healthcare system over the past two decades. The analysis combines a review of existing policies and practices with an analysis of national and international data, complemented by new and unpublished data from two OECD surveys, one covering Italian regions and autonomous provinces, and the other14 local areas. Comparative experiences from other OECD countries provide further insights into different models of social and health integration and the lessons they may offer for Italy.

Funded by
the European Union

PRINT ISBN 978-92-64-90719-5
PDF ISBN 978-92-64-78269-3