interlinks

Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

Developing and ensuring quality in LTC

National Report Italy

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1   Some data

The need of long-term treatments is strictly related to the level of disability and to chronic ills, mainly among the older people. In Italy the number of people with disability is constant, although there is an increasingly growing older people population living in their own household (+9%). The percentage of over-64 is about 22% of the Italian population, so that our country is at the first place in Europe for the highest number of older people people. However, to make the ageing population a more difficult problem is the demographic dynamic foreseen for the next years in Italy. In 2006 the National Institute for Statistics (Istat) has predicted a turnover of the age pyramid and that in 2050 one third of the Italian population will be more than 64 years old. The loss of functional autonomy increases together with the age: among the people aged 70-74 there is a 9,7% of disabled population while it becomes 44,5% among the people aged over 80 (Istat, 2006). Epidemiologically speaking, disability is strongly associated to pathological forms of chronic-degenerative kind: in fact among the disabled people, 59,4% suffers from serious chronic diseases.

2   LTC in Italy

In Italy, health and social systems are financed, regulated and organized separately. In order to understand the difficulties of integrated health and social service provision it is necessary to keep in mind that, when the public health system was born in 1978, Italy still lack a complete system of social protection on the national level. In particular, social services had not been regulated universally and homogeneously until 2000, when the legal framework and the financial basis for a national development of social services was developed (l.328/2000). Although the integration between the two systems has been one of the main themes of the Italian welfare policy of the last ten years, the two systems are still rather separated. Health System is still hospital centred even though the economic and financial crisis that is involving national and regional health system is placing investments in territorial network of health service.

The decrease of financial resources for social services is another factor that influence LTC services. The long-term care fund's reform was recently approved, but it is not bringing particular innovations.

In Italy differences and gaps between different areas of the country (Regions) are raising. National legislation only define guidelines for the development of health and social care, it describes some basic services that should be present in every region. It also delegates the detailed plans to regional institutions. There are variation between regions in term of economics resource, local culture, and attitudes of public administration towards innovation. North and central areas have more health and social services, whereas in the south there is a lack of services and less capability in investments.

According to the reform of title V of the Constitution, it's up to the Region to plan the services and regulate their functioning; Local Health Authorities (LHAs) and Municipalities, on the other side, have the function to supply services. In both the sectors, services can be either directly supplied or bought from other public or private supplying bodies accredited by the Region. Long-term care includes all types of health and social care as well as family care, which are by their nature long-term actions. In Italy, the

long-term care system includes three types of care aimed at satisfying the welfare need deriving from the older population who is not in need of LTC: in-home assistance, residential care and money support. The first two forms of assistance can have a prevailing health or social character, depending on the subject's condition, the aim and nature of services and the source of funding. Health care targeted to the older people includes medical, nursing, therapeutic and rehabilitation services, while social care is oriented to personal care and to preserve the person's living environment. Among the actions to financially support the older people there are dependant allowances, care cheques and vouchers supplied by LHAs and Municipalities.

Summarizing long term-care can include:

- Nursing care if medical treatment have been required
- Medical care: rehabilitation and continuous care
- Home help and personal care regarding home help, meals and personal care
- a period in a Rehabilitation hospital before coming back home (if necessary)
- combined care: remaining at home and spending the day (9.00-17.00) in a day care integrated care
- residential service where is delivered medical and rehabilitation care and aids for daily activities
- in cash services to buy private care services and to eliminate architectural feature that denies accesses to the disease people
- tele-assistance (in some areas Municipality granted this kind of service to older people with care needs)

Local Authorities Agency and Municipality would divide the costs of service according to DPCM 14/02/2001. Local Health Agency is in charge of the sanitary services (100%). Municipalities are in charge of the social services (100%), but people can pay a quota. LHA and Municipalities are in charge of the integrate services (50% each one) in Integrated Home Care program. NHS Local Health Authorities and Municipalities pay all or only part of the costs of home care services, it depends on the amount of financial resources of the person. If she or he is over ISEE[1] limit, she or he has to cover part of it by her own or family resources.

In order to take care of their own person and environment, most of the older people who are in need of LTC ask for informal care that can be provided by relatives, friends, people who they are acquainted with, and volunteers. Besides, in the last decade, together with the assistance given by public services and informal networks, in-home care has been developing as a service provided by private operators, mostly immigrant women.

3   Actors of quality

The quality system is basically made up of five key actors:

- The Ministry (Health and Social Policy)
- The Region
- The Local Health Authorities and Local Authorities

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[1]   An instrument to measure the social-economic condition of older people.

- The service suppliers
- The citizens

The Ministry of Health and Social Policy guarantees comprehensive quality criteria, which are valid all over the country, in order to ensure equal dignity and equal opportunities to all the Italian citizens. The Reform of the State towards federalism has limited the responsibility of central State for it has to legislate on:

- Essential levels of care (health) and essential levels of services (social services), services which must be ensured to all the citizens, available on all the territories and therefore planned by both Local Authorities in their zone plans and the Local Health Authorities in their action plans
- Criteria to separate free from paid services, according to the importance of the social need and the income (indicator of equivalent economic condition)
- Criteria to accreditation of services, to be followed by any regional laws.

The Region is the body that regulates the quality and plays a primary role in:

- ensuring the network variety and suitability
- assuring the quality of the different local services, either those adopting well-established organizational models or those implementing new approaches
- managing the mix of public and private services, thus regulating the quality of services provided for free or completely or partially paid by the citizens.

The Region defines the rules to allow functioning and accreditation, identifies the agencies in charge of quality control, and the most suitable tools and methodologies.

The Local Health Authority and the Town Council are respectively the holders of health and social services supply and the referees of quality towards the citizens. As referees, they answer for the quality of the services provided. According to regional directives, local authorities must authorize and accredit services. It is up to the Local Health Authority and Town Council to:

- create an integrated service network, so as to provide a certain number and range of services able to satisfy the citizens' needs
- ensure universal access, safeguarding the weakest subjects and providing equal opportunities, according to the need
- ensure a good functioning of any singular part connected in the network, by providing all citizens with the places and tools necessary to evaluate the services quality, thus helping their improvement.

Services suppliers must conform to the regional laws for authorization and, if they want to be entrusted with services by the public subject, they have to obtain accreditation and adopt the Service Chart.

In the last years, public organizations have progressively replaced directly managed services with services delivered in private-public partnership. Within this scheme, quality is regulated by the supply contract on the one hand, and on the other hand by a system of supervision and control on contract fulfillments. In addition, suppliers can choose to certificate themselves on the basis of voluntary rules and adopt those advices believed to be the most suitable to improve the service operators' skills as well as their business capacity (ISO 9000).

Citizens are those who testify the service quality and the quality of the network as a whole. The individual citizen, as a final user of the service, doesn't take part in the game, unless later, when an individual action plan is defined.

4   Quality system

In Italy, quality of health, social-health and social services is ensured by institutional instruments and voluntary certification.

Figure 1   Quality system for of health, social-health and social services in Italy

	Health	Social
Institutional	• Functioning authorization • Institutional accreditation (providing authorization) • Service Charter • Clinical governance • Deontological Code • Continuing Medical Education (CME)	• Functioning authorization • Institutional accreditation • Service Charter
Voluntary	• Accreditation of excellence • Certification ISO 9000	• Certification ISO 9000

Source: Adapted by Studio Come srl on the basis of the law, 2009.

4.1   Quality of health, social-health and social services in Italy

4.1.1 Functioning authorization

Authorization is the means by which the structures in charge of healthcare are given the possibility to actually do their activity, in accordance with a series of requirements, benchmarks and criteria defined by decree (DPR of 14/01/97). Whatever new health structure cannot supply any service without the necessary authorization (which is also required when you want to widen an already existing one). It follows that authorization is essentially an "obliged passage", without which a health facility is not authorized to do any activity related to health and social care, as in the legislative decree 502/92: "authorization is compulsory to all public and private facilities aimed at doing healthcare activities. It must be issued after verification of conformity to the basic structural, technological and organizational requirements which are defined at national level by a guidance and coordination act." Authorization alone doesn't allow the structure to operate on behalf of the National Health Service.

4.1.2 Institutional accreditation (providing authorization)

Institutional accreditation is a compulsory selection process for health care structures. It checks conformity with legal requirements and can authorize or not a structure to operate within or on behalf of the National Health Service.

Institutional accreditation answers to the need of organizing the National Health Service and the singular regional systems (for they can, within a framework of shared rules, organize the regional accreditation on their own way) according to quality guarantees, considering the effective needs of the population, the levels of assistance to be satisfied as well as the available economic resources. Accreditation basically states if a series of conditions are actually met, with the aim to select and identify those subjects who are eligible to be service suppliers on behalf of the National Health Service. Accreditation is issued by the Region to:

- professionals
- public facilities and equals
- non profit private facilities
- for profit private facilities

The aims of accreditation are as follows:

- to ensure reliability and quality of the medical care given to the citizens, who have the right to choose the place and the professionals within the accredited subjects, provided that specific agreements are signed or at least some relationships exist with the National Health Service,
- to ensure that all the structures have a set of instruments and technologies, that as for quantity, quality and features are suitable for the particular services provided as well as an appropriate personnel organization,
- to regulate entry and exit criteria to get in and out the system (access and exclusion)

While for private subjects accreditation is voluntary, for the public service suppliers it is compulsory. The lowest requirements to be a supplier and the further requirements to get accreditation are in fact tested at the same time. All the Local Health Authorities must submit an application for accreditation, at least for the location of the services and activities indicated in the regional plan for accreditation (e.g. locations of services dealing with rehabilitation, either as outpatient clinics or hospitals or day hospitals for both acute and not severe cases, including diagnostic units – such as blood tests and x-ray units, nuclear medicine, radiotherapy, dialysis and day surgery – hospitals for severe diseases with less than 300 beds, advanced medical specialties etc.) and must submit an application in case they activate new facilities s or new activities within existing structures; the activity start up is subordinate to the issuing of accreditation.

Institutional accreditation is a necessary instrument to ensure the satisfaction of the lowest criteria, but it not able to motivate healthcare facilities to continuously improve themselves; besides, the different organizational models of institutional accreditation implemented in the different Regions have highlighted substantial differences.

4.1.3 Contractual agreements

Accreditation doesn't allow free supply of services. Local Health Authorities make contracts with the accredited subjects in order to define what are the volumes and typology of the services provided to the customers, taking into account regional planning and financial costs. It follows that the Region and the Local Health Authorities define agreements with the public subjects and contracts with the private sub-

jects, in relation to the healthcare services that they can provide. Given that the choice is made also through comparative evaluations of quality and costs, being an accredited subject is not only an essential requirement to sign contractual agreements, but it also defines typology, quantity and quality of any specific activity for which it has been accredited.

4.1.4 Accreditation of excellence

It is about a voluntary accreditation in which a professional subject, external to the applicant structure, assesses a health organization according to well-defined standards which are fundamentally important to quality improvement. For instance, a hospital department is visited by technicians and doctors as members of scientific societies dealing with singular specialties.

Compared with the institutional accreditation which requires to comply with minimum standards, accreditation of excellence asks to comply with the possibly highest standards of quality. In Italy, the first experience of accreditation of excellence was made by the Italian Society for quality assessment and revision (VRQ) in 1992 together with the Italian Society of first aid, the Italian Association of emergency doctors, and all the operators in the Emergency services in the Friuli Venezia Giulia Region. So far, lots of implementations have been started up (first aid and emergency facilities, rehabilitation, nursing homes, out-patients' clinics etc.).

4.1.5 Certification

This term is used to describe the "seal" given to a service supplier on the basis of voluntary regulations. Certification of quality guarantees the capacity of a certified organization to structure and manage its own resources and productive processes so as to understand and meet the customers' needs. An organization in order to get a certification, has to activate an internal path to clearly state what are the processes of work like and describe them in a manual of quality, which must be always updated: assessment is made by one of the certification companies, on the basis of the UNI-EN-ISO regulations. The company making the certification has to periodically repeat the test in order to assess that the certified requirements are regularly valid. UNI is the body recognized by the Italian State, working for the production of voluntary regulations.

At first analysis, the elements to consider when assessing the quality of healthcare services refer to the following main categories:

- a suitable organization structure and a correct management of human and material resources as well as primary and support processes, which correspond to the standards stated by the ISO 9001:2000 and ISO 9004:2000 regulations;
- a suitable definition of the "technical" content of the services provided (service specifications), which correspond to a series of specific regulations among which particularly relevant are the diagnostic and therapeutic protocols and the medical-scientific documentation
- personnel qualification (basic training, know-how, intellectual capacity and social attitude, ethical behaviour) which is related to the mechanisms of recruitment, selection, training and vocational practice, awareness rising, motivation etc;
- correct performance of experimental activities of survey, analysis and diagnostics, which provide relevant background information on the soundness of the therapies adopted and are ensured by the conformity of the medical labs and clinics to the ISO/IEC 17025 or ISO 15189 regulations.

Healthcare services are included in the EA 38 sector "Healthcare and other social services".

4.1.6 Service Charter

Suppliers of public healthcare services, also under a contract system, are obliged to adopt the Service Charter on the basis of a general scheme of reference (DPCM 19 May 1995). Through the "Service Charter" in the healthcare field every facility, starting from the analysis of the specific customer's needs, has to identify its own quality indicators and set its own general and specific standards. The Service Charter aims at highlighting the course of treatment made by the customer in the healthcare service: if we take for instance the example of an admission to hospital, we have to underline the aspects related to entry, stay and discharge, while in the example of medical examination or treatment we should underline the customer's first contact to make a request and reservation, the very examination or treatment and a possible coming back to fetch a medical report.

4.1.7 Clinical governance

Clinical governance is an integrated approach to modernizing the National Health Service, which focuses on the citizens' needs in order to plan and manage health services, thus enhancing the role and responsibility of the doctors and health staff to promote quality.

Each quality programme has to ensure that every patient receives the most suitable treatment, that is able to produce the best possible result on the grounds of the available knowledge, by using as less resources as possible, involving the lowest risk of damages connected to treatment and to the fullest patient's satisfaction. From all that, it comes the definition of what characteristics an ideal health system should aim to:

- reliability
- effectiveness
- pertinence
- patient centrality
- timely performances
- efficiency
- equity

In the year 2005, the Ministry of Health produced a document on the clinical governance implementation policy. According to the Ministry's directions, the clinical governance requires a "system" approach and is to be carried out through the integration of twelve decisive elements:

- Lifelong learning: it is an irreplaceable tool allowing health staff to keep up with knowledge and skills, thus ensuring a high level of quality in healthcare services. Training programmes have to take into account motivations and personal needs and also focus on specific, measurable, achievable, real and planned goals, within a certain period of time.
- Clinical risk management: it includes a range of initiatives aimed at reducing the occurrence of damages or adverse events linked to healthcare performances (for instance prevention of therapy errors: just one therapy form to fill in with treatments in hospital).
- Clinical audits: it is a methodology of critical revision applied to clinical practice based on evidence and according to accredited guidelines.
- Evidence Based Medicine (EBM, EBHC): health organizations have to promote methodological approaches to epidemiologic evaluations and give the operators easier access to all the instruments allowing evidence of scientific results (documents, studies, databases, etc.)
- Clinical guidelines and Care paths: they are defined at regional and local level and represent an essential instrument of clinical governance in order to promote good clinical practice from a per-

spective of multi-disciplinarity and inter-professional cooperation. Another fundamentally important instrument of clinical governance relates to integrated care paths, which can be defined as "integrated care plans outlining the care process from admission to discharge". They include guidelines, make reference to explicit standards, involve different professional profiles, with the objective to improve interdisciplinary communication, avoid duplications of information and treatments, and so reduce variability in the clinical practice.

- Claim and dispute management: it must contemplate quantitative and qualitative case revisions as regularly occurring, making sure that the professionals involved get a feedback so as to foster the workgroup discussion, in order to continuously improve quality.
- Communication and documentation management: it must be implemented at all levels of the health organization: between health operators and patients, within the team (among colleagues and between colleagues and decision makers) outside the organization (with the other institutions, services etc.). For each discharged patient, diagnosis and therapy must be recorded.
- Research and development: it is not only important to support research projects but also to introduce research into the clinical practice and disseminate innovative practices.
- Outcomes: health service performance evaluation and comparison all over the Country is one of the main dimensions of the clinical governance. That evaluation involves the setting out of indicators currently measured at national level, which are able to reliably reflect the quality of care.
- Multidisciplinary cooperation: the quality of performances is connected to the activities made by a pool of professionals who have developed their ability to interact and integrate together. Within clinical governance programmes those attitudes must be strongly supported.
- Patients' involvement: all the evaluations about the quality of care must include the point of view of the patients and the patient's opinion must be systematically collected.
- Personnel's evaluation: evaluation must be linked to the objectives of the system and it has the double goal of improving the ability of doing a job, by bettering effectiveness and efficiency of the care activities, and providing some answers to the cultural expectations of each operator.

In Italy there are a lot of experiences on clinical governance implementation. In particular, they have dealt with training, clinical risk management, claims collection and disputes analyses, Service Chart adoption, Guidelines implementation etc. However, they are still fragmentary activities, not yet integrated into a policy of system. Only two regions, Tuscany and Emilia Romagna, have issued a regional law that sets out the clinical governance development lines. The regional law 23/12/2004 of the Emilia Romagna Region indicates a reorganization of the regional health system and in particular of the Local Health Authorities within a framework of clinical governance, by outlining some general guidelines. Tuscany's regional law 24/02/2005, with its article 43, on the contrary provides some detailed directions ready to be put into action, and defines in what sectors the clinical governance policies are to be first introduced.

Among clinical governance experiences, it is also to mention the project of the Lazio Region which is coordinated by the Health Service Agency, aimed at implementing an integrated screening programme that, among the main clinical governance elements, highlights training, risk management, customer partnership, transparency, measurement of outcome and process indicators, information management.

On 10th January 2007, the Ministry of Health approved the "Decree to introduce the National Reference System for the Patients' Security", which also ensures the activity of the Observatory for the Patients' Security, working on the basis of programmes yearly approved by the Minister. That system has been started as an experimental stage lasting for a period of two years. The National Reference System for the Patients' Security is like a channel through which healthcarers can get useful information about the different aspects related to patient security as well as emerging or strategically important events that can be avoid. Therefore, it can be taken as an instrument to ensure surveillance together with infor-

mation and recommendation exchange, by sharing the mutual knowledge ripened within the National Health Service, in order to ensure reliability in all the health performances included in the essential levels so as to safeguard the citizens' rights.

4.1.8 Deontological Code

The deontological code is a set of rules of professional behavior established for a certain professional category. Violations to the deontological code, according to their level of seriousness, can involve variously severe disciplinary actions, ranging from warning to temporary suspensions till the radiation from the professional register. Some rules in some specific deontological codes (such as the medical one) involve specific legal duties, officially acknowledged by the law, the violation of which may also lead to detention. Health and care jobs with a deontological code are: doctors and dentists, biologists, chemists, nurses, vets, midwives, psychologists, x-ray technicians, social workers.

4.1.9   Continuing Medical Education (CME)

Continuing Medical Education (CME) is a national programme of training activities, that has been running in Italy since 2002. It includes an organized and controlled set of training activities, both theory and practice, promoted by a scientific society, a professional society, a hospital, a structure specifically dealing with health training etc. with the aim of keeping high and update the expertise of healthcare professionals. Taking part into the CME programmes is compulsory to all the health carers (health personnel, both medical and not medical, employee and freelance, working in the public or private sector) and that is also mentioned in the Deontological Code. The CME programme will give a certain amount of formative credits to each medical area and to all the healthcare professions. According to the Ministry's directions, every health carer must acquire 150 training credits within the three-year period 2008-2010.

4.2   Quality of social services

4.2.1 Functioning authorization

The decree DM 308/2001 "Minimum structural and organizational requirements for residential and semi-residential facilities in order to get authorization to service and supply" regulates the subject, which has been subsequently defined by regional regulations. The authorization allows facilities to open a service for the citizens but it is not enough to become a supplier of a public body; in this case, a facility must also be accredited. In almost all the regional laws, authorization is based on the structural and personnel requirements (e.g. the highest number of guests allowed, the percentage of operators for guests, etc.). The authorization is released by the Municipalities or a delegating body.

4.2.2 Accreditation

Regions establish the requirements that public and private services must meet in order to become suppliers of the local authority (partnership agreement, fee, service voucher, allowances etc.). In that case, also the requirements of process and result are defined, by which accredited suppliers ensure a quality management (e.g. admission, care and discharge procedures, evaluation of results etc.). Among the requirements for accreditation, it is included the adoption of a Service Chart. Accreditation is a procedure of public evidence through which a local authority recognizes a service or an enterprise as having specific quality requirements; a local authority can buy services from a variety of suppliers and the same can do the citizens when they directly buy a service. Accreditation is therefore a must for the services wishing to take advantage from direct or indirect public benefits.

Accreditation was introduced in order to overcome calls for tenders and differently regulate competition between enterprises producing social services. Whereas a call selects a unique supplier, who actually becomes a monopolist in that area for the period of the contract, accreditation helps to build up an open market, where all the enterprises having the necessary requirements can take part in. In the past, quality of enterprises derived from the selection criteria of the calls for tenders. Now, with accreditation, it depends on the necessary requirements to obtain it and the systems with which the accredited enterprises will be periodically checked. So an open market is taking the place of monopoly.

4.2.3 Certification

It has got the same characteristics mentioned before for healthcare services. For the social services, UNI elaborated a series of technical rules, as an integration to the ISO 9000, suitable to the specific social services. In particular, there is a specific regulation for housing older people: it's UNI 10.881. Here it's worth to make it clear that all the UNI regulations require, first of all, that the subjects act according to national laws.

4.2.4 Service Charter

Among the minimum requirements to get the functioning authorization is that you adopt the "Services charter", a document in which the service or the facility commits itself to the citizens (artt. 5 and 6 DM 308/2001). The charter describes the services supplied, their duration, the operators involved, access conditions, opening time, waiting lists and customer's rights and duties. It indicates how and where to file a claim, activate possible claims against responsible people of the service in order to get compensation, if it is due. It shows what instruments are available to users and those who represent their rights in order to express a quality evaluation. It informs about free services and those requiring a payment (ticket or fee) as well as how to have access to allowances ad service vouchers (art. 13 L. 328/2000). This instrument is aimed at making the functioning of the service transparent and so verifiable by the citizens. The procedure to get the chart approved, explicitly includes the involvement of actual and potential service clients, the sharing of contents with them, and a formal subscription.

Figure 2   Common and different aspect of Quality System for health and social services

	Health	Social
Functioning authorization	Authorization is the means by which the structures in charge of healthcare are given the possibility to actually do their activity, in accordance with a series of requirements, benchmarks and criteria defined by decree (DPR of 14/01/97). Authorization is essentially an "obliged passage", without which a health facility is not authorized to do any activity related to health and social care. Authorization alone doesn't allow the structure to operate on behalf of the National Health Service.	It is a mandatory in order to get authorization to service and supply" regulates the subject, which has been subsequently defined by regional regulations. The authorization allows facilities to open a service for the citizens but it is not enough to become a supplier of a public body; in this case, a facility must also be accredited.
Institutional accreditation (proving	Institutional accreditation is a compulsory selection process for health care structures. It checks conformity with legal requirements	It is a mandatory for the services wishing to take advantage from direct or indirect public benefits. Accreditation is a procedure of public

authorization)	and can authorize or not a structure to operate within or on behalf of the National Health Service. Accreditation doesn't allow free supply of services. Local Health Authorities make contracts with the accredited subjects in order to define what are the volumes and typology of the services provided to the customers, taking into account regional planning and financial costs.	evidence through which a local authority recognizes a service or an enterprise as having specific quality requirements.
Accreditation of excellence	It is about a voluntary accreditation in which a professional subject, external to the applicant structure, assesses a health organization according to well-defined standards which are fundamentally important to quality improvement.	
Certification	It is voluntary. Certification of quality guarantees the capacity of a certified organization to structure and manage its own resources and productive processes so as to understand and meet the customers' needs. Healthcare services are included in the EA 38 sector "Healthcare and other social services".	It is voluntary. Certification of quality guarantees the capacity of a certified organization to structure and manage its own resources and productive processes so as to understand and meet the customers' needs. For the social services, UNI elaborated a series of technical rules, suitable to the specific social services. In particular, there is a specific regulation for housing older people: it's UNI 10.881.
Service Chart	It aims at highlighting the course of treatment by the user in the healthcare service. This instrument is aimed at making the functioning of the services transparent and do verifiable by the citizens. It is obligatory for health services.	It aims at highlighting the course of treatment by the user in the social service. This instrument is aimed at making the functioning of the services transparent and do verifiable by the citizens. It is obligatory for health services (minimum requirement to get the functioning authorization).

Source: Studio Come srl on the basis of law, 2009.

5   What is assessed

Accreditation in health care assesses minimum structural, technological and organizational require-ments. Among the structural and technological requirements are for instance electrical safety, hygiene on the workplaces, barrier-free premises etc. Among the organizational requirements are:

- Policy, objectives and activities, organizational structure
- Human resources management
- Technology resources management

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- Management, assessment and improvement of quality, guidelines and internal regulations
- Information system

Those general requirements are then adapted to the specific sector of care, according to its specific features. Among the minimum structural, technological and organizational requirements of rehabilitation facilities for people with physical, psychical or sensorial disabilities there are for instance:

- A multidisciplinary team made up of graduate health personnel, professionals in the psychological and pedagogical area, rehabilitation technicians, educators, occupational therapists, social carers;
- For each singular patient a Rehabilitation Plan must be arranged by a multiprofessional team, including monitoring activities to check evolution and changes in the disability (individual report for each patient);
- Suitable information and family access to the facility must be ensured together with a specific training offered to the patient before he's going back home;
- There must be a system to collect and file complaints made by customers;
- Rehabilitation facilities must gather patients in modules of 15 to 20 persons;
- Day-facilities must work 6/7 hours a day for at least 5 days a week.

Accreditation in social care assesses minimum structural and organizational requirements for day and residential facilities:

a) easily accessible location within a urban area , reachable by public means of transport so that users can take part in social life while visitors are helped to go and see them;

b) specific places for collective and socializing activities which are different from the bedrooms;

c) presence of social and health professional profiles, in relation to the type and specific needs of the users (as stated at regional level)

d) presence of a coordinator who is responsible for the facility

e) a guests' register and an individual plan must be outlined in order to detail the goals of care activity, its contents, the way how to achieve and assess results;

f) activities must be organized so as to respect the way of living of the guests, and keep their own pace;

g) adopting the social service Chart also means advertise the pricelist, with indication of the services provided.

In-home social care:

a) presence of qualified professional profiles according to the type of service and the standards defined by the regions;

b) presence of a coordinator who is responsible for the service;

c) adoption of a social services Chart including a detailed pricelist, with indication of the services provided.

d) setting up a guests' register and an individual care plan arranged for each person.

Voluntary certification of quality (ISO 9000) assesses all the business processes. These include the organizational structure, responsibilities, procedures, proceedings and resources activated to supply health, social-health and social services.

6   Incentives to measure, ensure and/or improve quality in everyday practice

Lack of compliance with accreditation criteria doesn't allow a service to act on behalf of the National Health Service or a social activity on behalf of Local Authorities.

Lack of compliance with the quality criteria of the voluntary certifications (ISO 9000) leads to certificate missing renewal.

In some calls for tenders, having a quality certification helps the candidate to get a higher score or ensures little facilitation at economic level (lower costs of bank guarantee).

Accreditation is compulsory for all the services and facilities wishing to operate on behalf of the National Health Service

Compliance with the *equal care levels* defined by the National Health Service and Local Authorities

- compliance with the bond of financial limits
- better planning ability
- improved economic control at regional level and better control on the service supply practices

Limits: Services and facilities are satisfied at minimum standard levels, as for the service supply practices and the service goals, and are not encouraged to improve.

Certification is a control-oriented activity:

- it's recognizable at International level
- it makes quality systems homogeneous among different facilities
- it produces easier and standardized assessments
- it makes clients feel safer

Limits:

- it's on voluntary basis
- it only ensures sufficiency
- the rule of reference is too standardized compared to the specific contexts
- it mainly takes into account structural aspects and only partly the process
- it doesn't involve the setting up of workgroups nor staff participation in the process to improve quality
- it increases bureaucracy in the service

7   Quality assurance and informal care/volunteers

Recently, some local services have activated – often as experiments – forms of support aimed at providing "relief" to a family directly involved in the care of a fragile person. These measures are usually provided together with some other actions (for instance social benefits) thus enhancing their outcomes with a multiplied effect on an older person with care needs and his/her family. Examples of those policies are temporary hospitalizations and relief stays, mutual self-help groups and psychological support.

Home relief services can be ensured in residential nursing homes, day centres or can substitute a family member or care giver at the old person's home. Those actions include some volunteers keeping him company and are limited to some control and help given to the person being in need of LTC.

Another recently widespread tool, particularly in the Northern Regions, are Self-Help groups. Those groups are made up of small voluntary organizations aimed at self-help and achieving specific goals. Those groups have as an objective to express problems, which are often common, about no longer older people in need of LTC living at home, by trying to find common solutions as well as offering mutual assistance.

Another kind of support is about Care Education (also for private migrant assistants), particularly useful in the first period of assistance. In fact, often the work of caregivers is underestimate by most of the people, as if acting in an informal place could make this activity less professional: it seems normal to believe that all the necessary skills to correctly run these activities are easily acquirable by practice or even naturally owned, especially when to do them is a woman, who has always been a reference point in the house and family care.

Finally, planning local social services sometimes involves actions in support of the private area in terms of tutoring: generally identified with the home assistant's profile, home tutor is the one who is at disposal of informal and main care givers (often a private migrant worker) in order to face the most difficult and critical phases of the care work (patient's worsening health conditions, emergencies, admission to and discharge from hospital, absence of the family assistant etc.).

8   Quality indicators

In the last years, national and regional laws have introduced a lot of indicators in health care and social assistance, but most of those indicators are focused on some aspects of the system, such as the costs of singular services or some assistance processes, dimensions and characteristics of the offer (number of beds available, number of general practitioners) the organization of health services and the use of resources.

For instance among the indicators pointed out in the DM 12-01-2001 "A System of guarantees to monitor health care" we can see:

- Availability of general practitioners
- Percentage of older people patients under Integrated Home Care
- Waiting lists for specialists and diagnostic tests
- Percentage of hospital structures having protocols for a protected discharge which involve local community ,etc.

On the contrary, not many are the proposals aiming at identifying indicators on health results, as effective measurements of the patient's health state after a pathological event and at the end of a specific assistance process. Among the indicators for patients suffering of cerebral ictus, so as highlighted in the focused research "Identification, experimentation, and validation of some process and exit quality indicators on health care" promoted by the National Agency for Health Regional Services in 2002, we can find:

- Percentage of patients admitted in the hospital within three hours after the beginning of the symptoms
- Percentage of patients having a CAT scan
- Percentage of patients assessed according to a disability scale
- Percentage of patients whose destination after hospital discharge is documented (in particular: percentage of patients going back home and percentage of patients transferred to long-term hospitals)

Just because there isn't a specific framework at National level, in 2004, the National Agency for Health Regional Services, set up a partnership as a permanent forum on the issues of quality and accreditation in health care, which involves 16 Regions and Autonomous Provinces (Basilicata, Provincia Autonoma di Bolzano, Campania, Friuli-Venezia Giulia, Lazio, Liguria, Lombardia, Marche, Molise, Puglia, Sardinia, Tuscany, Provincia Autonoma di Trento, Umbria, Valle d'Aosta, Veneto).

Among the themes focused, there is that one of quality criteria in the selection of suppliers accredited for services which are at charge of the National Health Service. These criteria range from aspects linked to clinic quality to a second group of aspects more linked to organizational quality, to end up with a series of mixed criteria:

- Presence of care paths (diagnostic-therapeutic paths or protocols of assistance) to get the best results
- Structure's ability to provide assistance to a person until his/her functional reintegration (the best level of rehabilitation) (structure able to ensure the fulfilment of the care path)
- Presence of protocols of shelter discharge (a plan of tailored care actions to be run at home after the patient's discharge)
- Pertinence (quality of services and performances): services given according to clinic indications of proved effectiveness, at the right time, and following to suitable procedures.
- Presence of formal assessment methods (e.g. ISO certification)
- Quality evaluation of the services supplied (effective, reliable, timely service etc.)
- Training (vocational updating courses and lifelong learning)
- Uniformity in filling up clinic forms and health files (in order to provide easier communication and information between operators and professionals and verify results)
- Implementation of monitoring systems on essential levels of performances
- Direct link to the local health authority's booking centre
- Accessibility (physical barriers, procedures to use services, filling papers, communication etc.)

In support of patients having had cerebral ictus, the State-Regions Permanent Conference approved an agreement between the Ministry of Health, Regions and Autonomous Provinces on the document concerning the guidelines to define a care path for patients with cerebral ictus (session of 3rd February 2005). That document reaffirms that therapies can only have full effectiveness if included within an assistance path ensuring a Stroke Care system. Here after are some examples of indicators defined in the agreement.

Pre-hospitalization phase: a fundamentally relevant element of quality is timing, both in the ability of patients, relatives and health operators to recognize an event occurring and in hospital transfer. The most important system indicators measure the frequency of use, by the system of local emergency, of diagnostic scales or specific codes for ictus. A quality indicator in the care process is about the proportion of patients getting to the Emergency Room shortly after the time when the symptoms started.

Hospitalization phase: The main problem is ensuring acute patients a suitable stroke care, by means of fundamental and integrated organizational conditions: dedicated areas of stay in hospital, multi-professional teams, diagnostic tests and suitable therapies, providing almost immediate rehabilitation assistance.

System Indicators:

- % of hospitals with CAT scan availability 24 h/24
- % of hospitals with nurses/doctors specifically trained in emergency care
- % of hospitals with dedicated areas of stay and dedicated human resources
- % of hospitals where systemic thrombolysis is available

Process Indicators:

- % of patients receiving a CAT scan within 6 h(24h) after entrance
- % of patients assessed by a multi-professional team within 7 days
- % of patients assessed for rehabilitation within 48 h (72h) after entrance
- % of patients assessed by a scientifically valid disability scale
- % of eligible patients submitted to thrombolysis treatment
- % of eligible patients submitted to aspirine or antiaggregating treatment within 48 h since the symptoms appeared

Post-hospitalization phase: The main problem is about ensuring lasting assistance and the "rehabilitation project" fulfilment after discharge from hospital. There aren't many available and easily manageable indicators in this phase. Rehabilitation paths effectively run should be detected by sample surveys or qualitative studies in the next 3 months or 1 year after the acute event.

In all the phases of the care path the main quality factors "of system" are:

a) availability and documented adoption of diagnostic-therapeutic or rehabilitation protocols which are explicitly and formally shared by the team;

b) running training activities for the professional development of the staff, targeted on the different phases of the care process;

c) initiatives aimed to inform and involve relatives and caregivers in the care decision-making process.

9   Cultural diversity as a subject in quality management

In our country there are foreigners coming from about 150 different countries: a variety of people with different biologic, cultural and religious characteristics. Immigration has changed the healthcare scenar-

io, although it didn't immediately adapt to the new health, social and cultural needs that "difference" brings about. Migration is quite a recent issue and only in the second half of the 90s, the planning of healthcare regional actions – Health Plans and regional laws – started to include a raising number of targeted initiatives and funding. As usual, we can see very different regional situations in our country: from one hand there is a tendency to provide specific services to the migrant public, by adopting specific ways of recruitment, and supplying settings, communication and information tools, while on the other hand it is hardly considered the possibility of having foreigners as service users.

Being the Region the body with the major competences on integration policy, whose task is to translate guidelines into proper local policies and define paths and procedures to safeguard foreign citizens, explains why we have so different ways of implementing the national laws as concerns foreigners' social assistance and health care, resulting in a range of different solutions. In fact some regions have advanced policies while others don't seem to be so focused on the issue, thus producing a disparity in the dissemination of services and distribution of funding. However there are some positive examples: regions such as Emilia Romagna, Lombardia, Lazio and Tuscany have invested in staff training and intercultural mediation in order to overcome inequality.

Within regular planning of foreign-user-oriented services, though they're not homogeneously disseminated across the country, some organizational practices have been adopted aimed at supporting foreign citizens to take advantage of them, such as:

- Networking activities
- Integration and synergy between public and social private sectors: Local Health Authorities, charities, non profit associations (Caritas, Lega Tumori), cultural mediation associations and migrant communities.

Usually they include strategies to help service access conditions, like admission managed by multiethnic staff, the presence of multidisciplinary teams and multiculturally trained staff, while migrant communities are involved in the service planning and supply, and there is an active offer of health services.

According to the available resources, the following initiatives are also planned and carried out: communication plans and multilingual tools in cooperation with the foreign communities; services of support to healthcare services and active supply of some medical treatments and diagnostic tests straight on the spot where foreign communities usually gather.

Generally speaking, what is lacking is an analysis of the achieved results (interim and ex-post) and an evaluation system to state strengths and weaknesses met in the implementation, which could provide a database to further planning in order to continuously improve it. On the contrary, quite common are the methodologies to survey the users' satisfaction, satisfaction questionnaires and focus groups.

Furthermore, some Regions (e.g. Emilia Romagna, Tuscany, Piedmont, Lazio) have started to include in their Service Charts (both social assistance and health care charts) some specific quality indicators taking into account the presence and the needs of foreign citizens such as:

- Offering simple, direct, not technical information about the service access procedures, by using information material in different languages, also available online.
- Ensuring cultural mediation for foreign and of different religion people.

In addition, there are lots of Local Health Authorities and Local Authorities promoting participation of foreign associations and communities in advisory bodies such as Users Committees or social policy

Councils and Tables to arrange Social Local Plans. Advisory Mixed Committees are district organisms aimed at fostering citizens' participation in the Local Health Authority's decision-making process as concerns the aspects related to service quality improvement. They are mostly made up of members of Charities, representatives of the District and a general practitioner and their aim is to ensure quality controls from the side of the demand, particularly on access paths to services, experimentation of quality indicators to evaluate the service from the users' point of view, experimentation of procedures to collect and analyze suggestions and complaints made by the citizens.

Social Policy Committees are set up at the Town Council premises by associations working on the territory of reference and included in the register of charities available in the same Town Council, with the aim of introducing proposals on service planning and functioning, also providing opinions on the decisions on services made by the Council. In a lot of municipalities and districts, they have set up Committees for immigration, with the specific aim of listening to the opinions of foreign citizens living in the area so as to adapt services to their needs.

Besides, arranging Local Council's Social Plans and monitoring their implementation as in the law 328/2000, requires the participation of the citizens who use the services. As a consequence, a lot of territories and socio-health districts have promoted the setting up of Tables to plan actions in which associations and foreign communities are involved, with the aim of supporting technicians and planners in the needs' survey, service planning and quality system. Unluckily, that participation as stakeholders is often a pure formality, because only the biggest and highly politicized associations, which are not very close to the citizens' needs, are asked to take part in. Moreover, they express non-binding opinions on administrative decisions taken by Local Authorities.

10 A brief (critical) evaluation of quality management in Italy

The quality of long-term care services shows relevant differences in our Country: apart from the subdivision of the services into two sectors (health care and social care) and a lack in the integration between the two as concerns quality at planning, supply and evaluation level, there are some advanced contexts – such as Emilia Romagna, Tuscany, Umbria, Piedmont, where the network of health and social care services is articulated and there are quality systems and tools (service regulations, quality manuals, service chart) - and some backward regional contexts, particularly in the south of the Country.

To these weaknesses it is to add the inherent complexity of quality evaluation in the different long-term care services. In fact, if it is difficult to identify quality indicators effectively able to evaluate formal structures such as retirement homes or hospitals, it's even more difficult when they refer to informal contexts including the patient's house and his/her friends or relatives' houses.

The different quality systems and the related indicators applied in our Country can measure actions on the basis of the structure characteristics (spaciousness of rooms and proportion of staff to patients), process (procedures and protocols evaluations) and results (prevalence of some medical conditions), but not much has been done in order to evaluate an effective correspondence of the services to the user's needs and features.

The paths traced to accredit facilities as well as health and social care services come from the need of making them comply with the minimum requirements whereas at present the emphasis is increasingly turning towards an all-accomplished quality, that also considers the patient's rights and lifelong-learning

opportunities for the staff. At the same time, the standard indicators to evaluate care quality, like for instance the proportion of staff to patients and suitable training, are not able to measure the quality of the services supplied by informal carers. Here too, our country is late.

Private services, actually set aside, have little influence on planning and quality control. Quality is regulated by a supply contract (partnership agreement) on one hand and on the other by a system of supervision and control on the fulfillments. The user, the final beneficiary of the service, only appears on a second phase, when after the initial evaluation, an individual action plan is outlined. It follows that, if the menu of the services or the package of the available services is quite narrow, his/her requests will have very little effect on the offer improvement. Municipalities can rely on a limited budget: they can offer some hours a week to a small group of older people people for free; the other older people, if have money, can find and pay a place in a retirement home or hire a private family assistant.   Usually, she is an immigrant woman without any specific training in the care work. Besides, though all the regional health and social care plans and the laws in support of older people identify as a strategic objective to ensure the citizen and his/her family continuity in the care and integrated care paths, this objective is still a challenge.

The presence of a variety of services and their fragmentation makes it necessary to build up integrated care paths as well as services and positions able to provide tutorship to the care path including some kind of planning, support and regular monitoring of the user's conditions, with the aim of following him throughout the phases of the care process, also supporting his/her family in its function to coordinate care and assistance resources. It is therefore fundamentally important to set up a unique front desk of access, which is connected to the phase of multidimensional evaluation in order to provide people with integrated assistance and define a responsible person for the specific case. It's important to indentify a tutoring position or a case manager who not only cooperates with a social carer, a medical practitioner and all the other professionals involved in the care process, but is also able to deal with each tutored person comprehensively, by offering his/her family a map of available resources, thus helping it to build up a tailored network of support, as an integration of the care provided by the main care-givers (family or private carer).

A network variety and the integration of chain services (expression meaning a set of services provided by different organizations but acting as they were segments, divisions of only one enterprise) are two key elements of quality services. Supply chain is the organizational objective that develops the idea of a coordinated and flexible network. In order to obtain that, public planning must have a leading role. The role of Local Authority is in fact to promote services chain integration, by arranging a multitude of care suppliers and providers who will otherwise run the risk of vanish one another or create disorder around the person receiving care. Supply chain gives another advantage: it is able to reduce the volume of improper treatments and lower the costs of non quality. Providing care to people who are in need of LTC asks for an enormous amount of energies, for it involves a great number of people who variously revolve around the patient including doctors, care professionals, volunteers and close family members. In order to rule the "care market" it is necessary to introduce, on the side of the offer, wider choice to the patients, so as to support their empowerment in the service, their cooperation and competence while at the same time, it is necessary to submit all the services to basic rules and quality controls, no matter who is the supplier and who is the customer.

Furthermore, within the system of quality, a citizen represents a special point of view, which is not only focused on strategic choices but is interested in the subtle quality emerging from the daily routine of services. If things go wrong, some are able to complain but some others might not be able; some take part in the management committees and negotiating tables but most of them are far from the administration machine and institutions. It's therefore important that, no matter his/her own fragility, a citizen

as a user of a service should always express his point of view and opinion about the service received, and the service should collect his/her opinions and take them into account. Shared evaluation is creating lot of methods, life stories, deep interviews, focus groups, questionnaires. The choice between those different methods depends on the context, the target and the economic resources. But it is fundamentally important to arrange those paths of shared quality with tools and locations to involve the weakest and less represented subjects too, in order to gather their opinions, suggestions, desires, and convey them into the quality system. In fact, it is not enough to support enterprises and services to adopt manuals, regulations and service charts together with all the documents aimed at showing fulfilment of procedures if we take out of the evaluation system the quality effectively received and perceived by the citizen. In social services, human relationship acts as a crucial dimension of quality.

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