

**The role of regions and municipalities in the Italian multilevel governance of eldercare: recent trends in a context of increasing needs and budgetary constraints.**

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**PANEL 4 – GOBERNANZA SUR DE EUROPA . RESTRUCTURING THE MULTILEVEL GOVERNANCE OF SOCIAL POLICIES IN SOUTHERN EUROPE. AN AUSTERITY-DRIVEN PROCESS OF RATIONALIZATION?**

*Abstract*

The aim of this paper is to analyze the role of regions and municipalities in the multilevel governance of long term care (LTC) for dependent elderly people, focusing on the Italian case. Despite the growing needs of dependent elderly people, Italy has failed to structurally reform LTC while, at the same time, an increasing privatization of care has taken place over the years, largely based on migrant (mainly irregular) workers. In this context, sub-national levels of government have not pressed for a structural reform of LTC opting, instead, for a market shift solution. In this paper we will further investigate this aspect, in particular suggesting that in the frame of a “vicious” layering which characterizes the multi-level governance of the LTC in Italy, specific mechanisms of “cost-shifting” have been adopted by regions and municipalities in order to cope with increasing financial pressure due to growing LTC needs.

*Key words*

Italy; long term care; regions; municipalities; multilevel governance

## 1. Introduction

The aim of this paper is to analyze the role of regions and municipalities in the multilevel governance of long term care (LTC) for dependent elderly people, with a particular attention to Italy over the last years.

The importance of the LTC is increasing in Italy and in the wider European context, given structural transformations which have affected both the socio-demographic dimension (aging population, changes in the family structure) and the socio-economic one (for instance, increasing female participation in the labor market). In this context, Italy is a paradigmatic example of the so called Southern European welfare model (Ferrera, 1996; Ascoli and Pavolini, *forthcoming*), in which the eldercare is mainly provided by the families given also a residual supply of formal services.

Despite the growing needs of dependent elderly people, Italy has failed to structurally reform LTC (Ranci and Pavolini, 2013). However important processes of change have taken place at the “bottom”, with an extensive recourse of the Italian families to a private care market, largely based on migrant (mainly irregular) workers (Da Roit, 2010; Costa, 2013).

Regarding these trends, the explicative factors seem to be various and taking place at different levels (Da Roit and Sabatinelli, 2013). More specifically, regarding regions and municipalities, several studies have pointed out that differently from other European countries, sub-national levels of government have not pressed for a structural reform of LTC in Italy, opting instead for a market shift solution (*ibidem*). In particular, the specific features of the arrangements regulating inter-governmental relations as well as the structural “weakness” of municipalities and the lack of interest of regions (mainly interested to safeguard the health budgets), in an institutional context characterized by a controversial process of federalisation, seem to have played a crucial role (Gori 2012; Da Roit, Sabatinelli 2013; Gabriele and Tediosi, 2014). In this paper, we will further analyze this hypothesis. In particular, we will argue that regions and municipalities have not actively promoted LTC reform because they have faced financial pressure, arising from increasing needs of dependent elderly people, also mainly through specific mechanisms of “cost-shifting” (Bonoli and Champion, 2014).

In the following sections, section Two describes the main features of LTC for dependent elderly people in Italy, and recent trends. Then, the role of sub-national levels of government within the multi-level governance of social policies will be framed both in general terms (section Three) and more, specifically, regarding the case of LTC for dependent elderly people (section Four) and the Italian case (section Five). Finally, Section Six analyzes the specific mechanisms of “cost-shifting”

adopted by regions and municipalities in Italy, while the concluding section summarizes the main findings.

## 2. The LTC in Italy: between residualism, institutional fragmentation and growing privatization

As well known, Italy is a paradigmatic example of the so-called Southern European welfare model (Ferrera, 1996; Ascoli and Pavolini, *forthcoming*). In this model, the LTC for dependent elderly people is mainly provided by family and intergenerational solidarities, in an institutional context in which welfare policies consist mainly of cash benefits while services are structurally lacking. This implies a sort of *unsupported familism* (Keck and Saraceno, 2010) or *passive subsidiarity* (Kazepov, 2010). Moreover another structural characteristic of the Italian LTC system regards a strong territorial differentiation both in “quantitative” terms (i.e. a higher care coverage in the Center-North of Italy than in the South) and “qualitative” terms (i.e. a higher relevance of services in the Center-North of Italy while cash benefits are more relevant in the South). These structural features are clearly synthesized by data collected in Table 1, in which the Italian case is compared with other European welfare systems.

**Table 1: The Italian LTC for dependent elderly people in a comparative perspective (% of beneficiaries on population aged 65 and over, various years)**

	Sweden	United Kingdom	Germany	Italy	Centre-North	South
Home care Cash*	-	-	6.0	11.6	10.4	14.7
Social home care**	9.3	12.5	1.6	1.4	1.3	1.5
Nursing home care***				4.3	4.7	3.3
Residential care****	5.8	5.0	3.8	2.2	2.7	1.0

\*2009; for Italy: 2011. *Source*: Rodrigues *et al.* (2012); Jessoula, Pavolini (2012).

\*\*2009: *Source*: Rodrigues *et al.* (2012); for Italy: 2011. *Source*: own elaboration from: Istat (2014a); Istat (2014b).

\*\*\*2009 : *Source*: Rodrigues *et al.* (2012); for Italy: 2012. *Source*: Istat (2014c).

\*\*\*\*2009: *Source*: Rodrigues *et al.* (2012); for Italy: 2012. *Source*: own elaboration from: Istat (2014d); Istat (2014b).

*Note*: for social home care and nursing home care, percentages cannot be added due to the fact that they can potentially refer to the same beneficiaries (Jessoula and Pavolini, 2012)

Another structural problem related to LTC in Italy concerns the fragmentation and a lack of coordination among the different levels of intervention involved (Costa, 2013; Fargion, 2013). In fact, LTC is delivered at three main levels. The first level consists of the *Indennità di*

*Accompagnamento* (Attendance Allowance, IdA), a flat cash transfer (in 2015: € 508,55) regulated by the central state and managed by the National Institute for Social Security (INPS).

This benefit is granted to all persons with total disability (regardless of income) and unable to perform the basic activities of daily life without help. Originally introduced during the 1980s as a support for disabled adults, the IdA has gradually developed into a measure for elder dependent people, given the progressive aging of the population.

There are several critical issues concerning this type of support (*ibidem*). For instance, it is not graduated in relation to care needs, and it can be freely used without any kind of public control. Moreover, entirely lacking is coordination of the IdA with the home and residential care services provided by regions and municipalities at local level. In fact, although access to the IdA is managed by medical commissions within the local health authorities (*Aziende sanitarie locali*, ASLs) (under the responsibility of the regional administrations), this measure is not coordinated with the home and residential care services provided by the ASLs.

Home care and residential care services constitute the second level of LTC. They are (in addition to hospital care services) under the responsibility of the National Health Service (*Servizio sanitario nazionale*, SSN) and are managed by ASLs financed by regions through the resources of the National Health Fund (*Fondo sanitario nazionale*, FSN).

With a decree issued on 29 November 2001 (article 54, law 289/2002) the central government defined the essential levels of care (*livelli essenziali di assistenza*, LEA) for the health care sector, in which also home care and residential care services for dependent elder people were included.

**Table 2 - Essential levels of care (LEA) for dependent elderly people: type of services, % of costs covered by the health care sector and social services**

	<i>Type of services</i>	<i>% of costs health sector - SSN</i>	<i>% of costs social services (municipalities plus user's copayment)</i>
Home care services	General and specialistic medicine	100	0
	Nursing care	100	0
	Rehabilitative care	100	0
	Personal care	50	50
	Pharmaceutical care, prosthetic and integrative	100	0
Semi-residential services	Therapeutic care, recovery and maintenance of functional skills	50	50
Residential care services	Care and functional recovery in intensive/extensive phases	100	0
	Therapeutic care, recovery and maintenance of functional skills	50	50

Source: own summary based on decree 29 November 2001 (article 54, law 289/2002).

Table 2 summarizes for dependent elderly people the main type of services foreseen within the LEA and the cost covered by the health sector and social services (the latter under the responsibility of municipalities in which also user's copayment can be applied). These services range from health services (like general and specialist medicine, nursing care etc) to personal care services in which non-medical personals are involved. Regarding the costs in the case of home care, health services are totally covered by the health care sector, while personal care services only half. For residential care the costs are fully covered by the health care sector in cases characterized by greater intensity and higher health needs (intensive and extensive), while for long term residential care, municipalities and the dependent elderly people concerned must bear half of the total cost.

As far as this latter aspect, in general terms, the national law does not provide specific indications on how the costs attributed to the social sector must be divided between municipalities and dependent elderly people, with the exception of the indicator which should be adopted for the means-testing (*Indicatore della situazione economica equivalente - ISEE*, equivalent economic situation indicator). However, as will be discussed in section Six, this aspect has been highly debated over the last years. Consequently, local authorities define users' co-payment with marked differences not only among regions, but also within the same region.

Regarding this aspect, it is important to notice that law 328 of 2000 defined the essential levels also for social services under the responsibilities of municipalities (*livelli essenziali delle prestazioni sociali*), including support for costs in the case of long-term residential care for dependent elderly

people. However, this measure, like the essential levels as a whole, was vaguely defined and not supported by guaranteed resources (Leon and Pavolini, 2014; Kazepov *forthcoming*).<sup>1</sup> Moreover, its implementation was structurally undermined both by the constitutional reform of 2001, which - in the wake of a controversial federalism - allocated the exclusive competence for social services to the regions, thereby creating a highly uncertain legislative framework, and by the new center-right government coalition - which took office after the national elections of May 2001 - which supported retrenchment of the central state in the field of social policies.

In this context, despite growing needs correlated with both the aging of the population and changes in family structure, a structural reform of LTC policy has not been undertaken in Italy over the past decade (Costa, 2013; Fargion, 2013). A minor exception was the introduction in 2007 of a national fund with earmarked resources for LTC policies by the center-left government. The purpose of the fund was to finance essential levels for dependent elderly people in the social sector. However, in this case too, the resources have not been guaranteed in subsequent years, thus undermining the impact of the initiative.<sup>2</sup>

In the wake of a substantial inertia at national level, a bottom-up redefinition of the welfare model has taken place over the years (Da Roit, 2010; Da Roit and Sabatinelli, 2013). More specifically, families have made increasing recourse to the private care provided by migrant workers (commonly called 'badanti'). Several factors operating at different levels seem to have supported this trend (Simonazzi, 2009; Costa, 2013; Da Roit and Sabatinelli, 2013): the presence of a vast, and widely socially and politically accepted, grey market, which made affordable the costs for private care to many lower and middle class families; the specific characteristics of the Italian welfare system, in particular the imbalance toward cash benefits and the existence of the IdA which transfers resources to Italian families without any kind of control; financial constraints which have hindered an expansion of the LTC public coverage coupled also with difficulties in reforming the IdA, due to the vetoes expressed in particular by organizations for people with disabilities and pensioners' trade unions worried about a potential risk of retrenchment behind the proposals of reform the IdA. Moreover, as we will see in the next sections, also the role of regions and municipalities within the specific system of multi-level governance of the LTC seems to be crucial.

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<sup>1</sup> Law 328/00 introduced a national fund to finance the essential levels for the social sector. However, the resources allocated to this fund are fixed yearly by the central government. This implies that there is no certainty of resources. Over the past decade, the resources have decreased from one billion euros in 2004 to less than 300 million euros in 2014 .

<sup>2</sup> The resources increased to 400 million euros in 2010, then decreased to zero in 2012 due to austerity measures. In 2014 the fund was allocated 340 million euros: an amount still very limited compared with the sum required to cover the potential need.

### *3. Multi-level governance and social policies: some considerations starting from the literature*

Over the last decades, welfare states have been affected by several processes of changes. Among these changes an increasing territorial reorganization of social policies has taken place both upward, with the increasing role of supra-national institutions, and downward with an increased role of regions and municipalities in regulatory terms (Ferrera, 2005; Kazepov, 2010). This process, coupled with a multiplication of actors involved (included private actors), has implied an increasing complex scenario of multi-level governance in designing, managing and implementing social policies (Kazepov, 2010).

Regarding this process, and limiting our focus only to the increasing role of regions and municipalities, the literature has pointed out both positive and negative aspects (ibidem). On the one hand, the shift of responsibilities and regulatory power to sub-national levels of government can favor a development of social policies better corresponding to territorial needs. Moreover, embedded in specific political strategies aimed to increase political legitimization, also policy innovation can be stimulated with a positive spillover towards other territorial levels of government (Bonoli and Champion, 2014).

Conversely, negative aspects regard in particular increased institutional fragmentation, potential overlapping of responsibilities and increased heterogeneity of social programs which can undermine a minimum standard of social citizenship in a national context (Kazepov, 2010). However it is important to notice that these potential negative outcomes are not to be taken for granted. In fact multi-level systems characterized by forms of “virtuous layering” can take place, like for instance in the case of the Nordic countries, where a clear attribution of responsibilities and resources among the different territorial levels of government implies a minimization of overlaps and inter-governmental conflicts (Aguilar Hendrickson and Sabatinelli 2014). On the contrary, in particular in the case of Southern European countries, a sort of “vicious layering” seems to take place, characterized by chaotic and not clearly framed inter-institutional relations (ibidem).

Finally, it's important to notice that also in a context of increasing budgetary constraints and permanent austerity the impact of a multi-level system can be controversial. In fact, on the one hand, it can imply a limit for retrenchment processes due to the presence of different veto points (Costa-Font, 2010). At the same time a multi-level system can also stimulate the spread of blame avoiding strategies (ibidem), based on the transfer to another level of government of the blame for unpopular policies (Ferrera, 2005). In this case we can mention a specific institutional mechanism: “cost shifting” (Bonoli and Champion, 2014). This mechanism can be performed both “within the rules”, i.e. using the degree of freedom allowed within a given institutional structure, or “changing



the rules” (ibidem). In the first case Bonoli and Champion (2014) mention, for instance, the case of able-bodied social assistance beneficiaries, which are covered by local scheme, but are shifted by municipalities toward the unemployment insurance under the responsibility of the federal state. The mechanism adopted is based on the provision of temporary jobs which allow to beneficiaries of social assistance to collect sufficient contributions in order to apply for unemployment benefit (regarding this process see also Kazepov (2002) who suggested the concept of “institutional ping-pong). In the second case, instead, the transfer of beneficiaries between different programs takes place due to, for instance, stricter access criteria for claiming a specific support which implies the shift to another programs under the responsibility of a different territorial level of government (Bonoli and Champion, 2014).

#### *4. Multi-level governance and intergovernmental relations in the reforms of LTC policies*

As we have seen regarding Italy, in the LTC policy field we have a complex system of multi-level governance in which, from an institutional point of view, different territorial levels of government are involved, ranging from the central state, to regions and municipalities. Moreover this complexity is increased also by the fact that different regulatory systems are involved, referring on the one hand to health services, which are based on a universalistic structure and, on the other hand, to social services which are provided by municipalities and strongly affected by discretion and budgetary constraints. Also in the other European countries we have this complex scenario (Lewis, 2001; Costa-Font, 2010; Ranci and Pavolini, 2013). Hence, in order to analyze the trajectories of change of LTC over the last two decades, the territorial multi-level governance and intergovernmental relations seem to be a crucial analytical dimension.

In general terms it's important to notice that in particular during the Nineties - but in some case already during the Eighties - in a context of growing needs and increased budgetary constraints, a central concern for many European countries has been the financial impact of LTC. In particular, the rising demand of care had put pressure on health systems, stimulating a significant increase of health expenditure (Ranci and Pavolini, 2013). In order to tackle this process, a central strategy has been an increasing shift of part of long term costs from health systems to social services and households. This process has taken place through different institutional mechanisms. For instance, a progressive reduction of the length of stay in hospital coupled with the identification of stricter criteria for hospital admission for dependent elderly people aimed to move them to nursing homes; a re-definition of the health and social care boundary regarding the financial coverage, in particular,



of residential care coupled with the support for the shift of long term care from (more costly) residential care toward (less costly) home care (Glendinning and Means, 2004; Da Roit 2010; Ranci and Pavolini, 2013).

This increasing shift of long term costs from the health system to social services has had a significant impact also in terms of territorial multi-level governance and intergovernmental relations. In fact, this process has implied that the burden and the financial pressure for LTC services has been progressively shifted from the central/regional levels of government, which are responsible for health systems, to municipalities responsible for social services. Moreover, for dependent elderly people this process has implied a shift from a specific regulative system, like the health care sector (based on universalistic or insurance systems), to the social sector, mainly characterized by residualism, higher discretionality and extensive user's copayment.

As a consequence of this increasing financial pressure on the social sector, in particular in the European countries in which at the beginning of the Nineties the LTC system was still residual and less developed (like for instance Germany and France), local authorities have pressed for national reforms aimed to introduce new LTC schemes at the central level (Da Roit and Sabatinelli 2013; Ranci and Pavolini, 2013). In particular, in the case of Germany, the adoption in the mid 90s of a new LTC insurance scheme has been largely based on pressure from local authorities (Alber, 1995) and also favored both by a specific structure of intergovernmental relations (in which specific institutional tools to exert pressure on the federal government and compose intergovernmental conflicts are foreseen) and by a specific pattern of financial federalism (based on a revenue sharing system) which has supported a sharing of fiscal problems (Cambell and Morgan, 2005).

##### *5. Intergovernmental relations and (missed) LTC's reform in Italy: the role of regions and municipalities*

Among the countries characterized by a residual and fragmented LTC system, Italy is the only national case in which a structural reform of the LTC system has not been implemented (Costa, 2013; Ranci and Pavolini, 2013). It's important to notice that starting from the Nineties several reform proposals were advanced. In particular, in 1997, the so called "Commissione Onofri", set up by the center-left government in order to reformulate the social protection system, suggested to introduce a specific national fund aimed to support dependent people, through a structural re-organization of schemes and resources already implemented in this sector, starting from the IdA (Costa, 2013).

Moreover, as we have seen in section Two, in 2000 and in 2001 the central government has defined the essential levels of care both for the health care sector and for the social sector, in which also home care and residential care services for dependent elderly people have been included. However, a rather vague definition coupled with the absence of specific earmarked funds have undermined their implementation. In addition, the constitutional reform in 2001 (which allocated the exclusive competence for social policies to the Regions) has increased the uncertainty and fragmentation of the institutional framework, thus hindering any attempt of welfare innovation and institutional reform (Gabriele and Tediosi, 2014). Hence a growing recourse to the private care provided by migrant women, often irregular and working in the gray market, has taken place (see section Three). As we have seen above, the factors behind this process are various and taking place at different levels. Moreover several authors have pointed out that also the role of regions and municipalities, in the frame of the specific system of intergovernmental relations is relevant. Nevertheless, studies regarding this aspect delineate a controversial picture.

In fact, on the one hand, it emerges a certain positive role of sub-national levels of government. In the wake of the institutional inertia at the national level, regions and municipalities have implemented new schemes and interventions which have increased the elderly care coverage (Costa, 2013; Leon and Pavolini, 2014). These measures have had also an important spill-over effect: for instance, the National fund for long term care introduced in 2007 at the national level was also stimulated and inspired by a series of similar initiatives first developed in some Italian regions (Arlotti, 2009).

On the other hand, some studies have pointed out also the fact that, differently from other countries, regions and municipalities have not pressed for structural reform, supporting a market shift solution (Da Roit and Sabatinelli, 2013). In fact the institutionalization of the migrant care model has been supported also by regional and local policies aimed to qualify and regularize this specific care market, like for instance cash measures for hiring a care worker with a regular contract, training courses for migrant workers and specific initiatives to match care supply and demand (Da Roit and Sabatinelli 2013; Da Roit et al. 2013).

Moreover, regarding intergovernmental relations, specific institutional and financial factors seem to have been relevant. Firstly the capacity of regions and municipalities to exert pressure on the central state is partly limited by the fact that formal bodies in which intergovernmental relations take place (the so called: *Conferenza Stato-Regioni*; *Conferenza Unificata*) have a low institutional

profile<sup>3</sup>, and are ineffective in solving intergovernmental conflicts<sup>4</sup> (Barberis, 2010; Da Roit and Sabatinelli 2013; Kazepov *forthcoming*).

Further from a financial point of view there are also other important aspects which seem to have limited the pressure from sub-national levels of government. The first regards the role played by the IdA. In fact the inertial expansion of this universalistic scheme - introduced since the 1980s for disabled people, which has covered an increasing number of dependent elderly people - has substantially mitigated the need for institutional reform (Costa, 2013; Ranci and Pavolini, 2013). In particular it's important to notice that the specific feature of the IdA, funded by central resources which are managed - in terms of application's assessment - by local health authorities under the responsibilities of regions, has created a perverse incentive to increase the number of beneficiaries (Gori, 2012). Thus, we can say that the expansion of beneficiaries has constituted for regions a strategic lever to mitigate the financial pressure on health care systems due to the growing needs of dependent elderly people. Moreover, regions have not pressed for structural reform of the LTC also because in the bargaining with the central state, the priority is generally to safeguard (or try to increase) the resources for health budgets, due to the fact that these costs cover generally more than 2/3 of the regional budget (Gori 2012).

Finally, another critical aspect regards also the distributional conflict along the territorial North-South cleavage which has hindered the implementation of the essential levels of care in the social sector (Gori 2012; Gabriele and Tediosi, 2014). In fact, this process would imply a re-distribution of resources in which southern municipalities could be advantaged, due to a lower level of services in the South of Italy (*ibidem*). But this scenario has not encountered the favor of Northern municipalities. Thus the implementation of the essential levels of care in the social sector has been stalled.

#### *6. Intergovernmental relations and cost-shifting: regions, municipalities and ... dependent elderly people/families*

As we have seen in the previous section, despite the increasing needs of dependent elderly people and a residual LTC model, regions and municipalities have not exerted pressure for a structural reform of LTC policy field in Italy. As pointed out by the literature, a crucial role has been played

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<sup>3</sup> These conferences are not foreseen by the Constitution: hence they depend by the State; moreover the decisions taken have not a clear legal value.

<sup>4</sup> It's not by chance that after the constitutional reform in 2001 these conflicts have risen exponentially and they have been regulated mainly by the Constitutional Court, in the absence of a political composition (Righettini and Arlotti, 2009; Barberis, 2010).

by the IdA, which has mitigated the need for structural reform, coupled with several criticalities regarding the system of intergovernmental relations (see above).

In the following two sections, we further investigate this aspect, adding a complementary hypothesis. More specifically we suggest that regions and local authorities have not exerted pressure for a structural reform of LTC because they have adopted a strategy of “cost-shifting” within the rules (Bonoli and Champion, 2014) aimed to manage the rising costs for LTC correlated to the increasing needs of dependent elderly people. In the case of regions this strategy is based on the transfer of health costs over the social sector. Instead, for municipalities, this strategy is based on an extended implementation of user’s (relatives) co-payment, in particular for residential care services. However it’s important to notice that these processes have been sanctioned by several judicial rulings because contrasting with national laws defined by central state. Thus the process of cost-shifting tends to be a very controversial matter.

#### *The transfer of health costs over the social sector*

As we have seen in section Two, home care services and residential services for dependent elderly people are foreseen by the LEA for the health care sector. These services must be guaranteed by the SSN and, as regards their costs, covered in part also by the social sector (users and municipalities). However, in many cases, in contrast with the LEA law these services are not guaranteed by ASLs. Thus waiting list systems are implemented. Moreover also health costs are not entirely covered by ASLs but are in part shifted onto the social care sector and families. Even though, in the Italian case, territorial variation in health services is crucial, due to a clear North-South divide in the level and quality of healthcare (OECD 2014; Vicarelli, *forthcoming*), this process tends to be a nationwide phenomenon which affects all areas of the country. In order to analyze this process, here follows a discussion of some regional administrations which usually perform comparatively well in healthcare delivery.

In the case of Lombardy in the north of Italy (the country’s largest region, with more than nine million inhabitants) several studies have shown that in the case of residential long-term care, where the SSN must cover half of the total cost (see Table 2), the coverage rate is instead lower: between 40 and 44 per cent (Guerrini, 2010; Tidoli, 2013). Hence shifted onto the social care sector and families with dependent elderly members are costs which are the responsibility of the SSN. Consequently, co-payment for residential care services significantly increases, so that for many families recourse to this type of service is very difficult or even impossible.

Also in another region, the Marche (1.5 million inhabitants in central Italy), a structural problem affects the coverage of health costs. In fact, for residential long-term care, the region implemented the LEA law in the early 2000s: a total daily cost of 66 euros (based on 100 minutes of daily care for nursing and personal care) was defined, with a 50 per cent division between the health system and the social care sector (co-payment included). However, for many years this division has not been guaranteed to all dependent elderly people in residential long-term care (Ragaini, 2013). In 2012, for instance, approximately one third of patients paid a daily charge higher than the 50 per cent division of the total daily cost (in some cases even more than 70 per cent of the total daily cost).

This shift of health costs onto the social care sector and families with dependent elderly members also emerges from analysis of several court rulings which have addressed this issue. For instance, according to sentence 1584/2010 issued by the regional administrative court (TAR) of Milan, the shift of health costs regards not only, as said, long-term residential care services but also those cases of particular care intensity that, according to the LEA law, should be entirely covered by the SSN (see Table 2). More specifically, the TAR sentence concerned the case of an elderly patient afflicted by a degenerative disease, in a coma vigil, and with primarily healthcare needs (for instance: artificial nutrition, catheter, treatment and prevention of decubitus and so on). The woman was in a residential care facility, and for many years, her relatives had entirely covered the daily costs whereas, according to the LEA law, the responsibility was of the SSN. Similarly, in 2012 an important sentence by the Supreme Court (no. 4558) ruled that elderly people severely affected by Alzheimer's disease have predominantly healthcare needs. In this case, therefore, the costs of residential care services must be entirely covered by the SSN, given the high intensity of the care needs. Also in this case, the relatives had for many years borne the costs of the elderly person's care in a residential institution managed by a municipality, whereas, as stated by the Supreme Court, the responsibility was entirely the SSN's.

Finally, it's important to notice that the transfer of health costs over the social sector in contrast with the LEA law has been contested also by municipalities. As declared recently by Federsanità-ANCI, an important association representing municipalities within the SSN, in many cases persons with health needs and requiring LTC are discharged improperly on municipalities. Hence the services foreseen for LTC by the LEA law for the health care sector are financially covered by municipalities and people in need and not by the SSN (Federsanità-ANCI 2014). Moreover, according to the last "Pact for Health 2014-2016", signed by the central state and regions in July 2014 (which has defined also an agreement regarding resources allocated to the FSN) the resources within the health expenditure for LTC services might be limited according budgetary constraints.

This implies that the transfer of health costs over the social sector is substantially confirmed and that, also in this case, the regions have tried to safeguard - within the bargaining with the central state - firstly the resources allocated to acute disease care which play a central role in the concentration of health expenditure managed by regions through the ASLs.

*Local authorities and users' (relatives') copayment for residential care: a highly controversial matter*

In the previous paragraph we have seen how Italian regions have tackled in many cases (and also currently) the rising costs for LTC needs through a substantial shift of health costs over the social sector. Thus a large part of the financial burden for LTC has been shifted to municipalities which are responsible for the social sector. At the same time local authorities have adopted an additional mechanism of cost-shifting, based on users' (relatives') copayment for eldercare services. That is in particular the case of residential care services, which are more relevant in financial terms (Fargion, 2013).

For this type of service, we have mentioned in section Two that national law does not provide specific indications regarding how the costs attributed to the social care sector must be divided between municipalities and dependent elderly people. The only exception regards the indicator that should be adopted for the means-testing: the ISEE, *Indicatore della situazione economica equivalente* - equivalent economic situation indicator. This indicator, introduced at the end of Nineties by the central government with governmental decrees 109/1998 and 130/00, included in the framework law 328 of 2000 (art. 25) on social policies (see section Two), is aimed to assess the economic situation of the families requiring social benefits (both national or local) or subsidized care services. It takes into account: taxable income, real estate values and financial values (in both cases with specific deductions); rent costs; the specific characteristics of the family (according to an equivalence scale). Moreover, as stated by governmental decree 130/00, an additional decree should have been introduced, according to which for disabled and dependent elderly people only the economic situation of the person requiring support (and not of the family as whole) should be considered. This implies a sort of "individual" means test. However this additional decree has never been implemented.

Hence in this institutional context, worsened also by the regionalization of competences for social policies to regions in 2001, municipalities have not adopted the ISEE for defining social costs attributed to dependent elderly people in case of residential care. In fact they have continued to

consider not the “individual” economic condition, but that of the family as whole, requiring payment from relatives well beyond the nuclear family (i.e including also not cohabitating child(ren)) on the basis of article 433 of the Italian Civil Code, which defines extensively the relatives obliged to provide support in case of need (Naldini, 2003).

However, over the years, several court rulings have condemned as illegitimate this type of municipal regulations (Gioncada et al. 2011). More specifically, the administrative courts have affirmed in many cases that the Civil Code regulates relations among private citizens and cannot be considered by the public administration. Consequently, the support foreseen by article 433 can be requested only by the subject in need (*ibidem*). On the other hand, the administrative courts have affirmed that the assessment based on an “individual” ISEE in the case of disabled and dependent elderly people, was to be implemented, despite the absence of a further governmental decree (*ibidem*).

In fact, according to sentence no. 4003/2008 issued by the regional administrative court of Milan, the lacking of this additional governmental decree was also a responsibility of municipalities. In March 2004, within the *Conferenza unificata* (see above), the central government advanced a proposal in which the implementation of the individual ISEE in case of disabled and dependent was foreseen. But the associations representing municipalities were opposed to it because too much expensive for local budgets. Hence the governmental decree was stopped (Gioncada et al. 2011).

In the wake of an increasing number of court rulings which have condemned municipalities for illegitimate regulations in the definition of user’s copayment for residential care, municipalities have exerted pressure on the central government in order to approve a decree aimed to “legitimize” these municipal regulations (Anci-Lombardia, 2011). This request has been substantially received by the central government within the general reform of the ISEE approved in December 2013. In fact, according to this reform, in case of residential care for dependent elderly people, the new ISEE considers the economic condition of the family plus, in case of need, also not cohabitating child(ren) (Toso, 2014). Thus an extensive user’s (relatives’) copayment seems now fully legitimate, even though remains unclear the combined impact with the Civil Code, according to which in case of need, as mentioned above, the support of the relatives can be requested only by the subject in need and not by the public administration.

## 7. Conclusions

This paper has analyzed the role of regions and municipalities in the multilevel governance of LTC for dependent elderly people, focusing on the Italian case.



The main features of the LTC in Italy are residualism and institutional fragmentation. Moreover, over the last decade, a growing privatization of care has taken place in the wake of a structural consolidation of a (largely gray) private market of care. This trend has been driven by various factors, including the inertial expansion of the IdA, the lacking of institutional reforms, financial constraints.

In a different way from other European countries, regions and municipalities have not exerted pressure for a structural reform of LTC policy field. From an explanatory point of view, in addition to consolidated hypothesis on this issue, we have discussed that a crucial mechanism through which sub-national levels of government have faced increasing LTC costs, is “cost-shifting” (Bonoli and Champion, 2014). This mechanism has taken place on the one hand through the shift of health costs (under the responsibilities of regions) onto the social care sector (under the responsibilities of municipalities) and dependent elderly people; on the other hand through extensive co-payment requested to dependent elderly people and their relatives by municipalities in particular for residential care. In both cases these processes take place in a very controversial manner, because contrasting with national law as ruled by several court sentences.

Among the factors behind these processes, financial constraints and institutional criticalities have played a crucial role. Focusing on the shift of health costs onto the social care sector, it is important to notice that the structural imbalances within the social expenditure, due to the great amount of resources still absorbed by the pension system (in 2012: 59.25% of total expenditure, while for EU-15: 44.09%)<sup>5</sup> coupled with financial constraints due to the high size of public debt, have severely restricted also the expansion of the health expenditure which remains well below other European countries (namely France and Germany) (OECD, 2014). In addition, a rather vague definition of the LEA for dependent elderly people by the Central state - due to the lacking of specific standard regarding coverage rate, care professionals, and the absence of a specific LTC earmarked fund within the FSN - has left regions and ASLs with wide margins of discretion in the implementation phase which have negatively affected the development of LTC services.

Moreover, in a context of increasing needs and budgetary constraints, the structural trait of “vicious” layering (Aguilar Hendrickson and Sabatinelli 2014) which characterizes the multi-level governance of the LTC in Italy, has strongly stimulated blame avoiding strategies and cost-shifting among the state, regions and municipalities, due to the fact that several interventions and different territorial levels of government are involved without a clear allocation and coordination of responsibilities and resources.

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<sup>5</sup> Source: <http://ec.europa.eu/eurostat/data/database>. Data retrieved: January 2015.

The final (negative) result is the reproduction of a LTC model characterized by structural criticalities, which regard the inadequate coverage of the needs of dependent elderly people, the reproduction of gender and social inequalities, due to the central role played by the family (and of women in the families) and intergenerational solidarities in a context of *passive subsidiarity* (Kazepov, 2010), and also the long term sustainability in the wake of profound changes which are affecting (and will affect) in the Italian society both the socio-demographic dimension and socio-economic one.

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