



# Disability, Work and Inclusion in Italy

BETTER ASSESSMENT FOR BETTER SUPPORT



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# Foreword

Disability policy is a priority for the Government of Italy. Reform of disability support is envisaged in the 2020 National Reform Programme, and the need to improve the social protection framework was reiterated by the Constitutional Court in July 2020. Disability reform is also necessary to align the medical definition of disability in use in Italy today with the functional definition in the United Nations Convention on the Rights of Persons with Disabilities, which Italy ratified in 2009. A framework law in late 2021 (the Enabling Act) sketches out the direction of forthcoming reform and entrusts the national government with the preparation of the reform. Designing an effective multi-level governance system is essential to this effort because in Italy, key elements of disability policy such as disability services, some disability benefits and the assessment of disability are under regional and local competence.

This report is the outcome of a two-year project, funded by the European Union and implemented by the OECD, aimed at supporting Italy in its reform journey. The most distinctive part of the project was the planning and execution of a pilot of a new disability assessment tool, which looks at peoples' performance and functioning capacities driven by the environment in which they live, i.e., their actual life situation, in addition to their health conditions and impairments. Four regions that reflect the diversity of the country volunteered to participate in the pilot and the project more generally: Campania, Lombardy, the Autonomous Region Sardinia, and the Autonomous Province of Trento. The conclusions and recommendations in this report build on the analysis of the situation in Italy and in these four regions, and on the evaluation of the assessment pilot conducted in the four regions between November 2022 and April 2023.

The project supported the government in four ways, i.e. through: i) an analysis of the system of disability assessment in Italy and selected countries in OECD Europe; ii) an analysis of the system of social protection for people with disability in Italy and selected countries in OECD Europe; iii) the organisation of assessment pilots in four regions of Italy, whose specificities in disability assessment and social protection had been previously investigated; and iv) ongoing support to the legislative reform process.

The preparation of this report involved several steps that contributed to shaping its conclusions:

- A series of online meetings with national key stakeholders and institutions responsible for the management of disability policy in Italy, including ministries, public institutions such as INPS and ISTAT which also provided essential data, and the main disability federations.
- A series of face-to-face meetings in the four participating regions with the authorities responsible for implementing disability policies and providing disability services. In an early phase, the project also included a similar series of meetings in a fifth region, Umbria, which helped shaping the project and the later discussions with the four participating regions.
- The provision of standardised online training and ongoing support to the four regions and the regional assessors, in preparation for and during the assessment pilot, the collection of harmonised pilot data, and the preparation of a robust statistical evaluation of the pilot results.
- A series of meetings to discuss the findings of the analysis and the pilot evaluation with key stakeholders, including the parliamentary committee responsible for drafting the new legislation.

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- For the Umbria region, the regional administration organising the study visit.
- The National Observatory on the condition of people with disabilities, the National Institute of Social Security, the National Office of Statistics, and civil society organisations representing people with disabilities (including FISH and FAND and their respective member associations).
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The painting on the front cover comes from *Ateliers Personimages*, a French non-profit association promoting artistic creation for persons with disabilities ([www.personimages.org](http://www.personimages.org)).

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# Executive summary

Italy has long aimed to reform its disability policies to address at least three long-standing policy issues: discrepancies with the UN Convention on the Rights of Persons with Disabilities calling for a change in disability assessment; the fragmentation of disability assessments and disability supports; and resulting inequalities across Italy's regions in the provision of disability services and take-up of disability benefits.

Social and employment outcomes for people with disability in Italy are ambivalent and difficult to interpret. Employment and poverty gaps between people with and without disability are both relatively low, and lower than the OECD average. However, this finding is not explained by higher employment rates of people with disability in Italy, or lower poverty rates. The lower disability gaps in Italy result from poor income and employment outcomes also for people without disability. This points to more general reform issues to boost social and employment outcomes for all people in Italy, which would also benefit people with disability.

Available disability benefits and services are quite adequate in Italy, and people entitled to benefits and services are, therefore, relatively well supported. However, take-up of supports is often low, because of both system complexity and lacking resources, and people excluded from support are often vulnerable. This shows the critical importance of disability assessment in deciding who is supported, and who is excluded. Many of those left out from support face considerable barriers to work and integration.

Support for people with disability varies across regions. The wealthier regions in the Northern part of the country are better placed to provide essential disability services than poorer regions in the South. Instead, the take-up of disability benefits, which are funded exclusively from national budgets, is much higher in the South and has been increasing over the past decade. The higher benefit take-up in the South (57% of the working-age population, compared to only 23% in the North) is also in part a consequence of stronger financial incentives to apply for benefits for people living in poorer regions: Being identical across Italy, non-contributory disability payments are more appealing, compared with the lower wages and poorer economic conditions in those regions, even though payments are not overly generous.

Regional inequalities are also the result of differences in disability assessment both across and within regions. The disability status assessment, which determines the degree of "civil invalidity" and the eligibility for nationally provided benefits and services, is overseen by the National Institute for Social Security but implemented at the provincial level, with a significant degree of discretion. Moreover, Italy operates five different disability status assessments in parallel, making the system inefficient and difficult to navigate. Needs assessments determining entitlement to sub-national services are implemented at the local level, with considerable variation across the country but, generally, a strong focus on the actual needs of people with disability. The two assessments – of people's degree of civil invalidity and of people's needs – are disconnected from each other.

Recent legislation in late 2021 points to the direction of forthcoming disability policy reform, which will start with a reform of disability assessment. Currently, civil invalidity assessment tends to discount mild-to-moderate health impairments, which nevertheless can lead to considerable disability, such as certain mental health conditions, and vice versa tends to overlook the abilities of people with severe health impairments. Incorporating the WHO Disability Assessment Schedule (WHODAS), which assesses

people's functioning and performance into the medically oriented civil invalidity assessment, would rectify this bias: disability assessment would become more accurate, be aligned with today's interdisciplinary understanding of disability, and ensure a better connection with any subsequent individual assessment of actual support needs.

A pilot of a new assessment conducted in four diverse regions of Italy – Campania, Lombardy, the Autonomous Region Sardinia, and the Autonomous Province of Trento – demonstrates that social workers in Italy can apply the WHODAS tool in a valid and reliable way, irrespective of the regional context. The evaluation also shows that WHODAS could be used effectively to flag to the assessors any significant disparity between functional capacity and health impairment, indicating the need for a more in-depth assessment. The weight given to the functional component of disability in the decision process, compared to the medical component, is a political choice.

To make disability policy more efficient and more effective for people with disability, the government should consider:

- Merging the five existing disability status assessments and adding a functional component to the narrow medical assessment of people's disability status by using the WHODAS questionnaire, which should be operated by social workers.
- Using WHODAS scores to flag discrepancies between the medical and the functional dimension of disability, with the aim to examine more closely the actual situation and capacity of about one-third of all people accessing the disability system.
- Reducing the discretion in disability assessment through clearer guidelines, harmonising needs assessments across the territory, and better linking disability status and needs assessments.
- Helping people with disability navigate the complex system through single points of entry (*Punto Unico di Accesso*, or PUA), which exist already in some regions and municipalities. PUAs should ideally be the only point of entry to the disability system, operate uniformly across the country, and have sufficient human capacity.
- Improving the efficiency of the social protection system through better data collection and systematic data sharing practices, financing mechanisms that prevent duplication of benefits and services, and better co-operation at the regional and national level.
- Reducing territorial differences by improving the capacity to deliver effective health and social services in the Southern regions and strengthening work incentives and work opportunities for people potentially entitled to disability benefits to address problems stemming from the model of a single income threshold and a single payment across Italy.
- Making employment integration of people with disability a priority by linking disability benefits to activation provisions, enabling public employment services to support people with disability able to work, and focusing on early intervention to prevent labour market exit.

# 1 Assessing social protection needs for people with disability in Italy

---

This chapter discusses overall social and labour market outcomes of people with disability in Italy. It finds that people with disability face poverty and employment rates comparable to their counterparts in many OECD European countries. However, the difference in employment and poverty rates between people with and without disability is lower in Italy than in other countries, pointing to general economic and labour market challenges in the country. The chapter also finds significant geographical segmentation, indicating regional differences in social protection needs.

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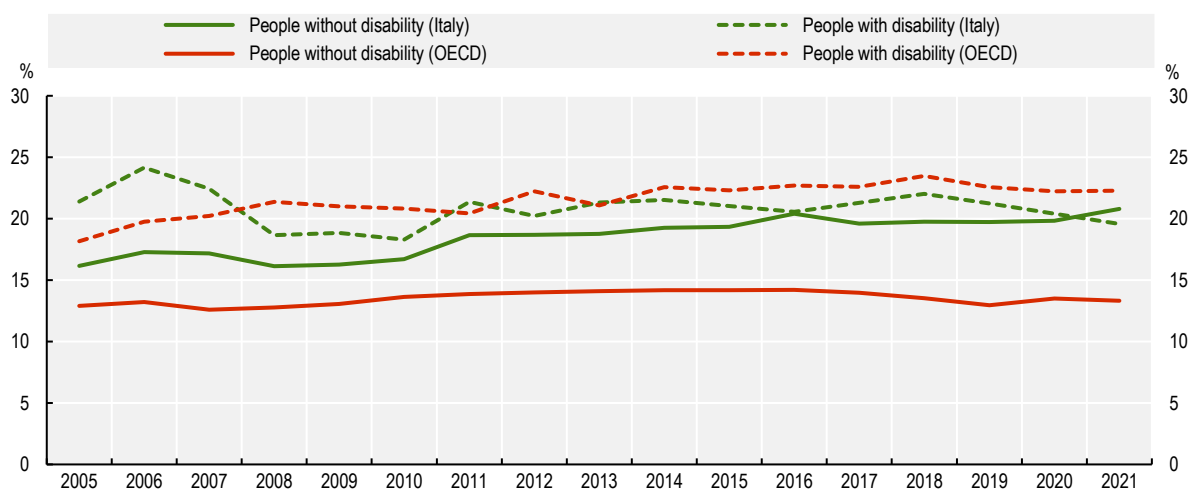
Assessing social protection needs requires understanding the risks people with disability are facing – the risk of falling into poverty or not being self-sufficient and therefore very vulnerable – and the extent to which social protection supports people in alleviating these risks. This section evaluates the poverty risks of people with disability in Italy and their labour market outcomes, including job quality aspects. The Italian context is highly segmented geographically; hence, this section also pays attention to regional differences in the needs for social protection.

### 1.1. Poverty risks of people with disability are relatively low in Italy

While the risk of poverty is high in Italy compared to the OECD average, contrary to most other OECD countries poverty is not much higher for people with disability. Figure 1.1 shows that people with disability in Italy have a poverty risk comparable to the OECD average for this group. People without disability, on the contrary, have a comparatively high poverty rate in Italy. Accordingly, the overall poverty risk in Italy is large but the disability poverty gap, i.e., the gap between people with and without disability in the risk of living in an income-poor household, is smaller in Italy than in the OECD on average.


**Figure 1.1. Poverty risks are generally high in Italy, but not so much more for people with disability**

Poverty rate of people with and without disability in Italy and OECD



Note: The data show relative income poverty, i.e. the share of people living in a household with an income below 60% of the median income. Household income is equivalised for household composition by dividing by the square root of the size of the household. OECD represents the unweighted average of 32 member countries, excluding: Colombia, Costa Rica, Israel, Japan, New Zealand and Türkiye.

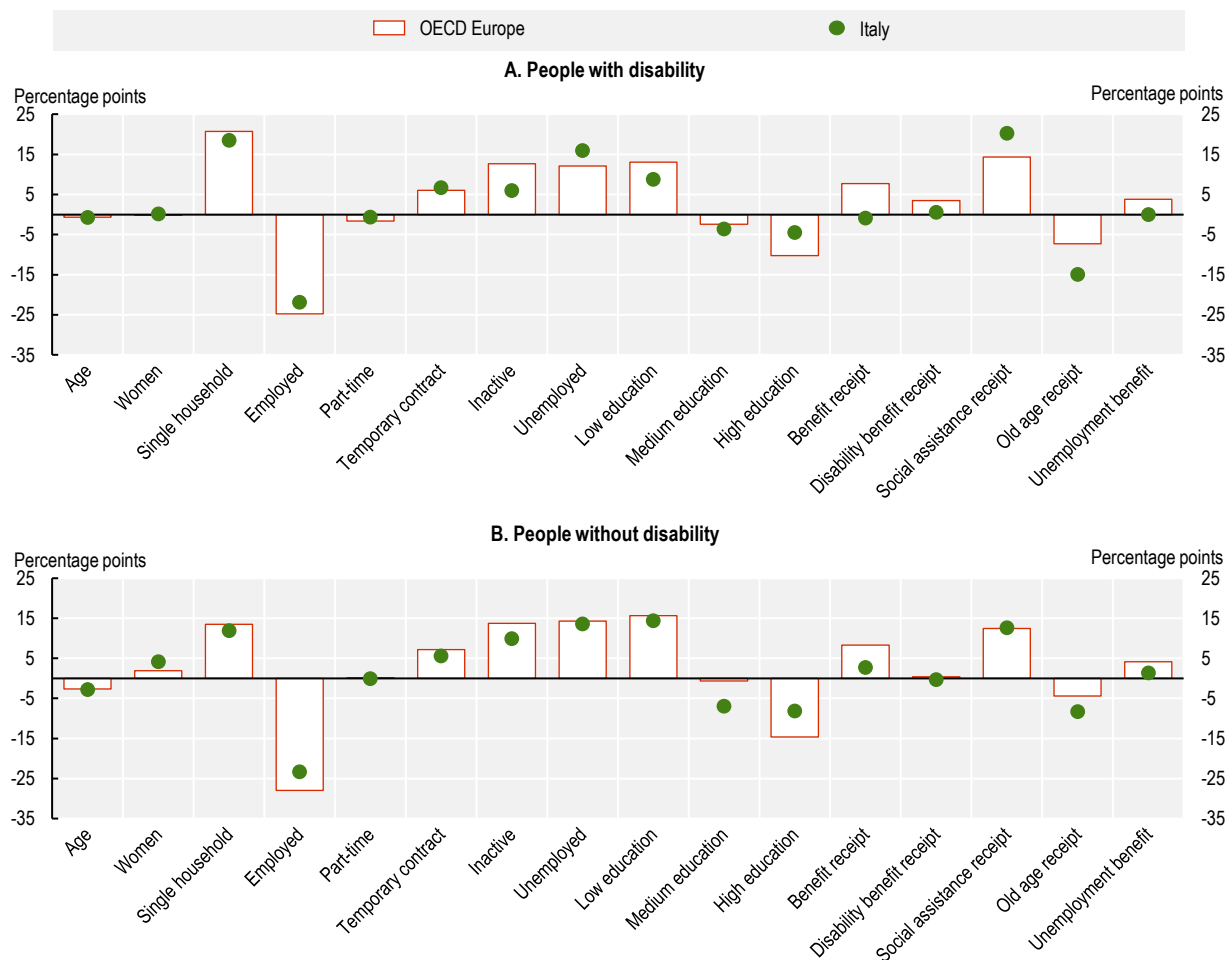
Source: OECD calculations based on European Union Statistics on Income and Living Conditions (EU-SILC, 2005-21) for European countries, the Household, Income and Labour Dynamics in Australia Survey (HILDA, 2005-17), the Canadian Income Survey (CIS, 2013-19) provided by Employment and Social Development Canada, Chile's Encuesta de Caracterización Socio-económica Nacional (CASEN, 2006-17), Mexico's Encuesta Nacional de Ingresos y Gastos de los Hogares (ENIGH, 2010-16), the Korean Labour and Income Panel Study (KLIPS, 2008-18) and the American Community Survey (ACS, 2008-18).

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Both in Italy and on average across OECD Europe, people living in poor households tend to be more often single, inactive or unemployed, and with low level of educational attainment and, if in work, more likely to have a temporary employment contract (Figure 1.2). This characterisation of poor households holds true for both people with and without disability, for both Italy and on average (Panel A compared to Panel B). In fact, socio-economic poverty differentials appear more pronounced for people without disability, reflecting the poverty alleviating role of social protection systems particularly for people with disability.


## Figure 1.2. People living in poor households tend to be single, jobless and poorly educated

Difference between poor and non-poor households by presence of a household member with disability, OECD Europe, average over 2018-21



Note: The bars represent the weighted average of 26 European countries: Austria, Belgium, the Czech Republic (Czechia), Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, the Netherlands, Norway, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Sweden, Switzerland and the United Kingdom.

Source: OECD calculations based on European Union Statistics on Income and Living Conditions (EU-SILC).

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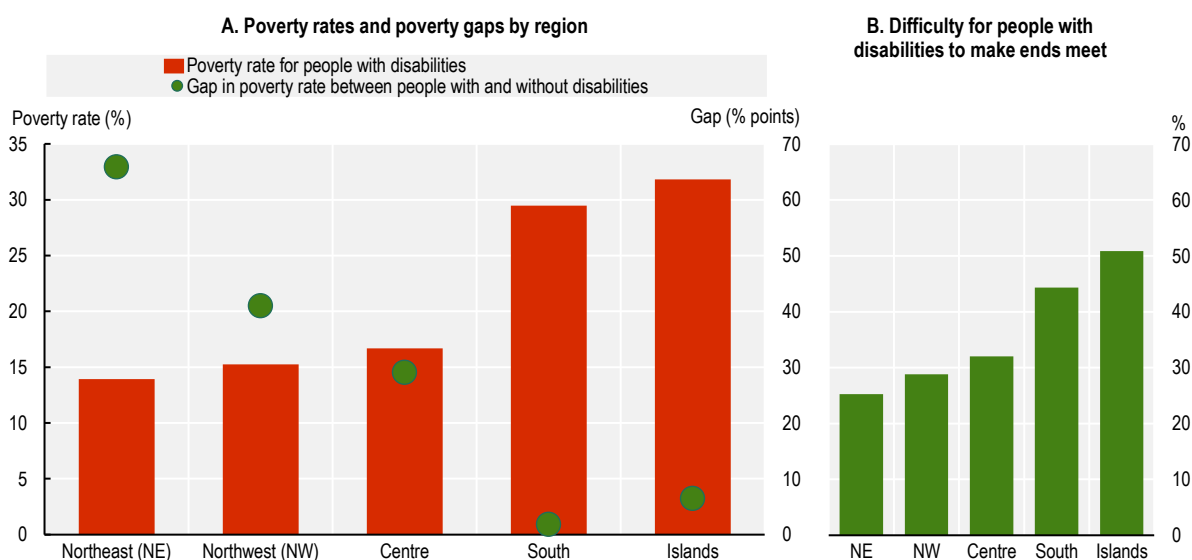
Regional differences in poverty risks are very large in Italy. Household survey data do not allow to look at regions, but only at broad regional areas at the NUTS-3 level (North-East, North-West, Centre, South and Islands). This regional split is meaningful, however, as it captures much of the regional differences in terms of wealth, labour market outcomes, and productivity. Figure 1.3 shows regional area poverty rates for people with disability and the gap in poverty rates between people with and without disability (Panel A). Poverty rates for people with disability in Southern regions and in the Islands are more than twice that of Northern and central regions. The gap in poverty between people with and without disability follows the opposite pattern, however: it is largest in Northern and central regions, and smallest in the South and the Islands. Or, in regions where poverty is high overall differences by disability are small, and vice versa when the overall poverty risk is low. These differences, again, also relate to the potential impact of social

protection: it can lead to large absolute alleviation of poverty in poorer regions, while the effects act at the margin of closing the disability gap in regions with lower overall poverty.


Figure 1.3 also shows the share of people with disability who make ends meet with difficulty (Panel B), possibly a more robust measure of poverty. As poverty rates are calculated based on a national poverty line, poverty could be underestimated in the North of the country, where the cost of living is higher, while it could be overestimated in the South. Differences between regions indeed appear to be smaller when looking at the difficulty to make ends meet, with that share ranging from 25% of all people with disability in the North-East to about 50% on the Islands. The high shares across the country demonstrate the importance of universal access to social protection for people with disability, complemented with strong efforts to sustain better employment outcomes as the main path towards self-sufficiency.

### Figure 1.3. Disability poverty risks and gaps differ remarkably across Italy

Selected poverty indicators averaged over the period 2018-21, by broad region



Source: OECD calculations based on European Union Statistics on Income and Living Conditions (EU-SILC).

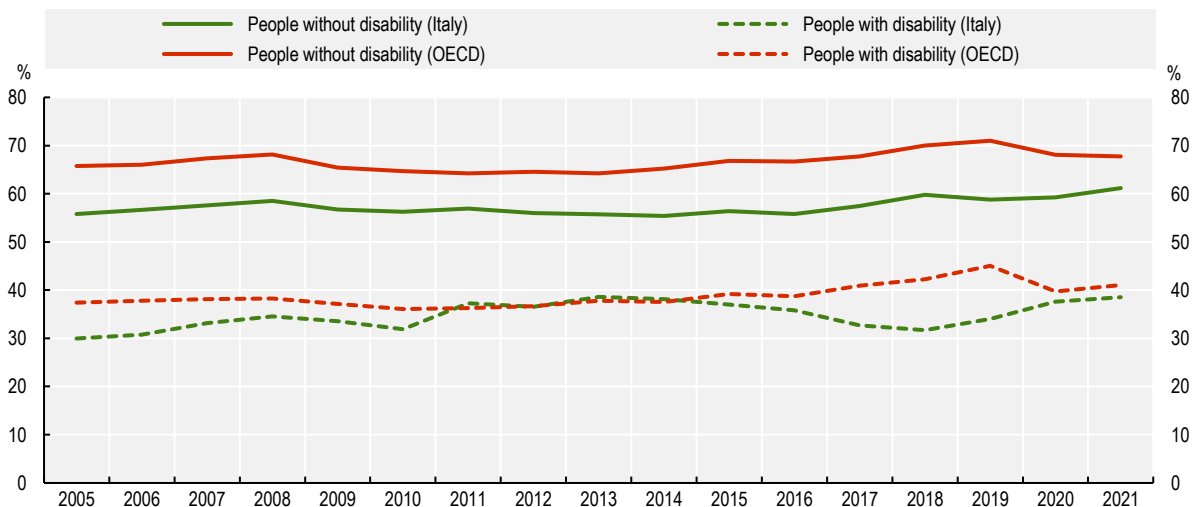
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## 1.2. Employment prospects of people with disability may not allow for economic self-sufficiency

Employment rates are generally very low in Italy, for both people with and without disability (Figure 1.4). Echoing the poverty findings, people without disability in Italy have employment rates that are much lower than the OECD average, whereas the disability employment gap, i.e. the difference in employment rates between people with and without disability, is below the OECD average. The employment rate of people with disability fell over the past few years, however, quickly widening the gap to the employment rate of people without disability. Decreasing employment rates for people with disability since around 2014 seem to explain the increase in the poverty risk of people with disability in the years before the pandemic.

## Figure 1.4. Employment rates are low in Italy and the disability employment gap is widening

Trends in the employment rate of people (aged 15-69) with and without disability in Italy and OECD



Note: OECD is the unweighted average of 32 member countries and excludes Colombia, Costa Rica, Israel, Japan, New Zealand and Türkiye. Source: OECD calculations based on European Union Statistics on Income and Living Conditions (EU-SILC, 2005-19) for European countries, the Household, Income & Labour Dynamics in Australia Survey (HILDA, 2005-17), the Canadian Income Survey (CIS, 2013-19) provided by Employment and Social Development Canada, Chile's Encuesta de Caracterización Socio-económica Nacional (CASEN, 2006-17), Mexico's Encuesta Nacional de Ingresos y Gastos de los Hogares (ENIGH, 2010-16), the Korean Labour and Income Panel Study (2008-18) and the US Current Population Survey (2007-18).

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In addition to employment rates, understanding job quality characteristics of people with disability is essential to fully understand the labour market context they face. Table 1.1 shows a range of labour market outcomes for people with and without disability (including resulting disability gaps) for Italy and on average across OECD Europe. Labour market indicators and disability gaps are comparable between Italy and the OECD average, with inactivity being relatively slightly higher among people with disability in Italy, and employment and unemployment slightly lower. Other outcomes include the type of employment contract, firm size, and job and earnings quality characteristics. Findings are as follows:

- People with disability tend to work more often in temporary and part-time jobs, both in Italy and on average across OECD Europe. Part-time employment, however, is relatively lower among people with disability in Italy than on average, which can be the result of social protection regulations that disincentivise work, or a lack of overall demand for part-time work, or both.
- Italian workers with disability tend to work more often in larger firms and less often in micro and small firms than workers without disability. These differences are larger than on average across OECD Europe. The under-representation of workers with disability in small firms in Italy is possibly related to the strong disability quota system in Italy, which imposes substantial obligations to hire people with disability for large firms.
- Earnings quality is higher in Italy than on average for both people with and without disability: the share earning low and very low pay is lower, and so is the disability earnings gap. The quality of the working environment, which is proxied by the incidence of long working hours, is also higher for both groups in Italy than on average.



**Table 1.1. Labour market indicators and disability gaps are comparable between Italy and the OECD European average**

Main labour market outcomes of people with and without disability in Italy and on average across OECD Europe, 2018-21

	Italy			OECD Europe		
	PWD (%)	PWoD (%)	Gap	PWD (%)	PWoD (%)	Gap
<b>Labour market indicators</b>						
Employment rate	36.0	60.1	24.1	40.6	66.7	26.0
Unemployment rate	8.2	9.5	1.3	9.5	6.8	-2.7
Inactivity rate	55.8	30.4	-25.4	49.9	26.5	-23.3
<b>Type of contracts</b>						
Self-employment	22.2	22.0	-0.2	14.1	13.7	-0.4
Temporary employment	27.5	18.1	-9.4	26.6	16.9	-9.6
Part-time employment	10.7	8.9	-1.8	15.0	8.9	-6.2
<b>Firm size</b>						
Share working in micro firms	23.6	28.1	4.5	22.9	22.8	-0.1
Share working in small firms	19.1	21.3	2.2	20.6	20.8	0.2
Share working in medium and large firms	21.2	18.0	-3.2	33.1	31.6	-1.4
<b>Job and earnings quality</b>						
Share receiving low pay (< 2/3 median hourly wage)	22.7	21.7	-1.0	29.5	22.2	-7.3
Share receiving very low pay (< 1/3 median hourly wage)	7.4	8.2	0.9	11.8	8.8	-3.0
Share working long hours (> 60 hours/week)	1.5	1.5	0.0	3.4	3.5	0.1

PWD: People with disability, PWoD: People without disability.

Note: OECD Europe represents the weighted average of 26 European countries: Austria, Belgium, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, the Netherlands, Norway, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Sweden, Switzerland and the United Kingdom.

Source: OECD calculations based on European Union Statistics on Income and Living Conditions (EU-SILC).

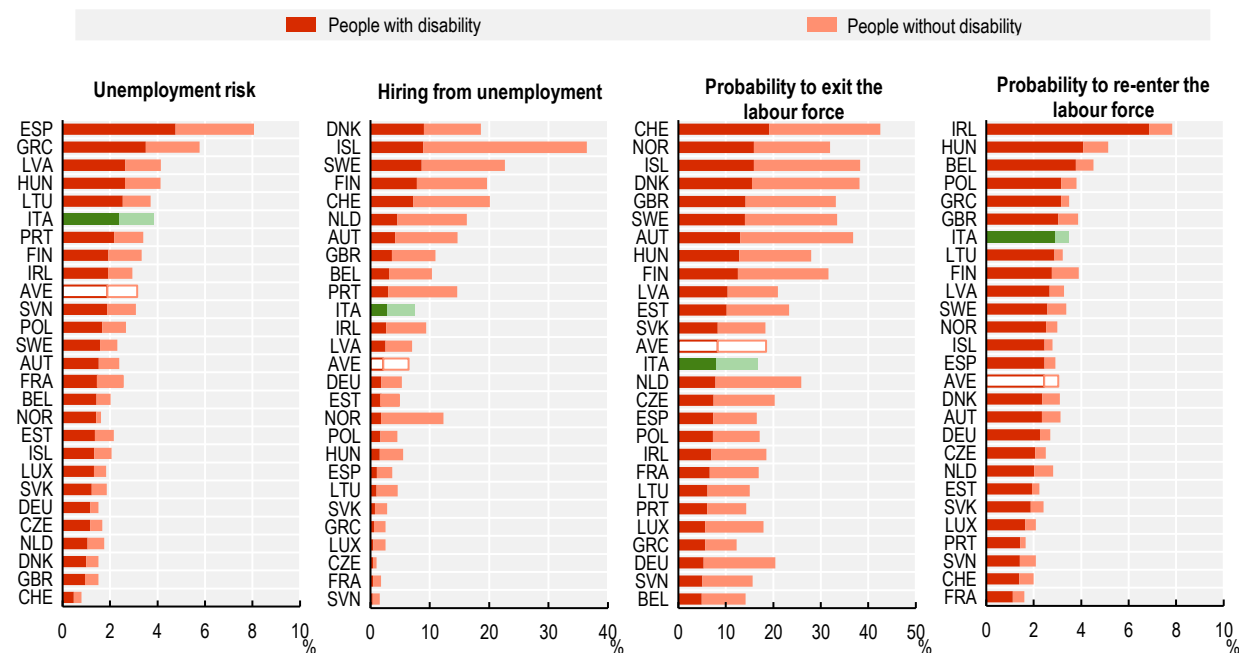
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People with disability in Italy face a high risk of unemployment (Figure 1.5), higher than for people without disability, although comparable to the OECD European average. Some countries stand out in terms of excess unemployment risk for people with disability, like Norway and Germany, but in most countries, including Italy, people with disability face a 40% higher risk of unemployment. At the same time, they also face a lower probability of being hired once they are unemployed, implying a higher risk of long-term unemployment for people with disability.

In Italy, people with disability face a risk of leaving the labour market that is comparable to people without disability (Figure 1.5). For both groups, the risk of exiting the labour market is comparable to the OECD European average. On the other hand, the probability to re-enter the labour force is relatively higher in Italy for people with disability, suggesting that exits from the labour force might often be temporary. These results need to be interpreted with caution, however. They represent observed transitions between states (unemployment, employment, labour force), meaning that comparisons across countries and between people with and without disability could be biased. On the one hand, there are potential misclassification errors, as survey respondents may frequently misclassify unemployment and inactivity (Samaniego de la Parra and Viegelahn, 2021<sup>[1]</sup>). This misclassification is even more likely in the case of people with disability because disability also fluctuates substantially over time. On the other hand, different countries have different labour market dynamism and thus different rates of transition between unemployment, employment, and inactivity. Different countries also have different requirements for people receiving disability benefits. In some countries, disability benefit recipients must register with the Public Employment Service as being unemployed. In other countries, disability benefit recipients are not allowed to work and classified as inactive. All these nuances make cross-country comparisons in labour market transitions difficult.

### Figure 1.5. People with disability in Italy face a higher risk of unemployment than on average across OECD European countries

Probabilities to become unemployed, to be hired from unemployment, to exit the labour force and to re-enter the labour force, 2012-20



Note: The white bars represent the weighted average of 26 European countries shown in the panels.

Source: OECD calculations based on the longitudinal European Union Statistics on Income and Living Conditions (EU-SILC).

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Overall, this chapter finds that in Italy poverty and labour market outcomes are quite similar for people with disability and people without disability, more similar than in many other OECD European countries. This is the result of two effects: first, people *without* disability generally have poorer outcomes in Italy than in other OECD European countries, and second, people with disability in Italy face outcomes comparable to those of people with disability on average. In relative terms, people with disability in Italy therefore appear to be faring better. What does this mean in terms of social protection needs and effectiveness? It could mean that people with disability meet a social protection system that is well placed to prevent poverty without jeopardising labour market outcomes. However, it could also mean that people with disability receive more informal support from their family than people without disability and thus require less state support.

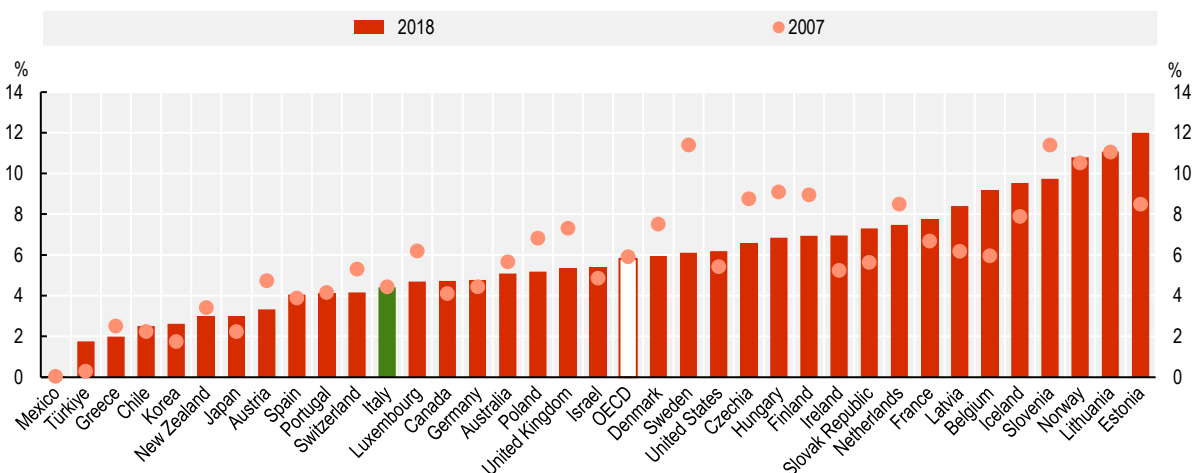
### 1.3. Disability benefits provide income to many but may lower their employment

Over 4% of the Italian working-age population receives disability-type benefits (Figure 1.6). This share is below the OECD average of 6% of the working-age population but comparable to other Southern European countries (Spain and Portugal) and countries like Switzerland and Germany. Generally, across the OECD, however, there is substantial variation in the share of disability beneficiaries, ranging from 0.5% of the working-age population in Mexico, to 12% in Estonia. Over the last decade, the share receiving disability benefits has remained stable in Italy. Again, there is substantial variation across OECD countries in the change of this share over time. Some countries experienced decreases of more than 2 percentage points, like the Czechia, Hungary and Sweden. Others saw an increase in this share, including Belgium, Estonia,

Iceland, Ireland, Latvia and the Slovak Republic. These countries have experienced substantial increases in the disability receipt rate of over 1.5 percentage points.

### Figure 1.6. Over 4% of the Italian working-age population receives disability-type benefits

Share of beneficiaries of the disability system over working-age population, latest data available



Note: Disability benefit receipt over population aged 20-64. Disability benefits include contributory and non-contributory programmes specifically targeted to people with disability, including transitional disability programmes. OECD is an unweighted average excluding Colombia and Costa Rica. Data for 2007 refer to 2009 (Chile) and 2018 refer to 2016 (Estonia, Germany, the United States). For Italy, data include the contributory disability benefit programme (Pensione/Assegno di invalidità previdenziale ordinaria), the non-contributory disability benefit programme (Pensione/Assegno di inabilità per invalidi civili), and the early retirement programme for people with disability (Pensione Sociale). Source: OECD (2022<sup>[2]</sup>), *Disability, Work and Inclusion: Mainstreaming in All Policies and Practices*, <https://doi.org/10.1787/1eaa5e9c-en>, Figure 4.1. Data for Italy has been updated using the Eurostat dataset Pensions beneficiaries at 31 December [SPR\_PNS\_BEN].

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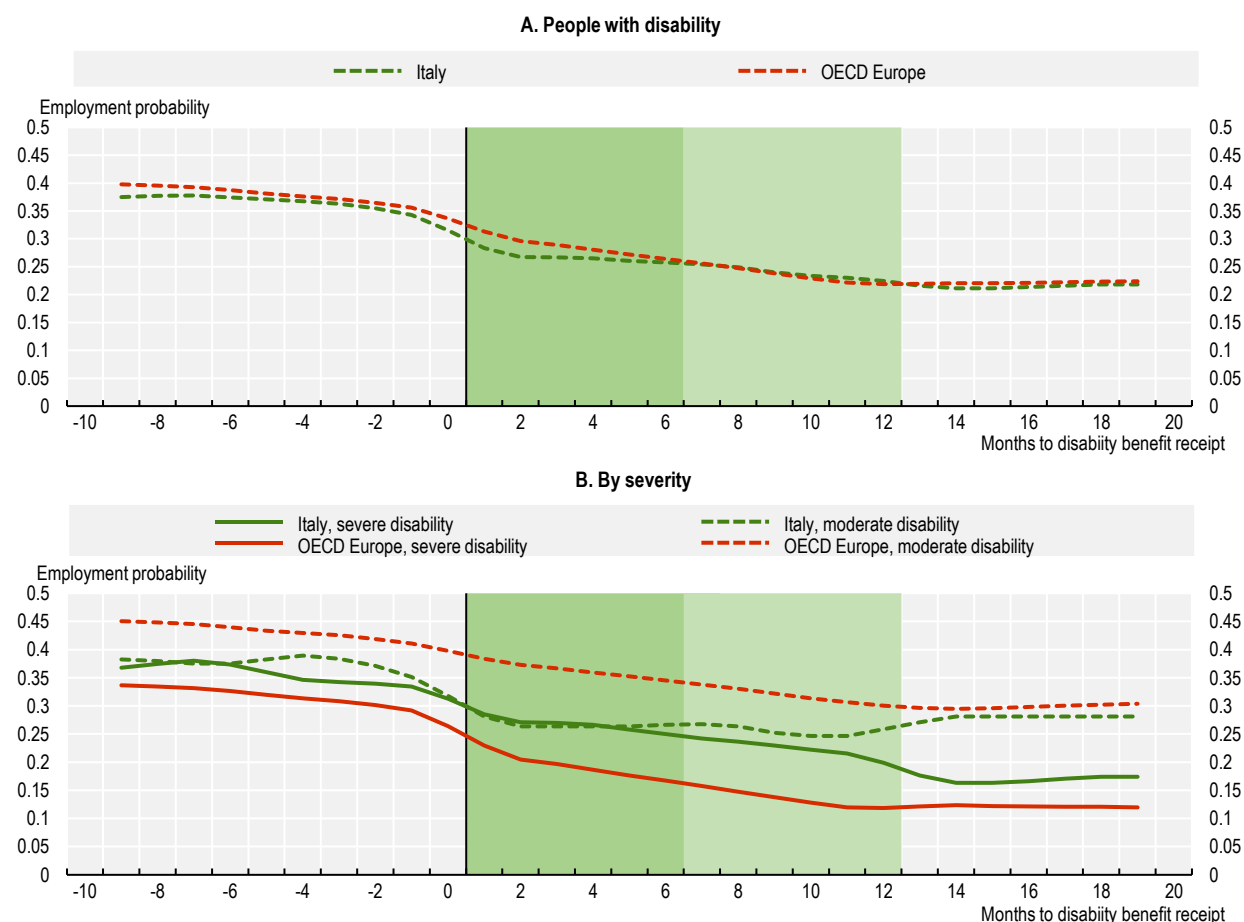
Like in most OECD countries, disability benefit receipt prompts a decline in employment rates in Italy, although comparatively more so for people with moderate disability. It is a well-established fact that the receipt of disability benefit (or in fact any benefit) can discourage work (Autor and Duggan, 2006<sup>[3]</sup>; Maestas, Mullen and Strand, 2021<sup>[4]</sup>; Ruh and Staubli, 2019<sup>[5]</sup>). The extent of the decline in employment can reflect the disincentives to work that the social protection system creates. Figure 1.7, Panel A shows the employment rate in the months leading to and following disability benefit receipt for people with disability in Italy and on average across the OECD. The employment rate of people with disability is slightly lower for people with disability in Italy than on average in the OECD even before the receipt of disability benefits. Differences are quite small, however, consistent with Figure 1.4 shown earlier. Figure 1.7 shows that the moment of disability benefit receipt is associated with a drop in employment. This drop is of similar size in Italy and on average across the OECD but slightly smaller in Italy, since the average OECD employment rate of people with disability converges to that of Italian people with disability in the months following disability benefit receipt.

Interestingly, the drop in employment appears to be relatively larger for people with moderate disability in Italy (Figure 1.7, Panel B). On average across OECD Europe, the receipt of disability benefits does not cause a drop in the employment rate among people with moderate disability, who seem to experience a rather continuous decline in the employment rate. This is consistent with the observation that disability may become more invalidating as time passes, or their labour market detachment may become stronger, making it more difficult to continue engaging in employment. The additional impact of benefit receipt seems muted in comparison with this continuous trend, suggesting a limited impact on employment from benefit

receipt. This is not the case in Italy, where the employment rate of people with moderate and severe disability drops the moment disability benefits are granted. Many reasons can be at play here, including as one explanation that disability benefits may have relatively larger disincentives to work for people with moderate disability in Italy than on average across OECD Europe.

### Figure 1.7. Disability benefit receipt prompts a decline in employment rates also in Italy, and more so for people with moderate disability

Employment probability around the months to disability benefit receipt, 2010-20



Note: Data are pooled for 2010 to 2020 on the months relative to the start of disability benefit receipt. As the precise month of the start of benefit receipt is unknown in the survey, it is assumed to start in January of any given year (solid line) for people reporting to receive benefits in the given year but not in the year before. Effectively, however, benefit receipt can start at any point during that year (area shaded in green). Benefit receipt most likely occurs within the first six months given that close to 80% of the surveys are conducted in the first two quarters of any given year. Employment probability is calculated using the monthly labour market status indicator from the labour force survey component of the survey. OECD Europe is the weighted average of 26 European countries: Austria, Belgium, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, the Netherlands, Norway, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Sweden, Switzerland and the United Kingdom.

Source: OECD calculations based on European Union Statistics on Income and Living Conditions (EU-SILC).

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Using self-assessed information on disability status, this chapter suggests that people with disability in Italy experience relatively low poverty rates, although their employment prospects may not allow for economic self-sufficiency. One critical link between these two findings is the disability benefit system: a substantial share of people in working age are receiving disability benefits in Italy, as elsewhere, which could be generating disincentives to work particularly for people with moderate disability. Understanding the social protection system is essential to understand how these factors interact and to answer essential questions on the functioning of the system for people with disability.

## References

- Autor, D. and M. Duggan (2006), “The Growth in the Social Security Disability Rolls: A Fiscal Crisis Unfolding”, *Journal of Economic Perspectives*, Vol. 20/3, pp. 71-96, <https://doi.org/10.1257/JEP.20.3.71>. [3]
- Maestas, N., K. Mullen and A. Strand (2021), “The effect of economic conditions on the disability insurance program: Evidence from the great recession”, *Journal of Public Economics*, Vol. 199, p. 104410, <https://doi.org/10.1016/J.JPUBECO.2021.104410>. [4]
- OECD (2022), *Disability, Work and Inclusion: Mainstreaming in All Policies and Practices*, OECD Publishing, Paris, <https://doi.org/10.1787/1eaa5e9c-en>. [2]
- Ruh, P. and S. Staubli (2019), “Financial Incentives and Earnings of Disability Insurance Recipients: Evidence from a Notch Design”, *American Economic Journal: Economic Policy*, Vol. 11(2), pp. 269-300, <https://doi.org/10.1257/pol.20160076>. [5]
- Samaniego de la Parra, B. and C. Viegelahn (2021), “Estimating labour market transitions from labour force surveys: The case of Viet Nam”, ILO. [1]

## 2 Disability status assessments and needs assessments in Italy

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This chapter describes and interprets disability assessments in place in Italy and its regions to determine eligibility for various national, regional, and municipal disability benefits and services. The report focuses on the situation in four regions: Campania, Lombardy, the Autonomous Region Sardinia, and the Autonomous Province of Trento. Disability assessment in Italy is highly fragmented by type of support and guided by layered pieces of legislation. Disability status assessments are medically oriented and discretionary, lacking technical and methodological guidelines and a scientific tool with strong psychometric properties. There is also no transparent link between the various disability status assessments (used for entitlement to national benefits) and the needs assessments (used for entitlement to municipal services). Current assessment practices in Italy diverge from the principles established by the Convention on the Rights of Persons with Disabilities (CRPD) and result in a lack of equitable support for, and inclusion of, people with disability.

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This chapter discusses the many disability assessment procedures currently in force in Italy and its regions. Outdated legislation affects Italy's ability to recognise functioning capacities of people with disability, provide adequate support and develop inclusive policies across sectors, such as social protection, labour, education, and health. In the absence of up-to-date national reference legislation, regions have adopted their own approaches, further contributing to large differences across the country in the number of people receiving and identified as needing support. The chapter focusses on four regions – Campania Region, Lombardy Region, the Autonomous Region Sardinia (henceforth, Sardinia) and the Autonomous Province of Trento (henceforth, Trentino) – which reflect the large geographic and governance variance across Italy.

## 2.1. Introduction

In the past 15 years, across the world the assessment of a person's disability status has been increasingly shaped by the Convention on the Rights of Persons with Disabilities (CRPD)<sup>1</sup>, adopted by the United Nations (UN) Assembly in 2006 and ratified by Italy in 2009. The treaty characterises people with disability as “those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”. A main feature of this characterisation of disability is the distinction it makes between people with impairments (i.e. problems at the body level) and barriers people face in interacting with their own environment (i.e. problems in performing activities because of underlying health conditions), and the emphasis it places on the latter in giving rise to disability. Such a strong emphasis on the actual experience of disability is not fully reflected in the disability assessment practices of many OECD countries yet, however. Concerns with the lack of attention to environmental factors and a strong focus on individual impairments have been repeatedly voiced by the UN Committee on the Rights of Persons with Disabilities, in its evaluations of State parties (United Nations, 2011<sup>[1]</sup>). This is usually the case for status assessment practices that rely on medical criteria, which are prone to an individualised approach and a de-contextualisation of disability.

A parallel driver of change in disability assessment policy and practice over the last few years has been the dissemination of the International Classification of Functioning, Disability and Health (shorthand, ICF),<sup>2</sup> an epidemiological classification instrument developed by the World Health Organization (WHO) that reflects the shift beyond elements of body impairment, to activity limitations and participation restrictions, which are reflective of the interaction of a person's impairment and her or his environment. ICF makes a distinction between *the intrinsic capacity*, which reflects the expected ability of a person to perform activities considering their health condition and impairment, and *performance*, which reflects the actual performance of activities in the real-world environmental circumstances in which the person lives. Information about capacity typically represents the result of a clinical inference or judgment based on clinical data, while performance is a true description of what actually occurs in a person's life. Based on a “bio-psycho-social”, or interactional, understanding of disability, assessment should adopt the latter performance perspective. To collect information of people's performance and measure disability as understood by ICF, the WHO has developed and extensively empirically tested a Disability Assessment Schedule, the WHODAS tool. It consists of a set of questions in six basic ICF functioning domains (cognition, mobility, self-care, getting along with people, life activities, participation), which allow capturing the performance of activities by an individual in his or her daily life and the actual environment. In being aligned with ICF, and with the vision of the CPRD, WHODAS has a role to play in the modernisation of disability assessment practices needed in several countries to better reflect the person-environment interaction.

## 2.2. A highly fragmented legal landscape

Disability status assessment in Italy today, especially the assessment of civil invalidity, does not yet reflect the characterisation of disability used in the CRPD and reflected in ICF. In addition, the system in Italy is complex and fragmented. The fragmentation of the assessment of disability in Italy is partly explained by the historical evolution of the various pieces of legislation that laid the ground for such assessment. Basic knowledge of these laws and the institutions applying them is a requirement to further understand the different disability statuses that can be attributed to people with disability, as well as the corresponding assessment procedures that coexist and sometimes overlap (see below). The fragmentation of disability status assessments in Italy creates a system that is inefficient, difficult to navigate, and failing to ensure equality across people and regions.

The national legal framework on disability is anchored in the Italian Constitution (1948). However, law 118/1971, which establishes the concept of civil invalidity (*invalidità civile*), also constitutes a pillar. People with civil invalidity are those who, due to a physical or mental, congenital, or acquired disorder, either have persistent difficulties in carrying out the tasks and functions specific to their age when they are under age 18 or over age 65 (1); or, have undergone a permanent reduction in working capacity of more than a third, when of working age (18 to 65 years) (2). Additionally, applicants that are unable to perform the essential acts of daily life or to walk also fall in this group (3). Qualifying for civil invalidity is a key requirement for people with disability to access economic benefits, with the assessment process being jointly managed by the National Social Security Institute (*Istituto Nazionale della Previdenza Sociale – INPS*) and the local health authorities. Entitlement to different benefits is related to the percentage of disability assigned through the assessment of civil invalidity.

Importantly, some exceptions apply to those who can qualify for civil invalidity status under law 118/1971, further attesting to the fragmentation of the legal framework. Blind and deaf people are strictly speaking not people with civil invalidity, because their disability status and benefits are regulated by different legal provisions. Law 381/1970 defines deaf individuals as those with congenital deafness or deafness acquired during developmental age (under 12 years), preventing them from the normal learning of spoken language. Law 382/1970 defines civil blinds as those that are totally blind (no residual vision or residual “binocular perimetric” visual field below 3%) (a) or partially blind (residual vision that does not exceed 1/20 with possible correction, in both eyes or a reduction of the visual field below 10%), (b) Law 107/2010 was introduced at a later stage to define the concept of deafness-blindness, mostly based on a combination of the above definitions. These laws also establish specific economic benefits to support impaired individuals, and the details of the assessment process, which shares the institutional context and most steps with that for civil invalidity. However, the number of individuals going through the assessments for deafness, blindness and deafness-blindness is small compared to the number of assessments for civil invalidity. Moreover, people with hearing or vision impairment not qualifying for deafness and blindness will also have to undergo the regular assessment for civil invalidity.

A second group of exceptions relates to individuals who do not qualify for civil invalidity because their disability arose in an occupational context. Laws 1 124/1965 and 38/2000 establish occupational diseases and work accidents to be considered in assessing work invalidity (*invalidità da lavoro*), through a process that is under the responsibility of the National Institute for Insurance against Accidents at Work (*Istituto Nazionale Assicurazione Infortuni sul Lavoro – INAIL*). Disability obtained in war-related settings is also regulated by separate legal provisions, which correspond to different designations including civilian invalids of war (*invalidi civili di guerra*) – laws 539/1950 and 142/1953, war invalids (*invalidi di guerra*) – law 367/1963, and war civil invalids (*invalidi per causa di servizio*) – law 214/2011). The different disability statuses correspond to different pensions and allowances, with the Ministry of Economy and Finance being the responsible authority for all war and military related pensions.

Last, and although not mutually exclusive with civil invalidity, there is an alternative system to obtain economic support in the context of disability, which applies only to those persons with a recent work history



and a record in contribution payments to social security. This contributory insurance system encompasses an additional legal complexity, as disability definitions and assessment procedures differ considerably depending on whether applicants were private-sector employees or self-employed (law 222/1984), or civil servants (law 335/1995).

Furthermore, and while most of the definitions described above work as alternatives to each other in the context of economic support, two other key disability-related laws were adopted later in time, to complement the portfolio of available support. These laws created additional disability statuses that are cumulative to the definitions described above, meaning that people with disability can apply for them regardless of whether they have also been assessed for civil invalidity, blindness or deafness, work/war (military) disability or disability in the context of the contributory insurance system:

- Law 104/1992 introduced the concept of “handicap”, which grants access to a range of benefits ranging from cost-sharing exemptions in healthcare to tax allowances and rights for family members, among others (see also Table 2.1). One essential difference from the definitions above is that the concept of handicap goes beyond the individualised and medical approach to disability, with more focus on the social context. It moves from only looking at the diseases/disorders and related impairments, to considering (1) how these result in limitations in performing activities and social participation, and (2) how such limitations entail a disadvantage in the social context. More specifically, law 104/1992 defines a handicap as a physical, mental, or sensory impairment, either stable or progressive, that causes learning, relational or work integration difficulties and as such is determining a process of social disadvantage or marginalisation. The law establishes two levels of handicap: an ordinary and a severe one. Individuals are attributed a severe handicap status when the single or multiple impairments that reduce their personal autonomy – compared to what is normal for the respective age group – lead to a need to receive permanent, continuous, and comprehensive assistance, either in the context of their individual tasks or when relating to others.

**Table 2.1. Benefits accessed through the assessment of civil invalidity, blindness, and deafness**

	Assessment with regards to	Age	Output	Benefits
Civil invalidity	Reduction of the residual working capacity	18 to 64 years old	= 67% (+ handicap) = 74% 100%	Choice of office location for successful candidates to public jobs; preference when applying for transfer to another office Disability allowance; two months of notional contribution for each year (max five years) Disability pension
	Persistent difficulty in carrying out tasks and functions specific to their age	Under 18 years or over 65 years	= 34% > 60% = 67% > 70% 100%	Prostheses and technical aids; free healthcare; tax breaks Social housing Subsides on public transport card; Health ticket exemption Exemption for criminal convictions of up to three years Exemption from co-payments for health treatments; Free transport card
	Unable to perform essential activities of daily life or to walk	No limits	100%	Attendance allowance
Civil blindness	Total or partial blindness (binding)	No limits	Yes/No	Prostheses and aids; Exemption from co-payments for health treatments; Free transport card
Deafness	Congenital deafness or deafness acquired in developmental age	No limits	Yes/No	Prostheses and aids; Exemption from co-payments for health treatments; Free transport card; two months of notional contribution for each year (max five years)

Note: for individuals below 18 years old the assessment does also consider whether the applicant has persistent difficulties in carrying out the tasks and functions specific to their age, but no percentage is attributed.

Source: Author's compilation.

- Law 68/1999 was introduced to promote the access to work of people with disability through support services and targeted placement, promoted by a disability employment quota. Disability in the context of this law is designated as *disabilità*, even though it is only one of the multiple disability statuses described in this section. In fact, disability for employment support does not have its own independent definition and specific assessment, as it is granted to those qualifying for civil invalidity (46% or more), blindness or deafness, work disability (33% or more) or war disability.

As for civil invalidity, blindness and deafness, the assessments of handicap and disability for employment support are also jointly co-ordinated by INPS and the local health agencies. These five concepts, which coexist under the non-contributory support system and are all an assessment of disability status, are also commonly referred to in Italy as baseline or first-level assessments. Such designation differentiates them from a second set of assessments that occur mostly at the regional or municipal level, to match the needs of people with disability to the existing support services (thus, also referred to as needs assessments).

The 2021 Enabling Act (Law 227/2021) provides the legal basis for a revision of the definition of disability and the corresponding assessment system, embracing the principles of the CRPD and compliant with the ICF. Thus, disability status assessments would no longer be guided by medico-legal criteria only, but would also assess the person's functioning, preparing the ground for stronger social participation. The Enabling Act, already mentioned in the Foreword of this report, also stipulates a unification of the different disability status assessment procedures in place, to address the fragmentation in disability legislation. The renewed disability status or baseline assessment would continue to determine eligibility for allowances, tax reliefs, and other benefits for people with disability, and could potentially be followed, at the person's request, by a multidimensional assessment used to determine an individualised, personalised, and participatory life plan, which would entitle them to a set of social and health services.

### 2.3. Several disability status assessments exist in parallel

Several definitions of disability co-exist in Italy, including those that correspond to the baseline or disability status assessments: civil invalidity, blindness, deafness, handicap, and disability for employment support. Although each of these five definitions corresponds to a different determination, described in detail in the following, they share some common aspects in the assessment process and implementation. The process followed by the baseline assessments consists mostly of three phases, in which INPS and the local health authorities alternate the level of involvement and lead. The specific responsibilities of INPS and the local health authorities in the process were modified in 2010 (law 102/2009), as part of a general process of decentralisation, thereby reinforcing the role of the former in several steps of the pathway.

General practitioners (GPs) are the starting point to apply for disability status assessments in Italy. Persons with a health impairment seeking a certification for disability (broadly defined) should turn to their GP, who in turn will orient the patient and prescribe the medical examinations necessary to certify the conditions that impair the applicant's functioning. These medical examinations can be conducted by any certified doctor, i.e. almost all practitioners in Italy – from those employed by local health authorities such as primary care physicians (*medico di assistenza primaria*) to freelance doctors working for the National Health Service. The person's GP should review the examinations and complete an introductory medical certificate (*certificato medico introduttivo*) on an online INPS platform.

The introductory medical certificate (form AP70) is an important element in the disability status assessment procedure, mostly because of the strong medical focus of disability determinations in Italy. GPs, therefore, play a key gatekeeping role in disability assessment, deciding the content of medical examinations and suggesting who should conduct them. This is similar in many other OECD countries, but the GP's medical documentation plays a very significant role in Italy in the formulation of the diagnosis and (sometimes) the functional evaluation and, thus, the resulting civil invalidity percentage of the person due to limited time and resources available by those assessing the disability status.

Following the completion of the introductory medical certificate, which produces a code valid for 30 or 90 days, the next step is taken by electronically applying to INPS using this code and specifying the different definitions of disability (e.g. civil invalidity and/or handicap and/or disability for employment) the applicant would like to be assessed for. The application can be done by the person with disability or a family member, very often with the support of associations of patients specific to the applicant's medical condition.

This second part of the process is under the oversight of the local health authorities, who electronically receive the information in the application and deal with administrative tasks such as booking an appointment with the medico-legal commission and inviting the applicant. The medico-legal commission meeting is the main event in the assessment procedure, and it should include the physical presence of the applicant. Importantly, and although differences exist across localities in the composition of the commission and in the criteria and tools used (see below), a medico-legal commission might conduct three baseline assessments at the same time: civil invalidity (or blindness/deafness, as the case may be), handicap, and disability for employment support, with only one meeting with the commission (with slightly deviating procedures across regions). How exactly the commission translates the clinical information into a civil invalidity percentage, is not very clear nor transparent but it has similarity with a *barema* method through which a set percentage of invalidity is attributed to a given diagnosis; a method that is based on experience but lacks scientific validity and reliability. Following the meeting with the commission and its decision, the local health authority completes the administrative process and sends relevant information and the proposed percentage of civil invalidity to INPS.

The last part of the process is the responsibility of INPS, which validates the outcome of the medico-legal commission and takes a final decision. When in agreement with the decision of the commission, INPS will communicate it to the applicant and set in motion additional eligibility testing steps needed to grant the benefits to which the applicant might be entitled, namely collecting socio-economic and income data necessary for means-testing associated with some of the disability payments. In cases where INPS disagrees with the outcome of the medico-legal commission, the application is put on hold for further investigation. Such investigation might happen based on the information already collected or require an additional assessment of the applicant. Although quantitative data is not available, anecdotal evidence describes the validation step by INPS as an important milestone of disability status assessments, with a considerable proportion of applications being put on hold for further investigation, mostly in what concerns high degrees of civil invalidity. This additional investigation has implications for the duration of the overall process, as it generally delays the decision by several months and might also require one more visit by the applicant for assessment purposes. Therefore, several measures have been introduced in the past decade with the objective of reducing the proportion of assessments put on hold by INPS.

Law 102/2009 introduced the participation of an INPS doctor in the medico-legal commissions, which should contribute to a better alignment between the decision by the commission and its validation by INPS. More recently, in response to the COVID-19 pandemic, INPS has also established the formal concept of a documentation-based assessment, which allows the additional collection of information for the verification procedure without requiring the applicant to appear once more before the commission. The success of these measures in streamlining the last part of the baseline assessments cannot be evaluated with the available data. However, information from field interviews suggests that the actual implementation of these efforts might be limited, due to the rare participation of INPS doctors in the medico-legal commissions. The final decision by INPS is not shared back with the corresponding local health authority, which prevents the latter from following the full assessment pathway for a considerable proportion of their applicants and to learn about the differences between its initial proposal and the final decision by INPS.

Importantly, there are some exceptions to the disability status assessment procedure described above, which is not followed by every region or province in Italy. One such exception results from a convention between INPS and some local health authorities (*Convenzione Invalidità Civile*, or CIC). Conventions are currently in place in some health districts of Campania (Avellino, Benevento, Caserta, and Salerno), Friuli

Venezia Giulia (Pordenone), Sicilia (Trapani, Caltanissetta, and Messina) and Veneto (San Donà di Piave, Verona, and Venezia) and in all health districts of Basilicata, Calabria, and Lazio. Through these conventions, some regions or provinces have transferred the full responsibility for the disability status assessment to INPS, making the regional branches of the institute responsible for taking care of the whole process, including the parts usually performed by the local health authorities. Although the first parts of the process remain the same in principle, in these regions or provinces a simplification can be observed with the removal of the verification step, because of INPS overseeing the medico-legal commission itself. By making the outcome of the commission the final decision of the disability status assessment, such conventions reduce the overall length of the application procedure and the resources usually needed for the verification procedure. One other exception to the default procedure followed for disability status assessments is observed in autonomous regions and provinces, such as Trentino. In Trentino, benefits are not attributed by INPS, but by the corresponding agency in the autonomous province.

### **2.3.1. Medico-legal commissions and assessments**

Despite the similarities in the procedure followed, there are also important differences in the disability status assessments for the different definitions of disability. The main differences are described below and pertain to the composition of the medico-legal commissions, the criteria and tools used in the assessment, and how the different outcomes link with access to benefits and services.

#### *Assessment for civil invalidity, blindness, and deafness*

The assessment of civil invalidity is a requirement for people with disability to access disability payments. The assessment of blindness and deafness can be considered as an equivalent to civil invalidity for these conditions, providing access to analogous benefits. Eligibility for the status of civil invalidity, blindness and deafness is, in principle, mutually exclusive, even though individuals might apply to be assessed for both civil invalidity and blindness, or deafness, if it is not clear whether they qualify for one of the latter two.

As established in law 295/1990, the medico-legal commission assessing civil invalidity should include three medical doctors, usually selected among those employed or affiliated with the local health authority. The president of the commission should be a specialist in legal medicine while one of the other doctors would be a specialist in occupational medicine. In practice, occupational doctors are often not available, and two of the three medical doctor positions are occupied by doctors of other specialties. The commission should also include a worker from the association representing the applicant's medical condition (such as Associazione Nazionale dei Mutilati e Invalidi Civili (ANMIC), Unione Italiana dei Ciechi e degli Ipovedenti (UICI), Ente Nazionale per la protezione e l'assistenza dei Sordi (ENS) e Associazione Nazionale di Famiglie e Persone con disabilità intellettiva e disturbi del neurosviluppo (Anffas)) and a secretary. According to the respective laws, the difference in the composition of the commissions assessing civil blindness (382/1970) and civil deafness (381/1970) is the requirement of the inclusion of a specialist doctor in the conditions being assessed – either an ophthalmologist or an otolaryngologist. Lastly, and since 2010, commissions should be complemented by a doctor affiliated with the regional branch of INPS, whose contribution to the assessment should reduce the likelihood of the application to be held for additional verification by INPS, following the decision by the medico-legal commission. In practice, however, INPS doctors are rarely present.

The commission mostly relies on the information gathered in the introductory medical certificate. While it may also collect additional information on the medical condition including examining the applicants in situ, the short duration of the visit (usually less than 10 minutes) is a common practice, leaving limited opportunity to interact with the applicant. An exception to the short-duration interaction seems to be in place in Trentino, where the commission is reported to spend on average about 25 minutes with every applicant. Another considerable difference for this autonomous province is that the commission is solely composed of one doctor specialised in legal medicine.

The determination of civil invalidity is a medicalised assessment by law: it aims to capture the permanent functional impairment resulting from certain diseases or disorders, which should in turn be properly characterised through clinical and laboratory data. In theory, the commission should consider: the extent of total or partial anatomical or functional loss of organs (1); the possibility of a use of prosthetic devices to ensure full or partial restoration of a function of the injured body organs and structures (2); and the importance, in work activities or in comparison to the functional standards for the respective age group, of the organ or body structure for the anatomical or functional damage (3). In practice, the commission uses the clinical information available to classify applicants with diagnoses linked to legally pre-defined percentages of civil invalidity. Beyond performing the diagnoses, the discretionary power of assessors is limited to choosing a value within ten percentage point intervals allowed for some health conditions or reducing/increasing percentages up to 5 percentage points, depending on the relevance of the impairment for the (potential) occupational activities of the applicant. In the case of severe cumulative impairments, the sum of percentages should be preceded by an evaluation of the real impact of additional conditions on the applicants' functioning. Impairments corresponding to less than 10 percentage points of civil invalidity are mostly not considered in cumulative terms. The decision is based on correspondence tables last updated in 1992, which may reflect outdated medical knowledge in many cases.

Several problems exist with the use of these tables which not only include conditions that are no longer relevant but also miss others that are increasingly important for disability determination today, especially with the wide spectrum of often very prevalent but still highly stigmatised mental health conditions. Equally important, the percentages attributed to diagnosis ignore 30 years of progress in medicine, which can attenuate symptoms and impact on functioning of most known diseases. Therefore, the use of such outdated correspondence tables adds to the inadequacy of a purely medical approach which attributes standardised percentages of invalidity to a diagnosis, ignoring the role of the environmental context for each applicant and the relevance of the interaction between the impairment and the environment.

Another inconsistency of the civil invalidity assessment lies in an additional disability definition that is only evaluated for those classified with 100% of civil invalidity. In this case, the commission also assesses the applicant's ability to walk or perform essential acts of daily life, although additional guidance on how to perform this evaluation is lacking. The output of this additional assessment is a binary decision on top of the civil invalidity percentage, giving access to additional support measures. Table 2.1 above summarises in simple terms how the output of the civil invalidity, blindness, and deafness assessments links to the availability of supports at the national level. While applicants are considered as having a civil invalidity with percentages above 33%, the most relevant supports are only available with percentages above 67%.

The recognition of a civil invalidity status is also a pre-requirement for the recognised disability status for employment support (46% of civil invalidity, see more below), and for some of the needs-assessment procedures that are conducted for persons to determine eligibility for and access to regional and municipal benefits and services.

### *Handicap assessment*

The assessment of handicap status results from the application of the definition provided in law 104/1992. This definition encompasses three elements and establishes that a handicapped person is someone who has a stable or progressive physical, mental or sensory impairment (1), which causes learning, relational or work integration difficulties (2), and results in social disadvantage or marginalisation (3).

While anyone can apply for a handicap assessment, including work and war invalids and those in the contributory disability insurance system, the assessment is often run in parallel with the civil invalidity assessment, including the visit to the commission. The handicap commission is similar in its composition to the civil invalidity commission except that it should also include a social worker. In Trentino, the social worker only complements a single doctor commission for the most complex cases, with a posteriori consultation happening more often. Overall, the addition of a social worker to a commission that is

otherwise mostly or exclusively medical reflects the different nature of the disability definition applied for the assessment of handicap. In fact, the concept of handicap is the only one among the coexisting disability definitions in Italy that provides some room for going beyond body-related and medical models of disability and exploring the applicant's functioning in the context of attitudinal and other barriers to functioning. While this is a positive aspect – and closer in line with the principles promoted by the ICF – it is unclear how this materialises in practice, given that no further criteria or tools are used by the commission, and the visit is nevertheless of very short duration. Handicap assessment can lead to one of three results: no handicap, handicap, and severe handicap. The distinction between the latter two categories is established by law 104/1992, which defines a handicap as severe if the decrease in personal autonomy – and accounting for the respective age of the person – leads to the need of receiving permanent, continuous, and comprehensive assistance, either in the context of performing individual tasks or in relating with others. In practice, this translates into evaluating the applicant's need to receive permanent support and care. The requirement of permanence implies some persistence in the impairment leading to reduced functioning and social disadvantage, while allowing for changes over time. Overall, and even though its definition is more in line with the ICF approach to disability, the handicap assessment also seems to be permeated with medical considerations omnipresent in the Italian system. For example, certain health conditions have been a priori determined as directly conferring eligibility to severe handicap status. This is the case for example for applicants undergoing dialysis (Ministry of Health guidance 17 November 1998), with Down syndrome (law 290/2002), with cystic fibrosis or with deafness (INPS internal communications).

A handicap status allows access to additional support measures, with severe handicap status often being a requirement. Additional benefits range from exemptions from co-payments for medical care allowing free access to health services to benefits for the individual and their family members in the context of labour participation (such as a right to three days of care leave per month, an extension of the period of parental leave, an exemption from night shifts, and flexibility in choosing the working location) and discounts and concessions such as tax allowances for the acquisition of aids and a tax exemption for the purchase of a motor vehicle. The handicap status is also an important first step in creating eligibility for supports provided at the regional level, after undergoing a needs assessment at the local level.

### *Disability assessment for employment support*

The assessment of disability for employment support (designated as *disabilità* in law 68/1999) differs from the remaining baseline assessments as it mostly consists of validating whether the applicant – who should be between 14 and 65 years old – qualifies through either civil invalidity with a percentage of at least 46% or by civil blindness or deafness, work invalidity with a percentage of at least 33%, or war invalidity.

The assessment of disability for employment support is often made in parallel with the assessment of civil invalidity and handicap. The assessment commission should be like the one evaluating the handicap status, including a social worker in addition to the medical members. While having a multidisciplinary panel would be certainly relevant for an in-depth assessment of people with disability for occupational purposes, the role of the commission in the context of law 68/1999 seems to be solely an administrative verification of other disability assessments result. Qualitative information about the applicant's occupational abilities might be included in the assessment report, but there are no guidelines on how to do this nor any evidence that can substantiate the prevalence of this practice.

Being assessed as having a disability for employment support allows individuals to qualify for a set of tools that should facilitate their targeted placement and participation in the labour market. The main benefit consists of being listed for further support provided by employment services at the provincial level (every region in Italy consists of several provinces). Furthermore, applicants that qualify through civil invalidity may obtain additional employment-related benefits when their percentage is above cut-offs such as:

- 50%: Eligibility for workplace adjustments, removal of workplace barriers, teleworking set-up.
- 60%: Qualification for the employment quota for people with disability that employers are mandated to fulfil (including for applicants already employed at the time of the assessment).
- 67-80%: Taxation for social security contributions reduced by 50% for the first five years.
- 80% (and with an intellectual or mental impairment): Waiver of social security contributions for the first eight years.
- Intellectual or mental impairment: guaranteed placement.

### **2.3.2. Reassessments and appeals**

Current processes of disability status assessment provide limited possibilities for an efficient re-evaluation of the outcomes of a first decision. No strict reassessment timings or renewal obligations exist for the results of any of the five definitions of disability status. Even though the commissions might include such requirements in the assessment report, the data available does not allow taking any conclusions on whether this is a recurrent practice. While some flexibility in defining the need for reassessment might be a good practice, allowing the commission to personalise such decision to the context of the applicants and their social context, reassessment conditions and periodicity should be regulated by legislation, with guidance and transparency around the criteria (to be) used in such decisions.

For applicants who do not agree with the outcome of the assessment, the opportunities to appeal against the decision are theoretically limited to a judicial process to be submitted up to 180 days following the decision. This process has been modified since 2012 (law 111/2011), with the aim of reducing the length of the litigation procedure – which could last several years – and to avoid overburdening the civil justice. Nevertheless, it still represents a complex procedure, potentially discouraging people with disability from pursuing it, as they must also bear some of the associated costs. The modified process of appeal entails a first step that precedes an extensive involvement by the judge and the usual judicial activities such as hearings. This first step consists of a preventive technical assessment (*accertamento tecnico preventivo*) carried out by a consultant: a medical doctor appointed by the judge. Only when the parties disagree with the outcome of the preventive technical assessment, will the process move to the usual judicial pathway, which is lengthy and resource-intensive (as it was already before 2012). Differently from the rest of the country, in Trentino it is possible to submit an administrative appeal within 60 days of the decision by the single-doctor commission. The appeal results in a second instance assessment by a commission of three medical doctors, one of which should represent the relevant association of people with disability.

Interestingly, and despite the heavy appeals process, there are no restrictions to the number of times a person can apply to be assessed, thereby starting the process from scratch. Together with the complexity of the appeal procedure, this might lead to unintended incentives to submit new requests and start the process again instead of appealing. In fact, INPS procedures provide applicants with a possibility of submitting a request to cancel an ongoing process/decision, in which case documentation backing such request will be evaluated by a higher commission of INPS. This evaluation has three possible outcomes: it might confirm the previous decision, it might cancel the current process/decision and send the patient to start the process again, or it might directly change the decision to what was requested by the applicant. In practice, this process seems to be the equivalent to an (inefficient) administrative appeal. It also highlights the limitations of the current judicial procedures in ensuring rights to argue against a disability determination that relied on an over-medicalised and outdated assessment in the first place.

### 2.3.3. Trends in disability status assessments

The following figures summarise trends over the past decade in the rates of applications and acceptance for civil invalidity and handicap assessments. The following developments can be observed:

- Applications for civil invalidity fluctuate from year to year but have been on a gradual trend rise until the COVID-19 pandemic, especially for the total population but to a lesser degree also for the working-age population. In 2021, the number of civil invalidity applications was back to the level in 2019 (Figure 2.1, Panels A and C).
- Applications for handicap are increasing sharply and have doubled between 2010 and 2017 for both the total population and the working-age population. Since 2017, the trend increase has flattened out. After a dip in 2020, the level in 2021 was higher than the pre-pandemic level (Figure 2.1, Panels B and D).
- Increases in applications for civil invalidity and handicap over the past decade for people of working age were largely driven by the regions in the middle and south of the country (Figure 2.2). The island regions (Sardinia and Sicily) are a noticeable exception, as they have seen a rapid increase in handicap assessments but no increase in civil invalidity assessments.
- For civil invalidity, regions with the largest increases had higher application rates already ten years ago; hence, the North-South divide has increased further, with rates in the North often below 1.5% of the working-age population every year and rates in the South over 2.5% (Figure 2.2, Panel A). For handicap assessments, rates were more similar across all regions ten years ago, fluctuating around 0.75% of the working-age population. Today, rates in the South are typically also twice the rate in the North (2% versus 1% of the working-age population) (Figure 2.2, Panel B).
- Acceptance rates are generally quite similar across regions and, overall, rather high, particularly for handicap applications. Acceptance rates for civil invalidity applications have converged to around 50-60% in all regions of Italy, as regions that used to have higher acceptance rates – both in the North and the South – have experienced a decline in those rates (Figure 2.3).
- Acceptance rates for handicap applications have remained high and largely unchanged between 2010 and 2021, around or even above 90% (Figure 2.4, Panel A). The majority is granted a “severe handicap” status but the distribution between handicap and severe handicap status differs considerably across regions (Figure 2.4, Panel B). Southern regions with a higher number of handicap applications tend to grant a severe handicap status less often than other regions.



**Figure 2.1. The number of applications to civil invalidity and handicap status in Italy are increasing**

Applications to civil invalidity and handicap for the total population and the working-age population, in thousands



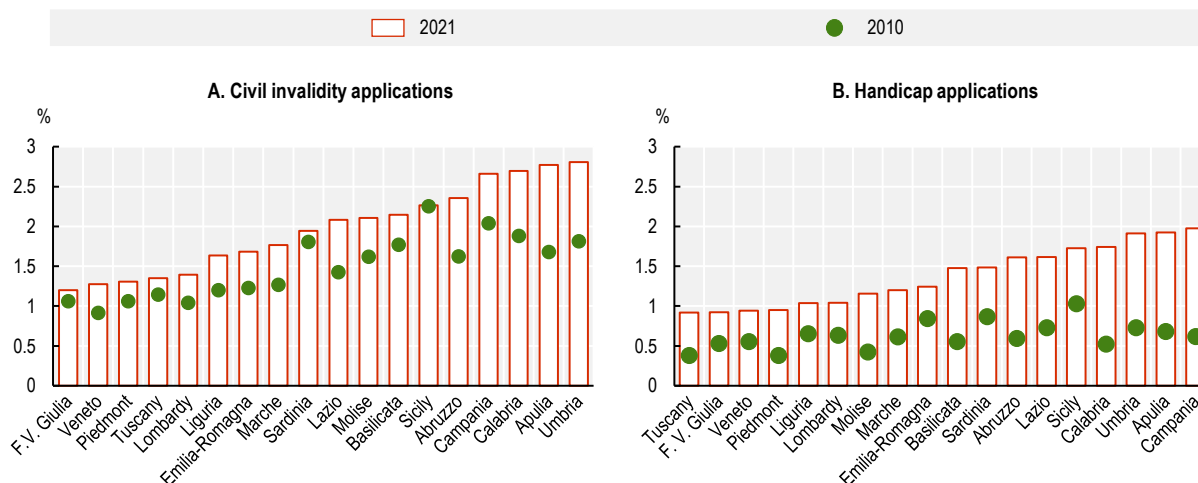
Note: Applications for civil invalidity and handicap assessment for the total population include all applications, irrespective of age; applications for the working-age population refer to people aged 18 to 67. Standardised applications are applications divided by the corresponding number of residents, presented over 1 000 residents. Data cover all Italian regions except Trentino and South Tyrol.

Source: OECD calculations using Istituto Nazionale Previdenza Sociale (INPS) data prepared for the OECD.

StatLink  <https://stat.link/201d1t>

### Figure 2.2. A few Italian regions are responsible for the large increase in handicap applications

Civil invalidity and handicap applications as a share of the working-age population by region, 2010 and 2021

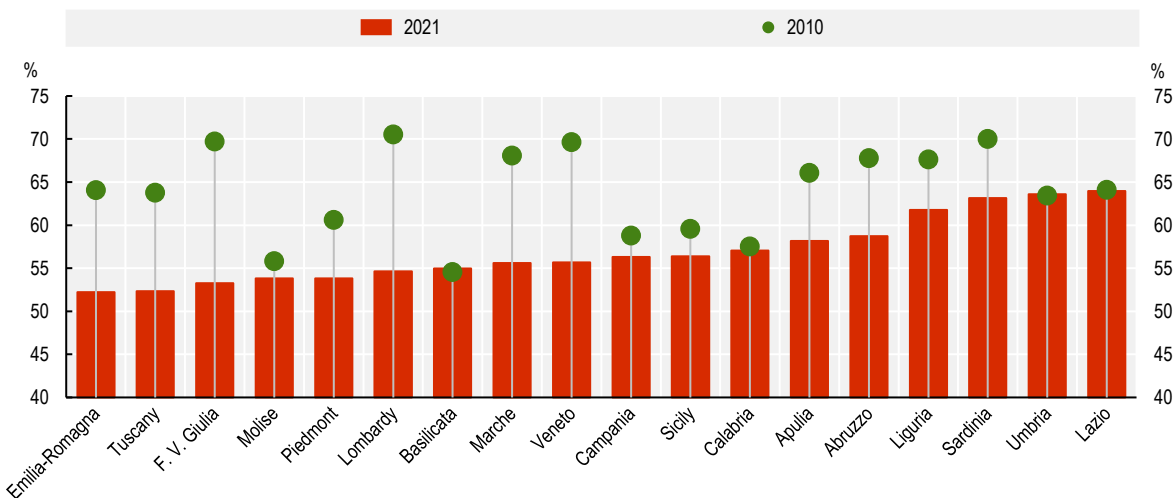


Note: Applications for civil invalidity and handicap for the working-age population aged 18-67 divided by the number of working-age residents.  
Source: OECD calculations using Istituto Nazionale Previdenza Sociale (INPS) data prepared for the OECD.

StatLink <https://stat.link/g7oknx>

### Figure 2.3. Acceptance rates for civil invalidity have converged across regions in the past decade

Share of granted civil invalidity status by region, 2010 and 2021

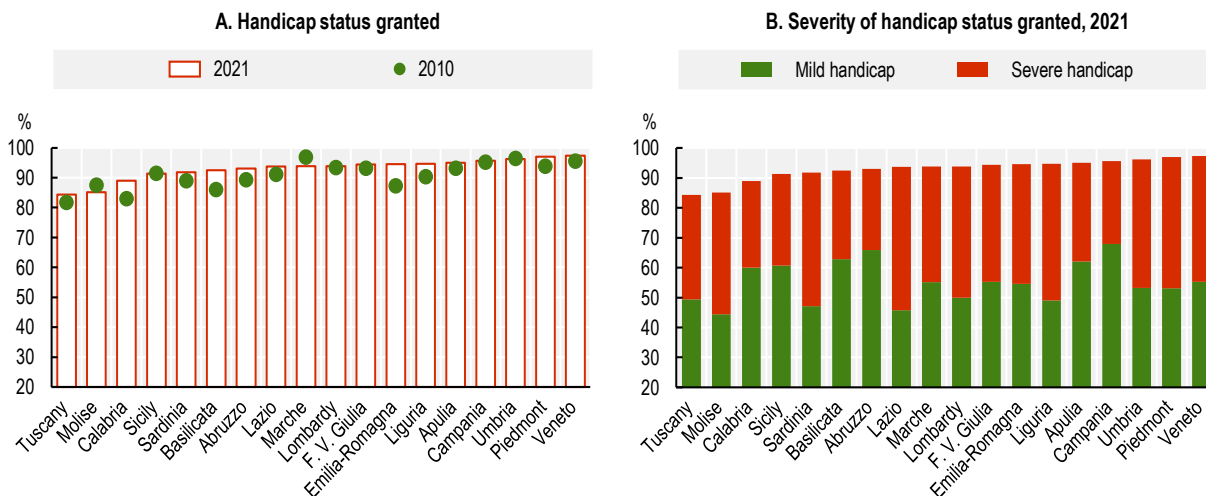


Note: Data shows the number of granted over the number of processed applications each year (the difference being rejected applications).  
Source: OECD calculations using Istituto Nazionale Previdenza Sociale (INPS) data prepared for the OECD.

StatLink <https://stat.link/j2sdha>

## Figure 2.4. Acceptance rates for handicap are high everywhere, particularly for severe handicap

Share of people who applied for handicap status successfully, by region, over time and by severity



Note: Data show the number of granted over the number of processed applications each year (the difference being rejected applications). Panel A includes both handicap and severe handicap status, while Panel B distinguishes the two types of handicap status in all accepted applications.

Source: OECD calculations using Istituto Nazionale Previdenza Sociale (INPS) data prepared for the OECD.

StatLink  <https://stat.link/ydsh9t>

### 2.3.4. Other disability status assessments

People with disability who have an employment history might (in addition) apply for alternative disability assessments (other than civil invalidity), to determine entitlement for disability insurance payments. Applicants in the contributory disability insurance system should have paid social security contributions on their income for at least five years (260 weeks), of which three years (156 weeks) should have been in the past five years. While these contributory requirements are the same for all employees, there are considerable differences in the disability definition, the assessment procedure and the key institutions involved depending on whether the applicants are private-sector employees or self-employed (law 22/1984), or civil servants (law 335/1995). The below description refers to the assessment for the former group mostly, as this affects a much larger proportion of the population.

Private-sector employees or self-employed workers are assessed for a reduction in their capacity to work due to a disease/disorder or a physical or mental impairment that should not be a consequence of their occupational activity. The reduction might be evaluated as partial, if above 33%, or as total. Partial and total disability correspond to different benefit payments, respectively the ordinary disability allowance (*assegno ordinario di invalidità*) and the ordinary disability pension (*pensione ordinaria di inabilità*).

At a first glance, the definition of disability in the insurance system seems to share some similarities with that of civil invalidity, which covers persons between 18 and 65 years who have undergone a permanent reduction in working capacity of more than a third. In practice, the key difference seems to lie on how the determination is done. While the civil invalidity percentage is obtained through a barema-like method, no additional methods or instruments are mandated for the assessment of disability in the insurance system. On the other hand, the evaluation of working capacity in the latter system should take into consideration existing aptitudes, and the job previously performed using those aptitudes.

The application to the contributory system follows a process like other disability status assessments, being submitted electronically to INPS and requiring a similar introductory medical certificate. There is, however, no role for the local health authorities in the whole process, which is fully conducted by INPS. The assessment is done by a single doctor from INPS who evaluates the medical conditions of the applicant. The INPS doctor should have in consideration the severity and persistence of the condition, the existence of adequate treatment and possibilities of rehabilitation, and the impact on functioning in relation to the work activity. This evaluation should include considerations about the applicant's education and training, past job experience and attitudes towards work, as well possible alternative/adapted career prospects. Although the assessment remains strongly medicalised, such considerations create an opportunity for a better analysis of the social context and environment than the application of the *barema* method. Under the insurance system, identical clinical conditions could in principle lead to very different percentages of disability – depending on the applicant's working skills, job tasks and suitable occupations. Nevertheless, the appropriate determination of disability in this context seems to be compromised by the lack of a reliable and valid instrument to convert the set of considerations above in the final numeric output required.

One other difference between civil invalidity and disability under the contributory insurance system concerns how binding the decision of INPS is in case of the latter, as applicants can choose whether they apply for the ordinary disability allowance or the ordinary disability pension: they have the right to opt for the allowance even when assessed by the commission as having total incapacity to work. In practical terms, applicants might choose the allowance due to the conditions coming with the eligibility for the ordinary disability pension: an obligation to cease any type of work activity, to be removed from professional registers and other related employment lists, and to be waived from unemployment insurance or other supplements to remuneration. There are certain professional situations, especially among self-employed and those running a family business, where applicants find incentives to pursue some professional activity even when they were assessed with full disability for that purpose. While in practice there is no data to evaluate how often this might occur, such a disconnect between the assessment decision and the benefit received highlights the limitations of the current assessment method to properly capture disability, as they might classify with full disability individuals who have the capacity, and prefer to, continue working. One last difference between contributory and civil invalidity assessment practices is that in the former those classified with partial disability and thus entitled to ordinary disability allowance must be reassessed after three years for a maximum of two times, after which the disability is finally considered permanent.

## 2.4. Needs assessments at the regional level vary considerably

### 2.4.1. *Fragmented access to regional and municipal services and benefits*

To access benefits and services at the regional and municipal level, people with disability must undergo a second level of assessment, in which their needs and the entitlement to health and social services and programmes to meet these needs are evaluated. While this approach has been adopted in many OECD countries, its implementation comes across many challenges in Italy. The main challenge stems from the fragmented and difficult to navigate social protection system at the regional and municipal level with a strict split between the health domain (*socio-sanitario*) and the social domain (*socio-assistenziale*). The complexity inherent in this divide is compounded by a service-driven approach to the needs of people, in which both the assessment and the entire client pathway are shaped by the services and programmes available and the way in which these are organised, including their sources of funding.

### *Entry points into the local system*

Needs assessments in Italy have historically been benefit and service-dependent, meaning that for each benefit and service offered by a region or municipality, a separate request should be placed, and a different needs assessment be conducted. In dealing with the complex needs of people with disability, regions have accumulated a considerable portfolio of services and programmes over the years. While the existence of these responses is a positive aspect, it becomes challenging for citizens to navigate the multiple application and assessment procedures of such a system, which often ends up being driven by supply rather than demand (or needs), potentially leading to a distortion of applications to fit the eligibility criteria.

Thus, the social protection system for people with disability – and more generally for vulnerable citizens – is characterised by multiple entry points and pathways to be navigated and a resulting multitude of needs assessments. In recent years, a proliferation of available programmes and benefits has only exacerbated this problem. Such a scattered system lacks efficiency and equity, as people with similar problems are likely to experience very different situations, involving different needs assessments, and different support, depending on their first contact and the interlocutor they find. This also puts a considerable weight on the individuals and their family, to navigate such a system that requires a deep understanding of administrative matters and, hence, much time and effort.

Two additional features of the Italian system increase remarkably its complexity. First, the fact that services and programmes are usually added on top of existing solutions, creating one more entry point or procedure to be followed, often depending on the part of the system that offers the service or programme and its funding source. Second, and most important, the large cleavage between health and social services at the regional level, from top (directorates-generals within regional administrations) to bottom (local health authorities and services provided at the municipal level) of the system. Although these two domains serve a similar population and their respective services may partly overlap in scope, their organisation and ways of working, and funding, differ considerably. The Constitutional Reform in 2001 has added to the complexity through a devolution of powers to lower levels of government by which social and health policies and affairs became a predominantly regional matter.

To overcome the fragmentation and lack of harmonisation in dealing with the emergence of complex needs, several Italian regions have decided to create single points of entry into the system (known as *Punto Unico di Accesso* – PUA, among other designations). A definition for these single points of entry was developed together by several regions (Veneto, Liguria, Emilia Romagna, Tuscany, Marche, Lazio, Abruzzo, Calabria and Sardinia) back in 2008, with a strong focus on the contribution to better integration between the health and social domains. This would happen through several functions assigned to the single points of entry, including an extended role in taking charge (*presa in carico*) of people in need, throughout the assessment procedures and into the care pathway (note that PUAs serve a broader population of citizens with chronic health conditions and long-term needs and/or in a vulnerable situation, not only people with disability.) In practice, regions shaped the functions of their PUAs based on the characteristics of their host region and its institutional setting. Studies analysing the performance of PUAs several years after their initial implementation pointed to considerable heterogeneity in the ways of operating, functions adopted and links to the health and social domains (Pesaresi, 2013<sup>[2]</sup>). Most of these limitations observed among single points of entry into the Italian social protection system seem to persist.

While some PUAs can have functions that are as limited as providing information about the resources available and how to access them, most of these structures are reported to operate at an intermediate level of support, whereby they are also responsible for functions such as a pre-assessment and referring individuals towards solutions not requiring further assessment or to multidimensional needs assessment by multidisciplinary units. This seems to be the model of PUAs preconised in the four regions studied, even though differences arise in practical terms, depending on the respective disability policy ecosystem. In Trentino, single points of entry have a limited scope, mostly due to the large role of legal medicine doctors within the local health authorities. In this region, legal medicine doctors' functions go beyond initial disability

assessments: de facto they end up being the entry point into the system. Furthermore, and due to the region's small population size, legal medicine doctors have an oversight of the overall pathway followed by people with disability. Single points of entry in Trentino are in practice mostly used by vulnerable citizens due to their age, rather than a disability.

Beyond basic or intermediate intensity, single points of entry can also operate at a more intense level. In this case, these structures should have a role in taking charge of the most complex clients from their case registration and data collection through the multidimensional assessments of their needs, the creation and monitoring of personalised plans, and management of the client relationship with service providers. In taking charge, PUAs should play a role in improving the system's governance and achieving an integrated and articulated process, which guarantees to individuals a smooth co-ordination of interventions to respond to their complex needs. However, no region could be identified where PUAs would consistently perform such a comprehensive single access and case management role. The closest to such a way of operating seems to exist only for certain programmes and their respective streams of funding. In Sardinia, for example, PUAs have an extensive role in supporting people with disability that enter inclusion programmes such as "After Us" (*Dopo di Noi*) and "Returning home" (*Ritornare a casa*). In Campania, these structures collect the needs of people with disability going through multidisciplinary assessment units, but do not follow these individuals further.

One other key aspect behind the role of single points of entry is whether and to what extent they manage to provide an integrated interface for the health and social domains. In Sardinia, PUAs are designed as structures of the health domain, belonging solely to local health authorities and, therefore, corresponding to second-level entry points that should follow a first contact with social services from the municipality (social domain). In other regions, even when PUAs are envisaged as having a role in integrating health and social domains, these structures seem to be linked to the health side in most cases and are counters or facilities as part of local health authorities, and a gateway to the multidisciplinary assessment needed for some health-related residential, semi-residential and (integrated) home care services. Among the four regions studied, Campania's *Porte Uniche di Accesso* display the strongest focus on the integration of health and social domains. In practice, actual integration is anecdotally only achieved in about a third of these single points of entry, with only five out of 72 located in municipal services rather than the local health authority. One of the main consequences of the failure to properly promote integration between the health and social domains is that these structures end up not performing the role of a unique entry point in the system. In fact, PUAs are likely not even the most common first point of contact, a place that is taken by social service providers of municipalities (social domain). Much like in Sardinia, municipal social workers of other regions often take charge of vulnerable individuals in a first instance, directing them to PUAs when the user has health or complex needs. The degree to which a PUA is an actual focal point for accessing multidisciplinary assessment units and health-related disability services varies between regions.

One last aspect that seems to hinder PUAs from performing according to their potential is the existing variation in the way these structures operate within regions. The four regions of interest not only differ in terms of the maturity of their single points of entry, but also with regards to existing legal provisions and guidance in how to implement them at the local level. For example, Sardinia was originally part of the regions that conceptualised the PUAs, while in Lombardy there seems to be less of a whole-of-region vision for the equivalent structures – *Sportelli Unici per il Welfare* (SUW). Lombardy seems to be the region with the poorest coverage of single points of entry and the largest internal variation, given that the existence of the structures is a direct result of local-level action and co-ordination between each local health authority (*Aziende Socio Sanitarie Territoriali – ASST*) and its corresponding group of municipalities (*ambito*). Nevertheless, within-region variation prevails even when regional standards are defined, such as in Sardinia and Campania. This is because the operational features of the single points of entry are also defined at the territorial/local level, with the articulation being left to the collaboration between local health authorities and territorial/municipal services, which in some circumstances appears to be flawed. Different ways of implementing their functions such as the fact that every PUA decides how to perform the

pre-assessment of needs leads to heterogeneity in the pathways followed by individuals from their entry into the system onwards and hinders the capacity of PUAs to promote equity. Overall, and although flexibility to adapt PUAs to the regional and local context might allow a more targeted response to the needs of the population, it also increases the likelihood of geographical inequalities and inefficiency, and ultimately prevents these structures from being easily identifiable and actionable instruments, and to achieve their integration goal. In their current form, PUAs fall short in truly representing a gateway to all the services and benefits available to people with disability. Lack of available data on the use of these instruments means that nothing is known about the actual proportion of individuals accessing care through PUAs.

### **2.4.2. Disability assessments as a starting point**

Second-level assessments at the regional level serve the purpose of matching applicants' needs with the support available (thus, also called needs assessments). It would, therefore, be reasonable to expect needs assessments to be carried out as a continuation of an earlier process of disability determination, and more specifically to build on the information and conclusions from the disability status assessments. In practice, there is a large disconnect between disability status and needs assessments, with limited usefulness of the former to the latter. Several reasons are likely to be behind such disconnect; reasons that are all connected to each other:

- The over-medicalised perspective of disability status assessments, which limits their utility for the evaluation of needs, where the role of the environment stands out as an important component.
- The format of the output of disability status assessments, as both the percentage of civil invalidity derived from medical records predominantly and the two handicap categories provide very limited information on the actual disability of the applicant.
- Considerable limitations in data sharing; assessment reports from the medical-legal commissions might contain additional information but there is no systematic mechanism in place to make these materials available for the purpose of the needs assessments.

The limitations described above are particularly salient for the status of civil invalidity, which, although the most relevant status for people with disability to access support, is barely relevant and considered for the needs assessment. Having a (severe) handicap status is more often a requirement for accessing services at the regional level, namely the eligibility for programmes such as “After Us”, or the “Non-self-sufficiency fund” (see the next chapter for details on those schemes). Even though a requirement for eligibility, the information obtained from the assessment of handicap is still of limited usefulness to a needs assessment. To compensate for the disconnect between disability status and needs assessments, several needs assessments still involve general practitioners or other medical doctors, to start the determination process from scratch. Doctors must provide information on the person's pathologies, thereby duplicating the compilation of the medical certificate in the first step of the disability status assessment application. In Sardinia, for example, the assessment report issued by the civil invalidity commission might be integrated into the process of applying for domiciliary support, but it is not an essential requirement.

### **2.4.3. A multitude of needs assessments exist in parallel**

Needs assessments are performed at the regional and local level in at least three contexts. First, the multidimensional assessment conducted by multidisciplinary teams that work closely with single points of entry. As the PUAs themselves, these teams should also have a role in the integration between the health and the social domains, and their respective services. In practice, needs assessments performed by these teams are mostly a requirement to access services provided by the health domain (including residential, semi-residential and integrated homecare approaches, and some inclusion programmes like “After Us”), rather than a comprehensive assessment that would provide direct access to the entire portfolio of existing

services in an integrated way. Therefore, needs assessments are also carried out by other actors in the disability system. This includes especially two types of assessments. On the one hand, service-specific needs assessments are conducted mostly by social workers affiliated with municipalities, to provide access to services of the social domain. On the other hand, needs assessment can be multidimensional and multidisciplinary but performed at the provider level, mostly by provider staff and often including the general practitioner or a social worker from the social/health domain, who accompany the applicant. For example, in Lombardy the multidimensional assessment for semi-residential services is carried out by the team of the facility (involving the co-ordinator and healthcare professionals) with the participation of municipal social workers. While provider-led assessments exist in several regions for direct access to private structures, Lombardy seems to be a special case. Due to the high degree of privatisation on the supply side, provider-led assessments are also possible for applicants that are publicly funded.

### *Multidisciplinary and multidimensional needs assessment*

Most needs assessments currently available at the regional level aim to be multidimensional, a concept that evolved from the geriatric assessment of need and was proposed in the early 2000s to promote the efficacy and appropriateness of social health services.<sup>3</sup> The multidimensional assessment method should allow to "define the integrated complex needs of the applicant with regards to health, assistance, custodial, psychological and socio-economic aspects, for example by observing both the cognitive and functional aspects in the social-residential context: income, type of dwelling, possible presence of architectural barriers, presence of care giver in the family, etc."

A multidimensional assessment is most often performed by a multidisciplinary team, although not always. In the Italian setting, there seem to be mostly two types of multidisciplinary teams: those that operate in the context of service providers, assessing applicants for a specific service; and the multidisciplinary assessment units, which are integrated/interinstitutional teams working closely together with the PUAs. These multidisciplinary assessment units can be named differently depending on the region – i.e. integrated assessment units (*Unità di Valutazione Integrata – UVI*) in Campania, multidimensional evaluation units (*Unità di Valutazione Multidimensionale – UVM*) in Lombardy, territorial assessment unit (*Unità di Valutazione Territoriale – UVT*) in Sardinia and multidisciplinary assessment unit (*Unità Valutativa Multidisciplinare – UVM*) in Trentino. Nevertheless, their composition shows common features across the four regions. For example, they usually include a medical doctor – either a general practitioner or a doctor affiliated with the local health authority, or both – and a social worker. Other possible members often include a nurse, or a doctor specialised in the medical condition behind the disability. Importantly, it seems to be commonplace across the four regions that the social worker participating in the assessment unit is either affiliated with the local health district (health domain) or the municipality (social domain). The latter will most likely be present when the person with disability first entered the system through the social services side and is then guided by a municipal-level social worker either to the single point of entry or directly to the multidisciplinary assessment unit, due to health needs. Campania seems to be an exception, as municipal social workers are described as being part of the units by default. When a municipal-level social worker is not present, multidisciplinary units will be fully composed by professionals linked to the health domain, and not truly interinstitutional. Given that the needs assessments performed are mostly targeted to the services available from the health side, these teams seem to have limited scope to foster integration themselves. Furthermore, the health-focused composition of the teams might favour a medical approach of disability in needs assessment, as applying a medical criterion is often perceived by assessors as reducing the discretion of the assessment. The medicalisation of multidimensional assessments in Italy is likely explained by the predominant use of these assessments for determining eligibility for services from the health domain. In other countries, needs assessments often involve social workers only, or social workers and rehabilitation specialists.

In the four regions examined, applicants with health needs can also be referred to the unit by general practitioners, municipal-level social workers or other actors. For example, medical-legal doctors from the



local health authority are entitled to refer applicants to be needs-assessed by the UVM in Trentino, where they also hold a major responsibility in disability status assessments.

One further aspect to highlight concerning the procedures followed by multidisciplinary assessment teams is the lack of a specific protocol for assessing needs. While recognising that multidimensional assessment teams should apply scientifically validated scales and tools critically reviewed at national or international level, the choice of these tools is usually left to each team or in the best case harmonised at the regional level. In the case of Campania, it has been set by a Regional Council resolution (324/2012) that UVI should use the multidimensional assessment card for people with disability (*Scheda di Valutazione Multidimensionale per le persone con Disabilità – SVaMDi*). The SVaMDi tool used in Campania is an adaptation of the instrument originally developed in the Veneto region to standardise the provision of essential levels of social and health support across places and to support teams in designing projects/plans targeted to the applicants. SVaMDi should provide information that facilitates the organisation of services at the regional level and allow for the monitoring of applicants' pathways. In its original form, this tool consisted of five parts, of which four are closely related with ICF domains (impairments to body functions, restrictions to activities and participation, environmental factors, and social evaluation) and would allow for the profiling of individuals in terms of functioning and severity. Completing each one of the four parts would be under the responsibility of different professionals, including general practitioners and social workers. The fifth part would be a cover (copertina) that would summarise the information provided in the remaining tool and conclude with the targeted plan, under the responsibility of the multidisciplinary assessment unit. Campania's adaptation of the original SVaMDi is described in Box 2.1. Although the different parts of the assessment card are defined at the regional level, each multidisciplinary assessment team has the flexibility to decide exactly which instruments and scales it uses within those different parts.

### **Box 2.1. Multidimensional assessment card for people with disability used in Campania (SVaMDi)**

Form A: Health assessment for access to local health services. It reports pathological conditions, level of functionality of some physiological functions, environmental factors that could represent facilitators or barriers for the quality of life of the patient, and co-morbid classes, and it also includes service proposals.

Form B: Specialised assessment for admission to local services. This form is further divided into five parts, which include a cognitive-behavioural evaluation, a functional evaluation, and the mobility evaluations. These assessments are carried out using validated tools.

Form C: Social evaluation. Collects personal data, including employment status, educational qualification, economic condition, housing and family condition, and support of the social network.

Form D: Multidisciplinary evaluation, which aims at creating the path for the patient.

Multidisciplinary assessment units of other regions are reported to be using tools with a similar structure, in a first step completing a set of instruments and scales and in a second step compiling the information and making recommendations, with the tools used depending on the services or programmes concerned. A tool like SVaMDi but focused on the elderly is used, for example, in Sardinia for the assessment of home care service entitlements (multidimensional assessment card for adults and elderly – *Scheda Valutazione Multidimensionale dell'Adulto e dell'Anziano – SVaMA*). On the other hand, Sardinia uses a specific needs assessment form defined by a Regional Council Resolution (63/12 of 11 December 2020) to assess applicants for the programme "Returning Home", which also includes the use of home care. In the case of residential and semi-residential services, Sardinia's UVTs use a set of clinical and functional scales and measures (e.g. CIRS, Bernardini, Barthel, Short Questionary and condition-specific ones if applicable) which are brought together with information on the social environment of the applicant to attribute him or her a profile. This profile should reflect three levels of intensity of the support needed in terms of healthcare

(medium, moderate, low, according to the Bernardini tool) and in terms of social assistance (medium, medium-high, high, according to the Barthel scale). In Trentino, the different scales and instruments used depend on the patient profile and the type of structure identified as a potential service, but the UVM should also complete a multidimensional evaluation form (*Scheda per la Valutazione Multidimensionale – SVM*). In the case of the assessment for the individualised life projects, Trentino’s UVM use an adapted version of the Veneto SVaMDi. Lombardy has introduced a similar tool in 2022 (*Scheda Individuale del Disabile – SIDI*).

Most of the multidimensional assessment tools aim to provide a module for the design of a customised project, describing an (integrated) care pathway that responds to the applicant’s needs. The role of the multidisciplinary assessment units could also be extended beyond the sheer assessment, for example, to periodically monitoring the implementation of the plan, and performing adjustments as necessary. In practice, both the design and the follow-up of personalised plans seem to have limited coverage for people with disability. While the approach is followed for specific programmes with their own funding stream (e.g. “After Us”, “Returning Home” in Sardinia), the outcome of the multidisciplinary assessment units will more often be driven by, and directed to, a type of service, rather than being a truly integrated tool that allows entitlement to across-the-board support.

Disability status and needs assessments in Italy are a complex matter, for two reasons: a multiplicity of different disability status assessments at the national level, uncommon in an international perspective; the regional-municipal responsibility for needs assessments which are often service or provider-led; and the absence of any link between disability status and needs assessment. The result is a system that is difficult to understand and therefore difficult to navigate and a system that creates considerable inequality, both between region and municipalities and between people in comparable situations or with similar level of disability. Streamlining, harmonising, and better connecting the different assessment tools will be important to make the system more efficient and more effective.

## References

- Pesaresi, F. (2013), “Le funzioni dei punti unici di accesso”, *Welfare Oggi* 1/2013, pp. 15-22, [2]  
<https://www.periodicimaggioli.it/rivista/welfare-oggi/1615069/2013/fascicolo/1618637>.
- United Nations (2011), *Including the rights of persons with disabilities in United Nations programming at country level: A Guidance Note for United Nations Country Teams and Implementing Partners*, United Nations Development Group, [1]  
[https://www.un.org/disabilities/documents/iasg/undg\\_guidance\\_note\\_final.pdf](https://www.un.org/disabilities/documents/iasg/undg_guidance_note_final.pdf).

## Notes

<sup>1</sup> See <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>.

<sup>2</sup> See <https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health>.

<sup>3</sup> See <https://www.agenas.gov.it/i-quaderni-di-monitor-%E2%80%93-supplementi-alla-rivista/371-punto-unico-accesso>.

# 3

## Social protection for people with disability in Italy

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This chapter discusses disability programmes offered at the national and subnational level, including contributory and non-contributory benefits managed and funded by the national authorities and a range of (health and social) services and other in-kind benefits provided by the regions and the municipalities. It concludes that the system is complex and difficult to navigate but also generally quite adequate for people who manage to access all supports they may be eligible for. However, many people fail to access support and many of them might still be very vulnerable. The chapter also finds a significant North-South divide, characterised by a strong reliance on nationally funded benefits in the South of the country, which lacks the capacity to provide stronger disability services. It concludes that reform is needed to improve the performance of the system, to address the large cross-territorial differences, and to achieve a shift away from the provision of benefits towards support for employment and self-sufficiency.

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Italy's national system of disability supports has changed little in the past two decades although services provided at the regional and local level are in the flux. A key concern, also demonstrated in this chapter, are considerable differences across Italy's regions in the provision and take-up of benefits and services. The 2021 Enabling Act is also addressing social protection issues. However, while the law is quite precise on the forthcoming reform of the assessment of disability, including the requirement for a single national body to manage the assessment of disability status, a review of the system of social protection in its complexity and organic nature was beyond the scope of the Enabling Act. However, it should be noted that the regulatory choice to link the identification of support for the person with disability to the elaboration and implementation of the personalised and participatory life project – the qualifying orientation of the implementing decree dedicated to the multidimensional assessment of disability – lays the basis for a significant change in the social protection process.

### 3.1. The national disability benefit system

At the national level, disability benefits are provided through a contributory system and a non-contributory system (civil invalidity), both managed by the National Institute of Social Security (INPS). Such a distinction is common in many OECD countries, but the Italian disability system is complex and fragmented. System complexity has its roots in the multitude of distinctions within disability programmes themselves. Within the contributory system, parallel systems coexist by regime (dependent employees, self-employed, “putative self-employed”, and different categories of employees) and within those regimes. Different occupations have different benefit systems, with differences in generosity but otherwise similar characteristics. Within the civil invalidity system, special parallel systems coexist for deaf and blind people, despite them at the same time also being eligible for the general non-contributory system. Table 3.1 summarises the different income replacement benefits for people with disability in Italy, focusing only on the general regime within the contributory system. The subsequent sections provide some detail on the characteristics of the contributory and non-contributory systems to shed some light on the multitude of benefits provided by the disability system, highlighting differences and overlaps between programmes.

**Table 3.1. Multiple national disability benefits coexist for people with disability in Italy**

Characteristics of income replacement benefits for persons with disability in Italy at the national level

	CIVIL INVALIDITY (NON-CONTRIBUTORY) SYSTEM				CONTRIBUTORY SYSTEM
	Disability pension (full and partial)	Attendance allowance	Disability pension for the blind (full and partial)	Disability pension for the deaf	Contributory disability pension (full and partial)
Name of benefit	Pensione di inabilità per invalidi civili (full pension) Assegno mensile di assistenza per invalidi civili (partial pension)	Indennità di accompagnamento	Pensione per i ciechi assoluti (full pension) Pensione per i ciechi parziali ventesimisti (partial pension)	Pensione non reversibile per sordi	Pensione di invalidità previdenziale ordinaria (Full pension) Assegno ordinario di invalidità (Partial pension)
Regulatory law	Law 118 (March 1971)	Law 18 (February 1980)	Law 382 (May 1970)	Law 381 (May 1970)	Law 222 (June 1984)
Type	Non-contributory, permanent	Non-contributory, non-permanent	Non-contributory, permanent, non-reversible	Non-contributory, permanent	Contributory, non-permanent
Responsible organisation(s)	INPS	INPS	INPS	INPS	INPS

	CIVIL INVALIDITY (NON-CONTRIBUTORY) SYSTEM				CONTRIBUTORY SYSTEM
	Disability pension (full and partial)	Attendance allowance	Disability pension for the blind (full and partial)	Disability pension for the deaf	Contributory disability pension (full and partial)
<b>Eligibility</b>					
Age	18 to 67	No age limit	18 and over	18 to 67	18 to 67
Disability assessment	Civil invalidity or civil invalidity for the deaf (if partial)	Civil invalidity + impossibility to walk or conduct activities of daily living	Civil invalidity for the blind	Civil invalidity for the deaf	Work-capacity assessment
Degree of disability	100% (Full) 74%-99% (Partial)	100%	100% (Full) 80% (Partial)	100%	100% (Full) 66%-99% (Partial)
Minimum contributory period	None	None	None	None	3 of last 5 years
Means-testing income threshold	EUR 17 271 per year (Full pension, in 2022) EUR 5 015 per year (Partial pension, in 2022)	None	EUR 17 271 per year (in 2022)	EUR 17 271 per year (in 2022)	None
<b>Generosity</b>					
Replacement rate or (average) monthly payment	EUR 292 per month (for 13 months, in 2022)	EUR 531 per month (in 2022)	EUR 310.17 or 292 per month for full and partial, or full in non-residential (for 13 months, in 2022)	EUR 292 per month (for 13 months, in 2022)	EUR 753.83 average monthly payment
Increased generosity	Increase for social reasons	N/A	Increase for social reasons	Increase for social reasons	Increase for social reasons
Benefit base	N/A	N/A	N/A	N/A	Average earnings in last 5 years (if more than 15 years of contributions) or variable period between the last 5 and 10 years (if less than 15 years)
Minimum and maximum benefits	N/A	N/A	N/A	N/A	Partial pension minimum EUR 6 816.48 per year if household income below EUR 12 170.72 for a single household and EUR 18 256.07 for a coupled household No maximum
Duration of benefits	Transition to social benefit at age 67	No maximum	No maximum	Transition to social benefit at age 67	Transition to old-age pension at 67
<b>Compatibility with other income sources</b>					
Labour earnings	Compatible	Compatible	Not compatible	Not compatible	Not compatible
Other INPS income replacement programmes	Attendance allowance Contributory benefits	All INPS pensions and allowances	Attendance allowance Contributory benefits	Attendance allowance Contributory benefits	Attendance allowance Non-contributory pensions
INPS in-kind programmes	Handicap	Handicap	Handicap	Handicap	Handicap
Regional benefits and services	Yes	Some	Yes	Yes	Yes

Source: Mutual Information System on Social Protection (MISSOC), [www.missoc.org/missoc-database/](http://www.missoc.org/missoc-database/), Istituto Nazionale della Previdenza Sociale (INPS) and discussions with country experts.

### 3.1.1. The contributory disability pension system

Workers with at least five years of social security contributions (three of which in the past five years) are eligible for pensions from the contributory system, which provides a disability pension that mirrors old-age pensions. Disability pensions can be full pensions, granted to workers with a full (= 100%) and permanent incapacity for any work, or partial pensions, granted to workers with an incapacity of at least two-thirds. Disability pensions are calculated using the old-age pension formula, but with a substantial difference for full disability pensions: like the regulations in most OECD countries, the calculation of a full disability pension includes a contributory bonus (*bonus contributivo*), which assumes a full contributory career until age 60. Partial disability pensions can be complemented with labour earnings, contrary to full disability pensions, but payments will be reduced accordingly.

Because of the contributory bonus, at any given wage and age, a full disability pension will be as high as a corresponding old-age pension (except for people working beyond age 60), making the system relatively adequate for those qualifying for a full benefit. In 2022, the average payment for a full contributory disability pension was EUR 1 074 a month, about 85% of the average old-age pension (which was EUR 1 285 per month in 2022) (INPS, 2022<sup>[11]</sup>). This difference reflects wage differentials between people with and without disability and the shorter insurance records of people with disability, in line with international evidence (OECD, 2022<sup>[2]</sup>). However, most recipients receive only a partial contributory disability pension with an average monthly payment of EUR 701 in 2022. The average payment across all full and partial benefits from the contributory system averaged at EUR 753 in 2022.

Contributory disability pensions are automatically transformed into old-age pensions upon reaching the statutory retirement age (age 67 in 2022), whereby years of receipt of a disability pension are counted as contributory years for the calculation of the person's old-age pension. The interaction between disability and old-age pensions creates some financial incentive for early retirement through the contributory disability benefit system but data to assess the actual extent of spill-over are not available.

### 3.1.2. The civil invalidity disability system

#### *Civil invalidity pensions*

The non-contributory disability benefit system provides a means-tested flat-rate pension to people with a civil invalidity certification. Just like the contributory system, also the non-contributory system provides two separated payments depending on whether someone qualifies with full civil invalidity (loss of 100% of work incapacity, *pensione di invalidità*) or partial invalidity (loss of three-quarters of work capacity or more, *assegno di invalidità*). The non-contributory system provides parallel benefits for people with disability qualifying through blindness and deafness for which also a special assessment is required (see Table 3.1 for a summary of all income-replacement benefits).

One particularity of the Italian system compared to systems in other OECD countries is that the flat-rate payment for both benefits is the same, amounting to EUR 292 per month in 2022, with a temporary increase in 2020 in response to the COVID-19 pandemic (INPS, n.d.<sup>[3]</sup>). In most OECD countries, payments for a partial non-contributory benefit (where they exist) would be lower than for a full benefit, reflecting the remaining ability for gainful employment capacity. A second particularity in Italy is that the earnings threshold is lower for those with partial civil invalidity than for those with full civil invalidity, making the system quite work-incompatible. To qualify for a full disability benefit, a person must have a yearly personal income below EUR 17 271, excluding the pension itself and any other disability-related payments (such as occupational pensions, or the attendance allowance described below). Instead, to qualify for a partial disability benefit, the yearly personal income should be below EUR 5 015. Thus, the system imposes stronger limitations (and poorer incentives) to work on people receiving partial disability payments, who in fact should be more able to complement their disability payments with income from work.

### *Attendance allowance*

An additional element to the civil invalidity system is the attendance allowance, an additional or top-up payment granted to people with a certification of full civil invalidity and the incapacity to walk or conduct activities of daily living independently. Attendance allowance effectively is a long-term care benefit linked to the non-contributory system through the assessment of civil invalidity; it is not means-tested and provides a flat-rate payment of EUR 520 per month. As a benefit for long-term care, attendance allowance is not discussed in detail in this report but Box 3.1 provides additional information on the levels of take up and spending for this payment. Effectively, attendance allowance is the most frequent benefit granted from the non-contributory system (68% of all benefits in 2022) and also responsible for three-quarters of total public expenditure on non-contributory disability payments.

### *In-kind benefits*

In addition to these financial benefits, the non-contributory system also includes a large set of in-kind benefits that are available to people with a civil invalidity certification, even if they do not qualify for one of the (contributory or non-contributory) disability pensions. In-kind benefits include money to purchase medical aids, such as prostheses and hearing aids, exemptions to healthcare co-payments, and free public transportation. But it also includes a judicial amnesty of up to three years of prison years, and a priority in choosing the seat of the public institution for those winning a public competition. Due to the lack of data on in-kind benefits provided by INPS, these are not covered in the following.

### **3.1.3. Descriptive statistics**

#### *Civil invalidity claims are key to the disability pension system in Italy*

More than twice as many working-age people claim pensions from the non-contributory civil invalidity system as from the contributory system. In 2022, close to 2.2% of the working age population were claiming a civil invalidity pension (partial or full), a share that has increased since 2018 (Figure 3.1, Panel A) while only about 1% were receiving a contributory disability pension. While most contributory claims are for a partial benefit, claims from the civil invalidity system are in most cases for a full benefit: 53% claim a full non-contributory benefit, 37% claim a partial benefit, and the remaining 10% of non-contributory claims are for full or partial pensions for the blind and pensions for the deaf. Incidentally, payment levels are identical for all non-contributory payments (see Table 3.1).

With less than 4%, the total share of people receiving a disability benefit in Italy is low in an international comparison. In particular, the share of people claiming contributory disability benefit is very low compared to other OECD countries with a comparable contributory disability pension system, like Austria or Canada (OECD, 2022<sup>[2]</sup>). It appears that the contribution requirements – five years of contributions of which three in the past five years – are too demanding for people to qualify for a contributory payment. This also explains why more people are claiming non-contributory payments which, at EUR 298 per months, are low and much lower than the average contributory disability pension, a difference that has widened over time.

Comparisons between the contributory and the non-contributory benefit system also must keep differences in the underlying disability assessment in mind. As explained in Chapter 2, eligibility for the contributory disability system requires a permanent loss in the capacity to work, evaluated on a case-by-case basis by INPS doctors. Instead, eligibility to the non-contributory system relies on the certification of civil invalidity which, with a strong medical orientation, de facto associates a degree of disability to every health condition. As the correspondence tables used in this process have not been updated since 1992, over time these two ways of assessing disability may have become more and more different.

### Box 3.1. The role of attendance allowance in the Italian disability system


Attendance allowance is granted to people with civil invalidity at 100% who require personal support to walk and conduct activities of daily living, although it is not earmarked to spending on personal support.

- A rough multiplication of the number of recipients in 2022 by their average payment indicates that EUR 1 billion was spent on attendance allowance in 2022, an amount 2.5 times higher than the total spending on civil invalidity pensions.
- Almost 20% of the recipients receive attendance allowance only (all others receive it together with a disability benefit), which is a proxy of those for whom the means-test is binding. Those in working age receiving attendance allowance, but not receiving a pension, are likely not eligible for a pension because they have an income above the means-test. This can both be because they earn above the earnings threshold, or because their wealth is above the eligibility requirements. Either way, INPS data for 2022 suggest that almost 20% of people are in this situation and receive an average monthly payment of EUR 500.
- There are three types of benefits within attendance allowance, in addition to a benefit for minors: the general attendance allowance, an allowance for the blind, and an allowance for the deaf. This mirrors the disability pension system, with the difference that the qualifying condition is the same in this case (impossibility to walk and conduct activities of daily living). Most importantly, a blind or deaf person with full civil invalidity can qualify for both their special benefit and the general one and, in case of co-morbidities, cumulate multiple attendance allowances. De facto, however, 97% of all people receiving attendance allowance, receive the general allowance.
- Receipt of attendance allowance has a strong age gradient. Table 3.2 shows that, except for people under age 18, receipt increases with age and is very high for those over age 70: at that age, 13% receive an attendance allowance. This strong age gradient, together with the lack of means-testing and earmarking, makes attendance allowance take-up dependent on the ageing of the Italian population. With current demographic trends, spending on attendance allowance is projected to increase by 42% until 2065 (Ministero dell'Economia e delle Finanze, 2022<sup>[4]</sup>).

**Table 3.2. Receipt of non-contributory attendance allowances is strongly related to age**

	Recipients of attendance allowance as a share of the respective population (%)
Under 18	3.1
18-19	0.9
20-59	1.0
60-64	1.9
65-69	2.5
70 and older	13.6
Total	22.7

Source: OECD calculations using pension data from Istituto Nazionale della Previdenza Sociale (INPS) ([www.inps.it/osservatoristatistici/6/37/o/378](http://www.inps.it/osservatoristatistici/6/37/o/378)) and population data from Istituto Nazionale di Statistica (ISTAT) ([http://dati.istat.it/Index.aspx?DataSetCode=DCIS\\_POPRES1#](http://dati.istat.it/Index.aspx?DataSetCode=DCIS_POPRES1#))

StatLink  <https://stat.link/qkamvh>

### *Regional differences uncover large financial incentives to claim disability benefits*

Regional differences in the take-up of disability benefits are large: while the national average stands at 3.5% of the working-age population, including both contributory and non-contributory benefits, some

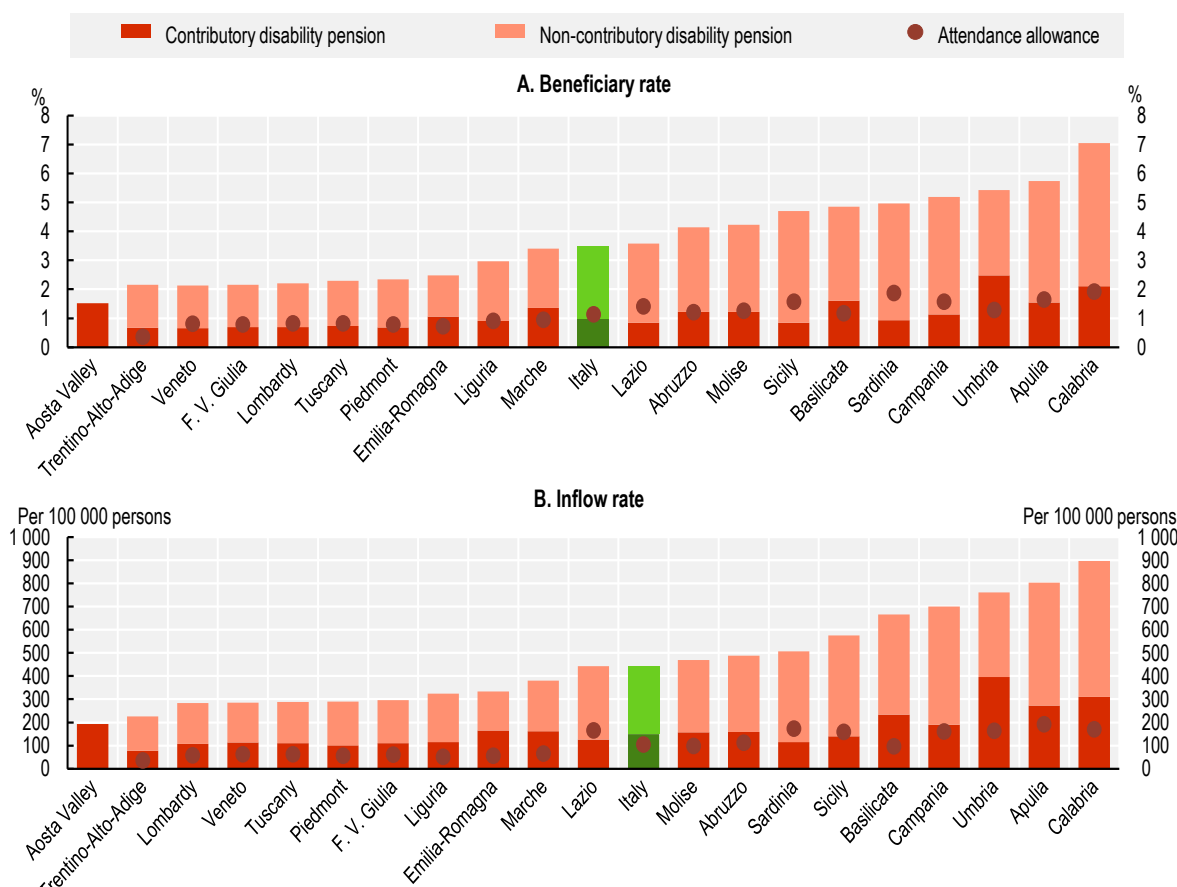


regions face a beneficiary rate of over 7% and others manage to keep the rate at around 2% (Figure 3.1, Panel A). Differences follow a North-South pattern: the Southern regions of Italy (like Calabria, Apulia, and Campania) and the Islands (Sardinia and Sicily) have a higher take-up rate than the Northern regions (such as Veneto and Lombardy). The proportions of the pensions coming from the contributory and the non-contributory system also vary across the territory, but to a lesser extent. On average, contributory pensions represent 28% of all disability pensions granted to people of working age. This share is substantially lower in the Islands and Campania, and much higher in Emilia-Romagna and Umbria.

Figure 3.1, Panel B also shows that territorial differences are likely to remain or even widen, as new disability benefit claims are highest in regions with already high beneficiary rates.

### Figure 3.1. Regional differences in the take-up of disability benefits are very large

Number of current recipients (beneficiary rates) and new recipients (inflow rates) of contributory and non-contributory disability pensions and attendance allowance, by region, 2022



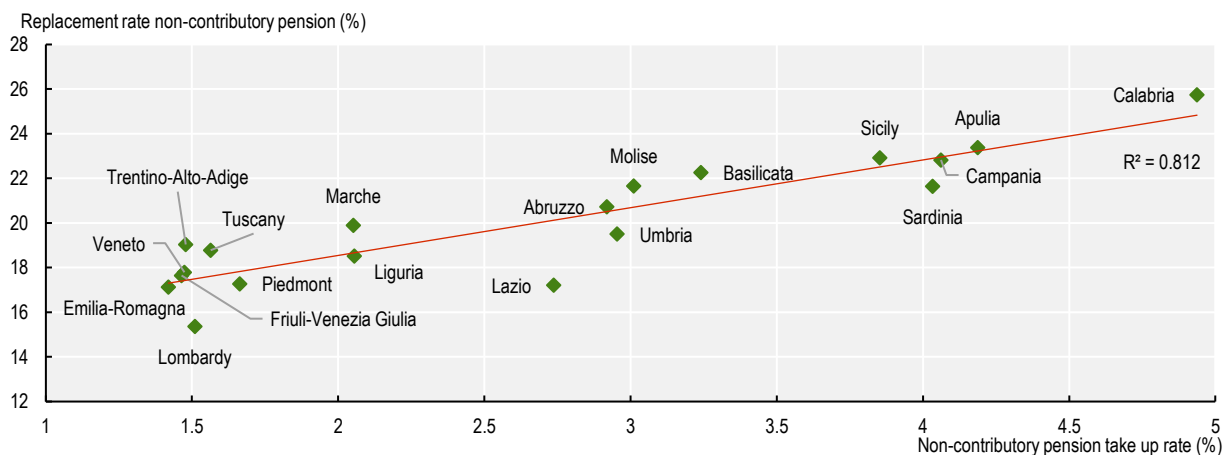
Note: The *beneficiary rate* is calculated as the number of contributory and non-contributory disability pensions and attendance allowance payments as a share of the working-age population. The *inflow rate* is calculated as new claims of contributory and non-contributory disability pensions and attendance allowance payments per 100 000 of the working-age population.

Source: OECD calculations using population data from the Istituto Nazionale di Statistica (ISTAT) ([http://dati.istat.it/Index.aspx?DataSetCode=DCIS\\_POPRES1#](http://dati.istat.it/Index.aspx?DataSetCode=DCIS_POPRES1#)) and beneficiary and inflow data prepared by Istituto Nazionale della Previdenza Sociale (INPS) for the OECD.

Financial incentives to claim the non-contributory disability pension play a large role in explaining regional differences. The level of payments of non-contributory pensions is the same for all regions, despite large differences in labour earnings, household income and costs of living. Because labour earnings are so much lower in Southern regions and the Islands than in Northern regions, the value of a non-contributory disability pension varies a lot across the territory. Figure 3.2 shows that differences in the value of these benefits (i.e. the average disability pension payment over average gross labour earnings) have a considerable explanatory power for the benefit take-up rate ( $R^2=0.8$ ): in regions where the average pension is high relative to labour earnings, far more people claim non-contributory disability pensions.

### Figure 3.2. Financial incentives to claim the non-contributory disability pension play a critical role

Value (relative to the average wage) and take-up rate of non-contributory disability pensions, 2020



Note: The replacement rate is constructed as the average non-contributory pension payment in 2020 (about EUR 300) over the average taxable gross labour earnings in each region. The take-up rate is calculated as the number of pensioners over the number of residents in the working age bracket. Results are not driven by a single region: removal of each region individually does not change the results.

Source: OECD calculations using population data from the Istituto Nazionale di Statistica (ISTAT) ([http://dati.istat.it/Index.aspx?DataSetCode=DCIS\\_POPRES1#](http://dati.istat.it/Index.aspx?DataSetCode=DCIS_POPRES1#)) data prepared by the Istituto Nazionale della Previdenza Sociale (INPS) for the OECD, and Ministry of Economy tax records ([www1.finanze.gov.it/finanze/analisi\\_stat/public/index.php?opendata=yes](http://www1.finanze.gov.it/finanze/analisi_stat/public/index.php?opendata=yes)).

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Strong financial incentives to claim disability benefits could create moral hazard if application to disability benefits is more lenient in regions where generosity is highest. However, data suggest that civil invalidity commissions are not more lenient in areas where financial incentives to claim benefits are highest.

Figure 3.3 shows that the acceptance rates of benefit claims (calculated as accepted claims over benefit applications in the period 2010-21 to account for years-long backlogs in processing claims) vary substantially across regions. However, the relationship between the replacement rate and the acceptance rate to civil invalidity is not very clear (correlation of 0.14).

Leniency could instead come from the eligibility conditions for non-contributory disability benefit payments, i.e. the means test. Since means-tested income is linked to the regional level of wages, it is to be expected that in regions where average wages are lower, it is more common to have an income below the means test. Thus, even if the acceptance to civil invalidity is equally lenient or strict across the territory, a higher share of those with a civil invalidity status will be eligible for a pension in poorer regions because of the means test.

This is an issue for means-tested benefit programmes in several OECD countries but the large North-South divide in Italy in economic development is a particular challenge. The regional differences in labour market

conditions raise a broader question on benefit levels and means-testing criteria, which are both set at the national level. Poverty alleviation in a centralised manner promotes regional redistribution but identical benefit levels in regions with very different earnings, will create differential disincentives to work. Large differences across Italy's region in the share of people looking for a civil invalidity assessment, discussed in Chapter 2, seem to be the result of such differences. At the same time, using the same means test in regions with very different living standards could, and empirically does, promote benefit dependency.

### Figure 3.3. The acceptance rate into civil invalidity is not strongly correlated to system generosity

Acceptance rate to civil invalidity and replacement rate of non-contributory disability pensions, 2021



Source: OECD calculations using data prepared by the Istituto Nazionale della Previdenza Sociale (INPS) for the OECD.

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## 3.2. Employment integration measures

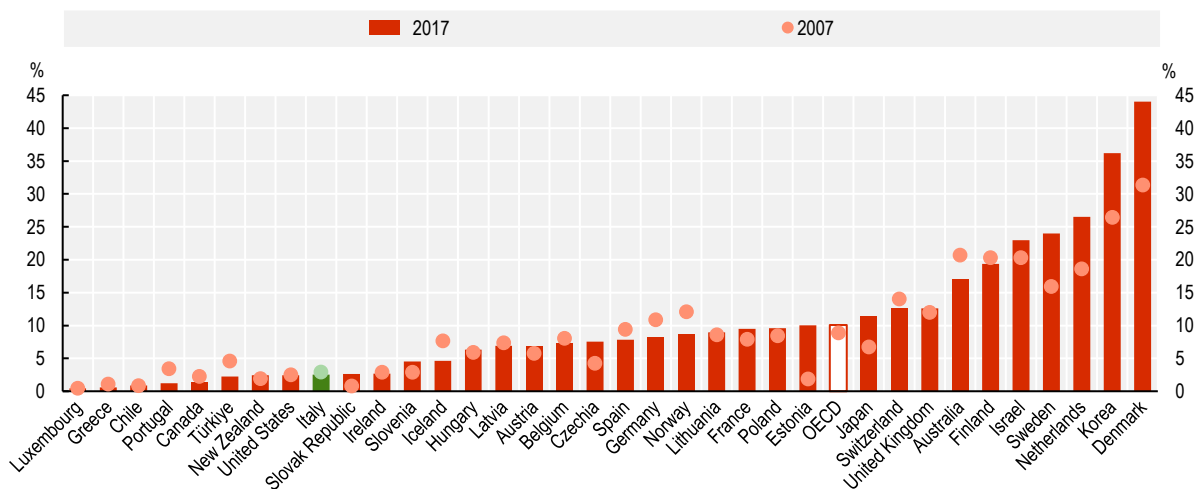
Effective labour inclusion measures and activation requirements for people with partial work capacity are particularly important under such circumstances, to address weak and unequal work incentives. In Italy, labour inclusion of people with disability is regulated under Law 68/99 (*Collocamento Mirato*) and corresponding services are provided by the Public Employment Service (PES) and the provinces, mostly in relation to the system of employment quotas, and more recently also including hiring subsidies.

People with disability with a partial civil invalidity certification or a certification of occupational incapacity can register in provincial employment lists, and the PES will facilitate the matching with jobs or employers who are looking to fulfil their employment quota. Technically, they can facilitate matching by providing career guidance to workers with disability and helping them define an employment project. At the same time, they can support employers in understanding their obligations in hiring people with disability and analysing the tasks available in the different jobs. The PES will support successfully matched workers and their employers in onboarding the job and monitoring their progress.

However, Italy is among the OECD countries which are spending only very little on active labour market measures for the inclusion of people with disability. Figure 3.4 shows that in 2017, in Italy only 2.5% of total spending on disability programmes was used for active measures (and, thus, 97.5% for payment of benefits), a share well below the OECD average of 10%. There is also no evidence that Italy's spending on employment measures has increased over the last decade.

### Figure 3.4. Italy spends very little on employment integration measures for people with disability

Active spending on incapacity as a share of total spending on incapacity, 2007 and 2017



Note: OECD is an unweighted average of the countries shown. Incapacity benefits include: disability pensions, occupational injury pensions, sickness allowances, rehabilitation services, other cash and in-kind benefits related to disability and all disability-related programmes offered by the public employment service (PES).

Source: OECD (2022<sup>[2]</sup>), *Disability, Work and Inclusion: Mainstreaming in All Policies and Practices*, <https://doi.org/10.1787/1eaa5e9c-en>, Figure 4.9.

StatLink <https://stat.link/nb4vcm>

Since registration with the PES is voluntary, few people with disability enlist to be supported in their job search (Table 3.3). Data suggest that in 2018, less than 65 000 people with disability registered with the PES under Law 68/99 to find employment through the employment quota. This is a low number compared to the 645 000 applications to civil invalidity in 2018, implying that only one in ten people granted a civil invalidity status opted to register with the PES. The number of people who find employment with the help of the PES is very low, as only 6% of those in the employment list in 2018 were hired in that same year. Most of these people were hired on temporary contracts (58%), which often do not get renewed, causing a substantial number of people transitioning out of employment soon again. The second major cause for transitioning out of employment are resignations, again highlighting the lack of obligations for workers in this process, followed by dismissals due to an objective valid reason.

### Table 3.3. Few of the eligible people with disability register with the public employment service

Take up, hiring rate and type of contracts granted through the employment quota, 2018

Metric	Value
Public Employment Service Registrations under Law 68/99	65 000
Share of registrations	10% of max number of registrations
Hired from Employment List	6% of registered
Type of Contracts Granted	58% Temporary

Source: Ministry of Labour and Social Policy (2021<sup>[5]</sup>), *Camera dei deputati relazione sullo stato di attuazione della legge recante norme per il diritto al lavoro dei disabili*.


Some more information is available on the compliance of employers with the disability employment quota. A substantial share of employers does not comply with the employment quota (Table 3.4). From the employer side, disability quotas in Italy are binding for firms with 15 or more employees: firms with 15 to 35 employees should employ one person with a certified disability, two persons for firms with 36 to 50 employees, and 7% of the firm employees for firms with more than 50 employees. The quota for firms above 50 employees is large compared to other countries using quotas, such as Germany and France (both using a quota of 6% of the workforce) or Korea (using a quota of 2%). This is possibly one of the reasons why quota fulfilment was only 71% in 2018 (Ministry of Labour and Social Policy, 2021<sup>[5]</sup>). At the firm level, data show that 44% of firms do not fulfil their quota, particularly large private firms, among which 60% do not meet the 7% quota. This finding is also reflected in territorial differences: in Northern regions, where firms are larger, quota fulfilment is lower than in Southern regions. It is important to note that while sanctions for not fulfilling the quota are also comparatively severe in theory, amounting to EUR 150 per working day per unfilled vacancy, the number of sanctions imposed is small (one sanction for every ten firms not fulfilling the quota), contributing to the limited compliance with the quota.

**Table 3.4. A large share of employers does not comply with the employment quotas**

Quota fulfilment by firms, 2018

Metric	Value (%)
Disability quota fulfilment	71
Firms not fulfilling quota	44
Large private firms not meeting quota	60
Share of sanctions for non-compliance	10

Source: Ministry of Labour and Social Policy (2021<sup>[5]</sup>), *Camera dei deputati relazione sullo stato di attuazione della legge recante norme per il diritto al lavoro dei disabili*.

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Temporary hiring subsidies seem to have increased the hiring of workers with disability, but numbers remain small. Since 2015, firms hiring workers with disability can have access to temporary hiring subsidies covering up to 70% of the gross wage. Firms hiring workers with psychological disabilities receive a larger subsidy, both in terms of the minimum degree of disability of the worker to qualify for the subsidy (45% for mental health, compared to 67% for physical health), the duration of the subsidy (60 months compared to 36 months), and its generosity (70% of the gross wage regardless of the degree of disability, compared to 35% for those with physical disability with a degree of disability under 79%). In 2016 and 2017, about 3 000 workers with disability were hired through a hiring subsidy, almost reaching a maximum usage of the resources allocated to the subsidy, and resulting in a budget-driven drop to only 800 workers in 2018 (Ministry of Labour and Social Policy, 2021<sup>[5]</sup>). Despite the additional incentives for hiring workers with psychological disability, only one-quarter of the hired workers belong to this category. Table 3.5 shows that 74.5% of the workers hired in 2016 were still employed in 2018, a figure that is expected to decrease as subsidies reach their limit, but also a figure that remains encouraging compared to the effectiveness of other employment incentives across OECD countries (OECD, 2022<sup>[2]</sup>). The fixed budget for hiring subsidies, EUR 20 billion per year, however, implies that the outreach of this policy can only be limited, much like the regional measures discussed above.

**Table 3.5. Temporary hiring subsidies seem to have boosted the hiring of workers with disability**

Metric	Value
Workers hired (2016 and 2017)	3 000
Workers hired (2018)	800
Still employed (2018 from 2016 hires)	74.5%
Total annual cost	EUR 20 billion

Source: Ministry of Labour and Social Policy (2021<sup>[5]</sup>), *Camera dei deputati relazione sullo stato di attuazione della legge recante norme per il diritto al lavoro dei disabili*.

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The data presented in this section are old and given that the importance of active employment measures for people with disability in the policy debate has increased, it is likely that the spending and take up are higher now. However, the lack of recent data is symptomatic of a more general issue of lacking evidence in Italy. Each regional PES is responsible for monitoring the take up and outcomes of employment integration measures, but in many regions this exercise is not adequately conducted, or data are not publicly available. Given this lack of cohesive data, it is difficult to measure the take up of employment integration measures, let alone its effectiveness. For labour inclusion measures less regulated than the employment quota, such as training or reasonable accommodation of workplaces, there is even less data.

### 3.3. Meeting the needs of people with disability by regional and local supports

Regional and local authorities play a crucial role in Italy in supporting the functioning and capability of people with disability by providing a range of in-kind benefits. Regional in-kind benefits fall under two main areas: health services and social assistance/social services.

- Regions directly provide most health services for people with disability through Health Agencies (*Aziende Sanitarie*). As described in Chapter 2, these services are initiated by a multidimensional assessment and an individual plan, and include medical, infirmary and rehabilitative services at home (*domiciliare*) or semi-residential and residential structures (*semi-residenziale, residenziale*). The same types of services are also granted to people with mental health problems and pathological addictions (DPCM 12.01.2017).
- Municipalities provide social services, aimed at guaranteeing support to individuals and families with social needs of various kind, including needs related to care and social inclusion of people with disability (Law 328/2000). Specifically, the latter include a multidimensional assessment and an individual plan, residential and semi-residential assistance, homecare and at-school assistance, educative support at home and at school, socio-labour services (e.g. work experiences and SIL – *Servizio Inserimento Lavorativo*), and social transport.

The division between health and social services does not correspond to the realities of the needs of people with disability. Often, their needs are complex and include several of these areas. Several interventions from the health and social realm can, and often will, concur, consistent with the aim of a multidimensional and tailored set of interventions for the specific needs of people with disability. This requires, or would require, a substantial level of co-ordination, especially as there is no single point of entry that assesses the needs and activates the delivery of services (again, see Chapter 2).

#### 3.3.1. Residential and homecare services

Residential services and homecare can be provided both by Health Agencies and by municipalities. The main difference between the services offered by the two entities is that residential and homecare services

under Health Agencies have the objective to meet medical needs, while those under municipalities have a social inclusion objective. However, many residential, semi-residential and homecare services cater a mix of medical and social inclusion needs.

Spending on residential and homecare services for people with disability represents almost 1% of GDP (Table 3.6). Health Agencies alone spent 0.92% of GDP in 2019 on homecare and residential (and semi-residential) services, capturing most health spending on people with disability, excluding staff costs and other expenses that are difficult to attribute. For reference, total healthcare spending was 8.5% of GDP in 2019, implying that spending for people with disability, including those with mental health issues and lack of autonomy, represent 11% of the total spending on healthcare (OECD, 2023<sup>[6]</sup>).

Spending on services for people with disability by municipalities was 0.11% of GDP in 2018, out of a total 0.42% of GDP spending by municipalities (ISTAT, 2022<sup>[7]</sup>). Homecare and residential services represent 45% of the municipal spending, indicating that also from the social inclusion side, a large part of resources go to providing residential, semi-residential and homecare services.

Spending on residential services remains high, despite efforts to promote the de-institutionalisation of people with disability. In line with the UN Convention on the Rights for People with Disability, Italy is supporting the de-institutionalisation of people with disability by increasing homecare financing. Three funding initiatives implemented in the last decades aim at promoting the transition from residential to homecare services: the Non-Self-Sufficiency fund (FNA), established by L. 296/2006; the “Fund for the assistance of people with severe disability without family support (“After Us” Fund), established by Law 112/2016; and the Family Caregivers fund (DM 26.07.2016; L. 205/2017 art. 254) with the aim to promote legislative intervention toward caregivers support. While this increase in specific funding is visible in terms of the much larger coverage of homecare compared to residential services (see Chapter 4), the cost of residential services per user is much higher, resulting in a greater overall spending.

### Table 3.6. Spending on residential and homecare services represents almost 1% of GDP

Spending on homecare and residential services for people with disability by actor, as a share of GDP (%), 2019

	Homecare	Residential	Total
Health Agencies	0.28	0.64	0.92
Municipalities	0.02	0.03	0.05

Source: OECD calculations using BDAP – Ragioneria Generale dello Stato, Modello di rilevazione dei Livelli di Assistenza, <https://bdap.opendata.rgs.mef.gov.it/content/2019-modello-di-rilevazione-dei-livelli-di-assistenza-degli-enti-del-ssn> (2019), Istat Spesa Sociale dei Comuni [www.istat.it/it/archivio/7566](http://www.istat.it/it/archivio/7566), and OECD GDP data <https://data.oecd.org/gdp/gross-domestic-product-gdp.htm> (accessed October 2023).

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Many residential structures are a jointure between municipalities and Health Agencies, offering medical and inclusion services. However, municipalities can also offer non-medical inclusion residences. Taking the example of Campania, residential solutions can range from autonomous apartment-sharing (*Gruppo Appartamento*) to more structured cohabitation situations (*Comunità Alloggio*), to proper residential structures where some minimum health services are also ensured (*Comunità Tutelare per Persone non-autosufficienti*). For semi-residential structures, the offer can vary even more, depending on municipal initiatives. For instance, the municipality of Cagliari in Sardinia sets up centres to promote creativity, where people with disability are helped socialising and improving their mental well-being through theatre workshops, animation and body expression, or painting.

Homecare services are also provided by both health authorities and municipalities. Health authorities will finance infirmary, rehabilitative, medical, and psychological support services at home or outpatient. Municipalities' homecare services include homecare intervention assistance (*servizio assistenza*

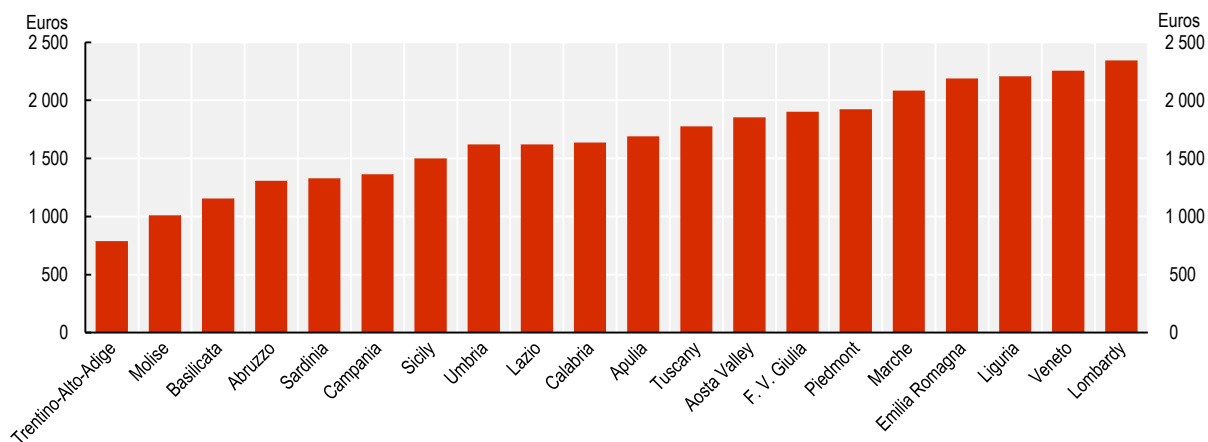
*domiciliare*) for the support of social integration (e.g. educational support, transports) and basic care for independent living (hygiene, meals, mobilisation, caregivers support, etc.). Homecare services can be granted either directly or through the reimbursement of family costs (e.g. *assegno/voucher di cura*).

While residential and homecare services are a regional and local competence, the national government regulates its provision by setting minimum levels of service provision (= minimum standards). Since 2001, the Ministry of Health sets standards for Health Agencies (*Livelli Essenziali di Assistenza*, LEA) which, for people with disability, mostly relate to the minimum numbers of beds in residential and semi-residential structures. Most recently, the 2022 budget law (law n. 234/2021) sets minimum standards also for social services (*Livelli Essenziali Delle Prestazioni Sociali*, LEP), aiming to close large regional disparities in the provision of social services, including residential and homecare services for people with disability.


Despite substantial efforts to harmonise minimum levels of service, regional differences in service provision continue to be large, again following a strong North-South divide. Figure 3.5 illustrates this for the case of spending on health services for people with disability: spending ranges from EUR 1 011 per person in Molise to EUR 2 343 per person in Lombardy. Similar data for spending on social services are unavailable but as these services are provided locally, differences across the country are likely to be even larger.

### Figure 3.5. Regional differences in service provision are large, following a North-South divide

Per-capita spending on health services (homecare, semi-residential and residential) for people with disability, 2019



Source: OECD calculations using BDAP – Ragioneria Generale dello Stato, Modello di rilevazione dei Livelli di Assistenza, <https://bdap-opendata.rgs.mef.gov.it/content/2019-modello-di-rilevazione-dei-livelli-di-assistenza-degli-enti-del-ssn> (2019) and Istituto Nazionale di Statistica (ISTAT) population data.

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It should be noted that available data do not allow measuring the number of service users. Moreover, the data presented in Figure 3.5 are a lower bound for total spending on health services, particularly for those regions with substantial autonomy in the management of their healthcare system, as they capture only healthcare spending falling under the monitoring process to the national government. This is very relevant for instance for the Autonomous Province of Trento, where some spending is not reported in this figure, explaining the low per capita spending for this region.



### 3.3.2. Social services

Social services include employment and social inclusion initiatives tailored for people with disability, typically administered by municipalities. Social services include the support by social workers to orient people with disability on the services and in-kind benefits available, on multidimensional assessments, and on the administrative costs of individual plans. They also include means-tested economic supports, for instance contributions for housing contributions to residential and semi-residential fees (*integrazioni rette*), vouchers for care services (e.g. *assegno di cura*), specific contributions supporting people with disability in the work or training stages (*indennità di partecipazione*), and cost sharing or fee reductions for relational, cultural and recreational services. The largest spending however goes to employment and social integration services, described in more detail in the following.

#### *Employment integration*

Most regions roll out programmes like the “Servizio Inserimento Lavorativo” (SIL). Targeted at people with disability registered under L.68/1999, these programmes aim to enhance social and vocational skills of individuals looking for work and can serve as preliminary steps or alternatives to traditional employment. The interventions range from inclusive training internships to employment grants.

Other employment programmes include local grassroots initiatives, many of which are financed by the European Commission (through ESF funds), such as the INCLUDIS project in Sardinia, which aims to provide work experience to people with disability. Funding for this project was close to EUR 6 million for 1 223 people with disability, or close to EUR 5 000 per person. Of those 1 223 participants, 719 ended up in an internship in one of the private co-operatives partnering with municipalities for the purpose of this project. There is no information on how many ended up in employment.

#### *Social inclusion*

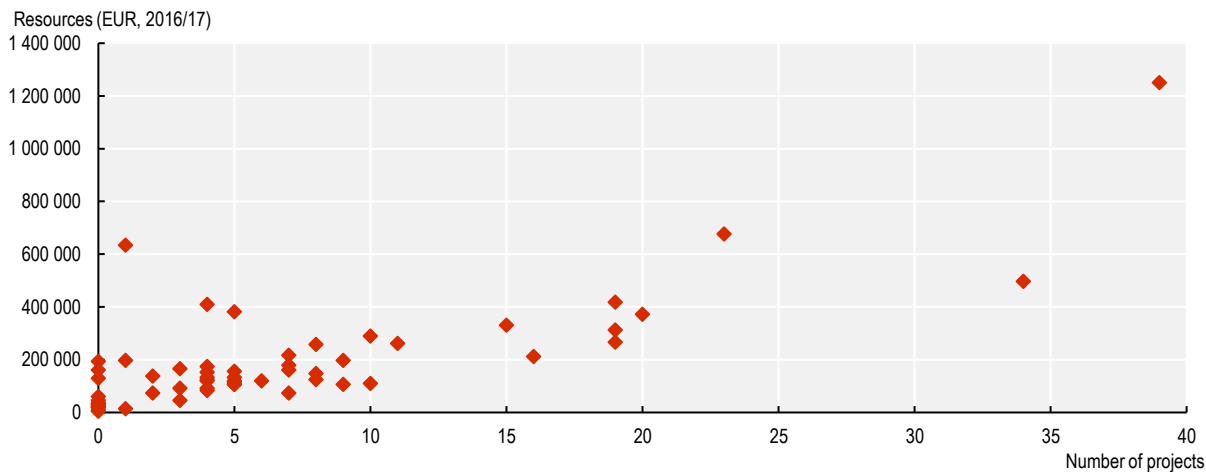
Social inclusion services are designed to facilitate daily living at home and within the broader community. Examples are socio-educational services often delivered via individual tutorship, family mediation, projects to promote independent living, co-housing assistance, mobility and transportation provisions, and caregiver support. It is also noteworthy that individuals with disability receive priority for social housing allocations (L.104/92). The overarching goal across these initiatives is promoting the highest degree of independent living. The establishment of the Support Administrator role (L.6/2004) stands out as a significant move towards bolstering autonomy and self-determination for people with disability.

The largest social inclusion programmes are the “*Dopo di noi*” project (Law 112/16) and the “Independent Life Project”. Both projects are available in most regions since they are financed by national-level funds. The two programmes have a similar goal, in that they provide support (financial and in-kind) to people with disability of working age with a handicap certification to support their independent living. The two projects are funded by separate funds, and thus require parallel bookkeeping, a clear duplication of work for local authorities and a barrier for users in deciding which programme to use. Beyond duplication, and despite being a national priority, data show the limited reach of these projects, at an extraordinary cost.


By way of example, in Sardinia (2020), out of 41 000 individual plans, just 58 people benefitted from an Independent Life Project (for a financing of EUR 1.3 million, or EUR 22 413 per person). For Campania, data suggest that in 2016-17, 394 people benefitted from the “*Dopo di noi*” project. Figure 3.6 plots the take-up of *Dopo di noi* in every single municipality (and consortium) in Campania against the total resources assigned for this project. The average cost per user is EUR 28 274, a magnitude comparable to the Independent Life Project in Sardinia. The large variation in resources used for this project, despite the small number of users in many municipalities, is astounding. This highlights the clash between specific earmarked funds provided by the national government without assuring the necessary capacity at the local level, to implement the programmes equally and effectively.

### Figure 3.6. Independent living projects: High costs per user at the expense of a limited reach

Resources assigned for the *Dopo di Noi* project in Campania and number of projects, by municipality, 2017-18



Source: OECD elaborations with data shared by Region Campania.

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The next chapter builds on this description of disability supports available in Italy and takes a broader system perspective to assess the effectiveness and performance of social protection for people with disability. It raises the importance of looking beyond disability systems only to assess the adequacy and coverage of social protection for people with disability; highlights how disability assessment may contribute to system inefficiencies; and looks deeper into geographical inequalities of the social protection system.

## References

- INPS (2022), *Osservatorio sulle pensioni erogate dall'INPS*, [1]  
<https://www.inps.it/osservatoristatistici/6/37/o/378> (accessed on 3 October 2022).
- INPS (n.d.), *Incremento delle prestazioni di invalidità civile (invalidi civili totali, ciechi civili, sordi e titolari di pensione di inabilità previdenziale)*, 2020, <https://www.inps.it/news/incremento-delle-prestazioni-di-invalidita-civile-invalidi-civili-totali-ciechi-civili-sordi-e-titolari-di-pensione-di-inabilita-previdenziale> (accessed on 19 November 2022). [3]
- ISTAT (2022), *La Spesa dei Comuni per I Servizi Sociali (The Expenditure of Municipalities on Social Services)*, <https://www.istat.it/it/archivio/253929>. [7]
- Ministero dell'Economia e delle Finanze (2022), *Le Tendenze di Medio-Lungo Periodo del Sistema Pensionistico d Socio-Sanitario*. [4]
- Ministry of Labour and Social Policy (2021), *Camera dei deputati relazione sullo stato di attuazione della legge recante norme per il diritto al lavoro dei disabili*. [5]
- OECD (2023), *OECD Health Statistics 2023*, <https://oe.cd/ds/health-statistics>. [6]
- OECD (2022), *Disability, Work and Inclusion: Mainstreaming in All Policies and Practices*, OECD Publishing, Paris, <https://doi.org/10.1787/1eaa5e9c-en>. [2]

# 4 The effectiveness of support for people with disability in Italy

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Based on available data and evidence, this chapter attempts to assess the effectiveness and performance of social protection for people with disability in Italy. The chapter looks at four main aspects: system coverage, system adequacy, system equity, and system efficiency. It concludes that the system is quite adequate for people able to access all support they could be entitled to but that it suffers from a high rate of non-access and under-coverage, especially for disability services and among people with less severe disability. Together with significant territorial differences, this creates a system that is neither particularly fair nor particularly efficient.

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The national, regional, and municipal responsibility for benefits and services for people with disability is complex in Italy, generating considerable fragmentation of both services and benefits, and sometimes also creating duplication of support in a rather non-transparent way. This chapter attempts to assess the effectiveness of social protection support for people with disability in Italy, by looking at four main aspects: (1) system coverage, (2) system generosity, (3) system equity, and (4) system efficiency. It finds that the Italian system has both strengths and weaknesses.

## 4.1. The coverage of the social protection system for people with disability

### 4.1.1. People with severe disability receive social benefits in most cases

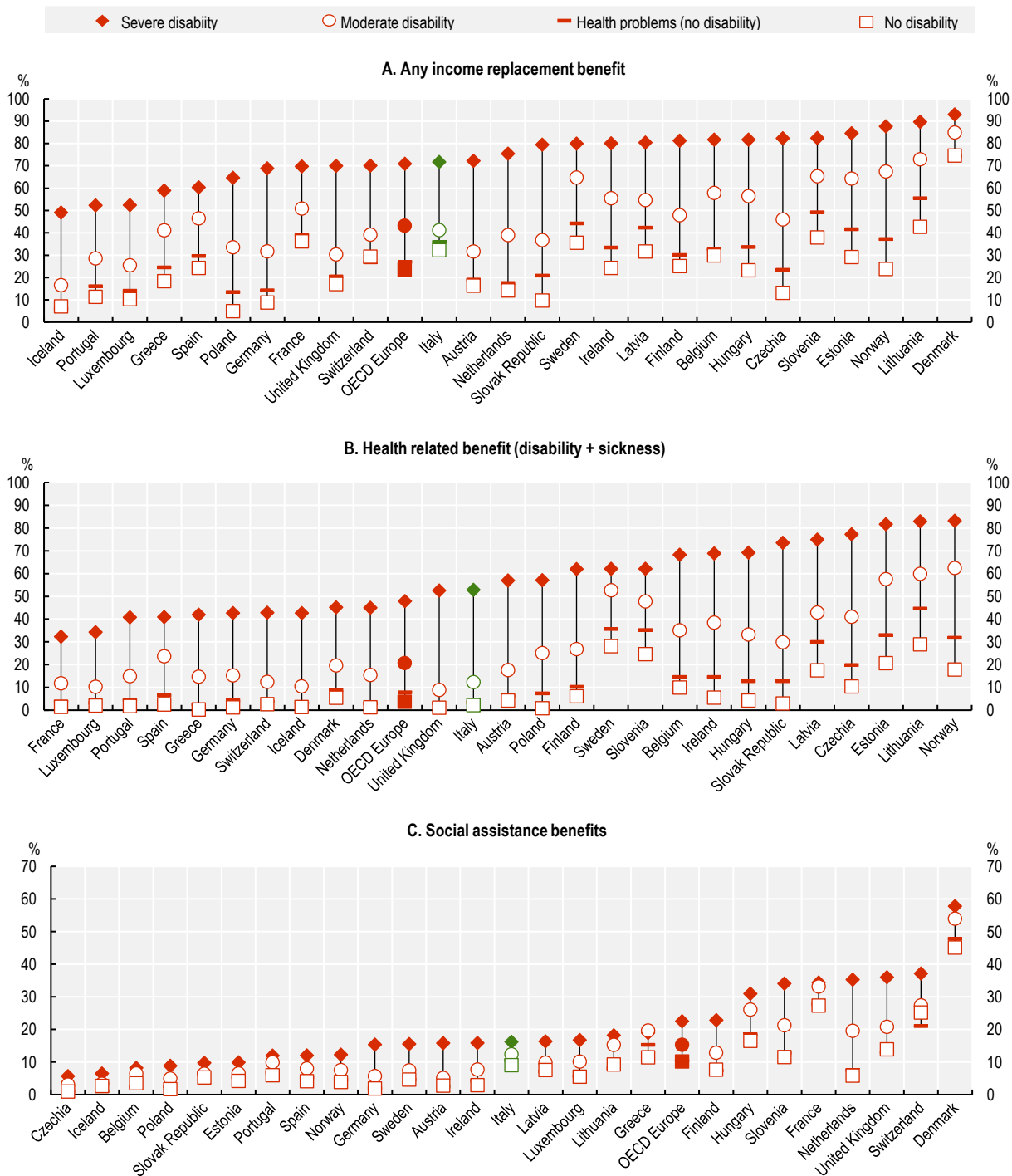
In Italy, around 70% of people with severe disability receive some social or income replacement benefits (Figure 4.1, Panel A). This share is in line with the benefit coverage of people with severe disability across OECD European countries on average although below the share observed in many Nordic countries and some Central and East European countries. Coverage by social benefits falls to around 40% for people with moderate disability, a level below the OECD European countries average and only a little higher than for people in Italy with chronic health issues but without disability. Regional differences in overall benefit coverage rates, not presented here, are relatively small in Italy, for both people with severe and with moderate disability.

Overall, most people with self-reported disability in Italy receive social benefits other than disability benefits, a finding that holds true among many OECD European countries. In Italy, 53% of people with severe disability are covered by health-related programmes, compared to the overall 71% who receive any benefit – suggesting that disability benefit is well targeted to those most in need (Figure 4.1, Panel B). The coverage by disability benefits in Italy falls to only 12% for people with moderate disability, however, a low share compared to the OECD Europe average of 21% and shares of 30-50% in many Nordic countries and some Central and East European countries. Figure 4.1 also shows that in Italy very few people without disability or health issues are receiving disability benefits (false positives). On the contrary, the data do not allow to identify people in need of support who do not receive any benefits (false negatives). With a disability assessment approach that is still predominantly medical, in Italy the group falling through the cracks could potentially include many people with mental health conditions.

In some countries, many people with disability are covered by social assistance programmes, either as a top up to their disability benefit, or as a main benefit if household income is low. In Italy, the coverage of people with disability through social assistance payments is below the OECD Europe average, particularly for people with severe disability. People with moderate disability in Italy also have a coverage from social assistance below average across OECD Europe, but the difference is smaller than for people with severe disability. Finally, some 22% of people with moderate disability receive unemployment benefits in Italy, a share that is much higher than the OECD Europe average. This is potentially a positive outcome if it means that these people are registered with, and engaged by, the Public Employment Service. Data do not allow making this conclusion, however, and other evidence seems to suggest that Public Employment Services in Italy are generally under-resourced and poorly developed (OECD, 2019<sup>[1]</sup>).

**Figure 4.1. Most people with severe disability are covered by income replacement benefits**

Benefit receipt rate for working-age population in OECD European countries, average over 2018-21



Note: OECD Europe is a weighted average of the 26 European countries shown.

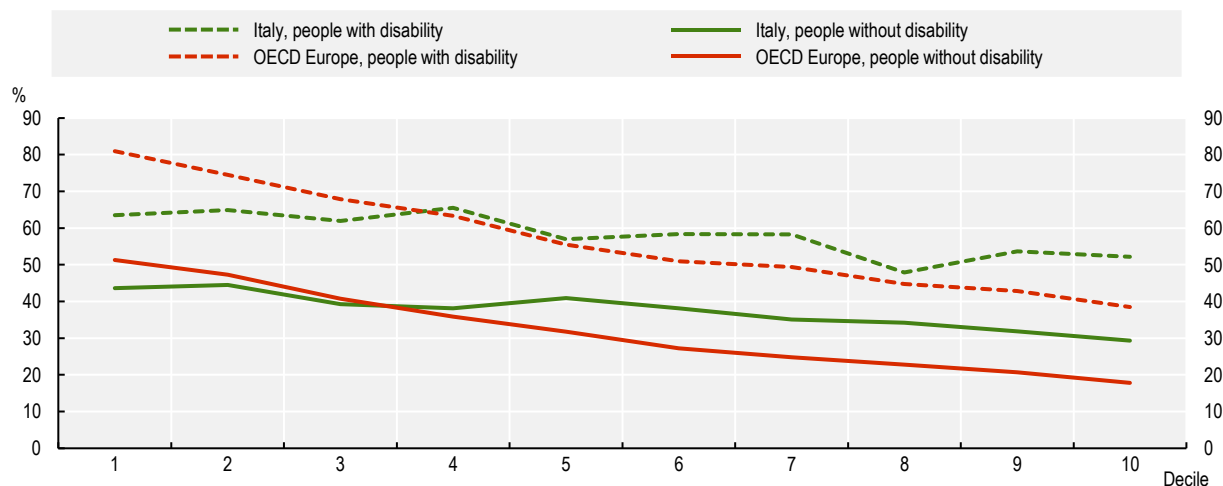
Source: OECD calculations based on European Union Statistics on Income and Living Conditions (EU-SILC).

For people with disability in Italy, the incidence of and dependence on income replacement benefits across the income distribution is not obvious. On the one hand, social assistance and means-tested benefit receipt will inevitably have a higher incidence among lower-income households. On the other hand, contributory disability benefits could have a higher incidence in higher-income households if low-income households more frequently do not meet the contribution requirements. At the same time, high-income households may also be less reliant on benefits more generally, which could imply a higher rate of benefit incidence among low-income households. Empirical data shed some light on this and the importance of different objectives of social protection, including poverty alleviation and insurance against income loss.

The distribution of benefit receipt across income deciles is flatter in Italy than on average across OECD Europe (Figure 4.2). This means that in Italy a similar share of middle-income and low-income households receives benefits, among both people with and without disability. High-income households receive less benefits than the other groups but more than average across OECD Europe. Whether this is a desirable outcome, depends on the objectives of the social protection system. In Italy, as in many OECD countries, the social protection system for people with disability has both an insurance role (i.e. the system aims to compensate for a loss in income capacity due to disability) and a poverty alleviating role (i.e. to compensate people for the additional costs of disability). The flat distribution of benefit receipt across income deciles suggests that the insurance effect is stronger than the poverty alleviating effect. In-depth administrative data would be needed to understand the degree to which this is caused by people receiving more than one benefit (e.g. contributory as well as non-contributory payments).

### Figure 4.2. The distribution of benefit receipt across income deciles is rather flat in Italy

Distribution of social protection beneficiaries by income decile, average over 2018-21



Note: OECD Europe is the weighted average of 26 European countries: Austria, Belgium, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, the Netherlands, Norway, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Sweden, Switzerland and the United Kingdom.

Source: OECD calculations based on European Union Statistics on Income and Living Conditions (EU-SILC).

StatLink  <https://stat.link/zsrg0y>

#### 4.1.2. Home assistance coverage is high, but social services seem underdeveloped

The coverage analysis so far is partial to the extent that it focuses on income replacement benefits only. As discussed in Chapter 3, a large part of the social protection system for people with disability consists of in-kind benefits provided by regional and local governments. Table 4.1 uses administrative spending data

for 2019 by regional and local governments on in-kind support for people with disability, overall and per user, to estimate the likely number of users of residential services, home assistance and social services (as no direct data on service users and service coverage is available). The results are shown as a share of people with disability in each geographical area, with coverage of residential services and home assistance compared with the number of people with severe disability, as these services are targeted to this group, and coverage of social services compared with all people with disability, as part of broader employment and social inclusion policies.

Coverage of residential services is very low, at 1% of people with severe disability on average across Italy, while about 26% of people with severe disability seem to receive home assistance. The latter share varies substantially across regions, reaching 70% in the North-East but being around 10% in the South and Centre. In a society aiming to close institutions for people with disability, a low coverage on residential services and a high coverage on home assistance is a very desirable outcome but the large territorial differences are problematic. Social services, however, seem to be insufficient across the country, although again more so in the South, with only 6% of people with severe or moderate disability being serviced on average. It appears that in Italy also social services are targeted to people with severe disability mostly.

#### Table 4.1. Many people receive home assistance but too few people receive social services

Coverage of regional and local in-kind services for people with disability over the relevant target population, 2019

	Residential services		Home assistance		Social services	
	PWD (%)	PWSD (%)	PWD (%)	PWSD (%)	PWD (%)	PWSD (%)
North-West	0.31	1.33	6.06	26.07	7.90	33.98
North-East	0.44	1.82	17.04	70.93	7.27	30.25
Centre	0.18	0.68	2.96	11.22	5.82	22.11
South	0.09	0.40	2.02	8.51	3.48	14.69
Islands	0.24	0.84	5.04	17.89	7.46	26.45
<b>Italy</b>	<b>0.25</b>	<b>1.01</b>	<b>6.47</b>	<b>26.20</b>	<b>6.29</b>	<b>25.46</b>

Note: PWD: Persons with disability, PWSD: Persons without severe disability.

Source: ISTAT (n.d.<sup>[2]</sup>), *Disabilità in cifre*, <https://disabilitaincifre.istat.it/>.

StatLink  <https://stat.link/pbuwqn>

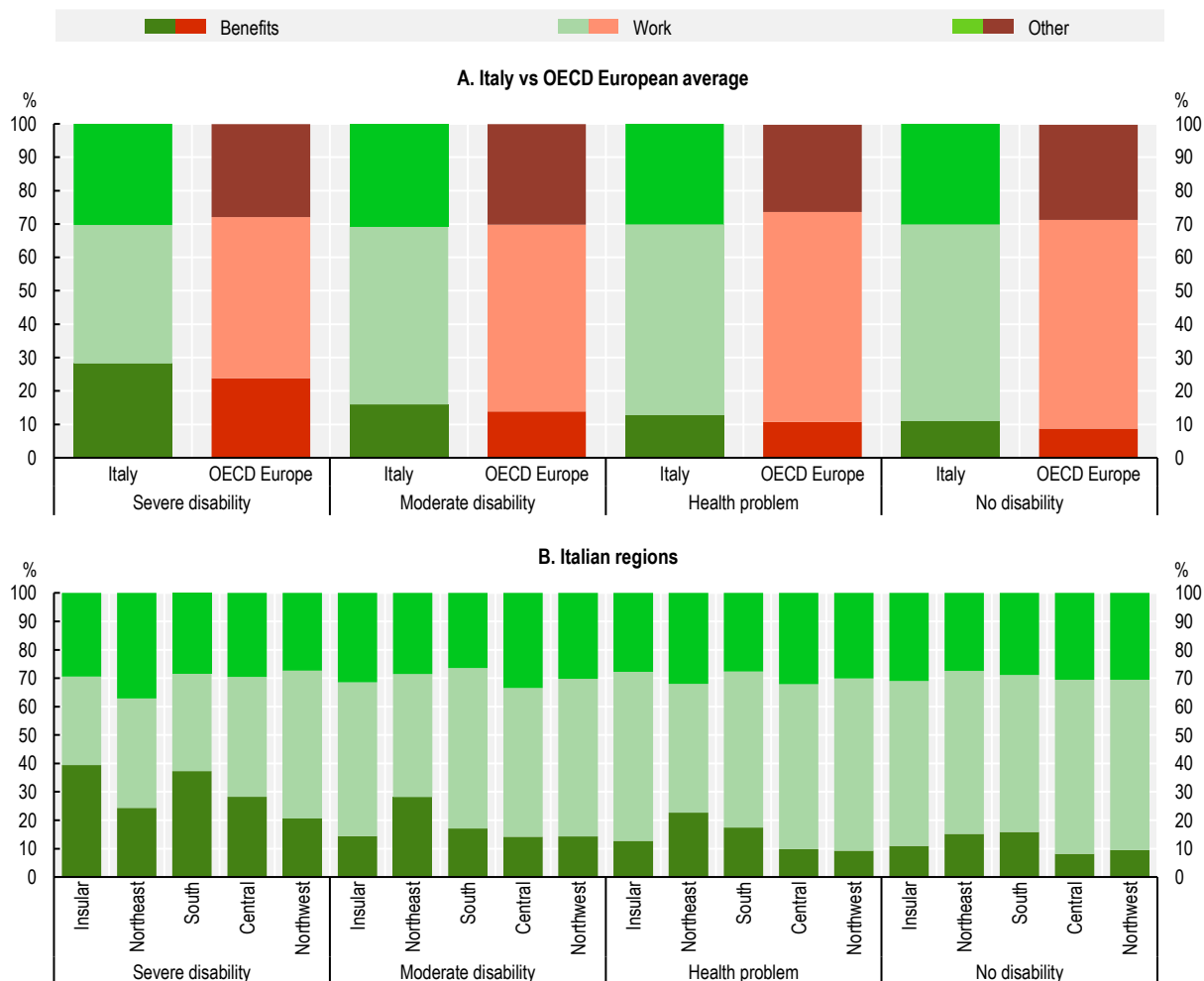
This coverage analysis is limited in three main directions. First, spending and users of services for people with disability does not cover the entire group of people with disability, as support for people with mental health problems or with pathological dependencies are covered (and budgeted) under different areas of spending. Second, this analysis does not allow understanding how many people would like to receive services but remain excluded, nor how many people could benefit from services. Overall, much better data is needed to understand the extent to which people with disability are covered through in-kind support, particularly social and labour inclusion services. Lastly, this analysis excludes the efforts of the Public Employment Services to integrate people with disability, given a lack of respective data.

#### 4.2. The adequacy of the social protection system for people with disability

Overall, the social protection system is quite adequate for people with disability in Italy, possibly explaining the moderate poverty levels of this group and the relatively low disability poverty gap (i.e. the rather small difference in poverty levels between people with and without disability). Figure 4.3. shows that the share of income received from income replacement benefits is higher in Italy than on average in OECD European countries, particularly for people with severe disability.


### Figure 4.3. The social protection system seems quite adequate for people with disability in Italy

Share of household income from benefits, work and other sources, by type of severity, average over 2018-21



Note: OECD Europe is the weighted average of 26 European countries: Austria, Belgium, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, the Netherlands, Norway, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Sweden, Switzerland and the United Kingdom.

Source: OECD calculations based on European Union Statistics on Income and Living Conditions (EU-SILC).

StatLink  <https://stat.link/OkI3tp>

On the one hand, contributory disability pensions for full and permanent work incapacity are quite generous in Italy, with a replacement rate well above the OECD average (OECD, 2021<sup>[3]</sup>). On the other hand, people with disability can also claim social protection programmes not targeted to people with disability only, including especially a guaranteed minimum income (*Reddito di Cittadinanza*). This benefit can be used to complement low disability pensions to the level of the minimum income.

Importantly, in Italy many (older) people with disability receive old-age pensions through early retirement programmes, which are generous and account for a large share of the benefits received for all groups. In line with the findings in Chapter 1, the figure also shows that earnings from work represent a smaller share of total income in Italy than on average across the OECD. Other sources, like family transfers, are somewhat more important in Italy than on average, again especially for people with severe disability.



### 4.3. The equity of the social protection system for people with disability

A critical distributional issue in Italy is the large North-South divide in social protection coverage. Regional differences in take-up rates of income replacement programmes are very significant, with a strong impact of the respective financial incentives to claim benefits, resulting in much higher benefit reciprocity rates in regions with lower average wages. Regional differences are also very large in respect of the regional capacity to deliver services, albeit in the opposite direction, with Northern regions spending much larger amounts per capita on health and social services for people with disability. Taken together, and probably oversimplifying a very complex issue, Northern regions provide more services directed to meeting the needs of people with disability while Southern regions provide more cash benefits. This is also the result of the different funding mechanisms: Southern regions, being poorer, have less capacity to complement and increase the funds for health and social services received by the national government. On the contrary, social benefits are nationally funded and not bound by, or related to, regional spending capacity.

There is a good case for a renewed legislation on basic minimum levels of services across Italy, which could be a vector guaranteeing a more equal treatment of people with disability across the country. From a legislative standpoint, significant steps have been made in the recent past. For health services, basic minimum levels of services have been updated in 2017. Basic minimum levels of social services have at least found a preliminary definition in the “National plan of interventions and social services 2021-23”.

A second distributional issue in Italy to emphasise is the relative generosity of regional services per user, in combination with limited population coverage. The analysis shows that spending on regional services, particularly regional social services, is quite high per user. While there are no data on the potential target group, i.e. people who would need to receive services and in-kind benefits but do not, consultations with key stakeholders suggest that regional resources and actual users of the system fall well short of the potential target group. In a context of limited resources, and with very expensive services being provided by the regions, this suggests that only a lucky few get to receive those services. This raises the question how to define who needs help most, highlighting the importance of adequate needs assessments for people with disability, discussed in some detail in Chapter 2 of this report.

### 4.4. The efficiency of the social protection system for people with disability

It is also crucial to look at the capacity of the social protection system to alleviate poverty in view of the level of public social spending, to understand and assess the efficiency of the Italian system. This section looks at the poverty prevention impact of social protection, by looking at poverty levels that would arise without any social transfers, and contrasts that finding with the cost of social protection. It also discusses, only in a qualitative way, the issue of duplication of services and benefits for people with disability in Italy provided by different levels of government, as available data are not good enough to assess the incidence and cost of such duplications.

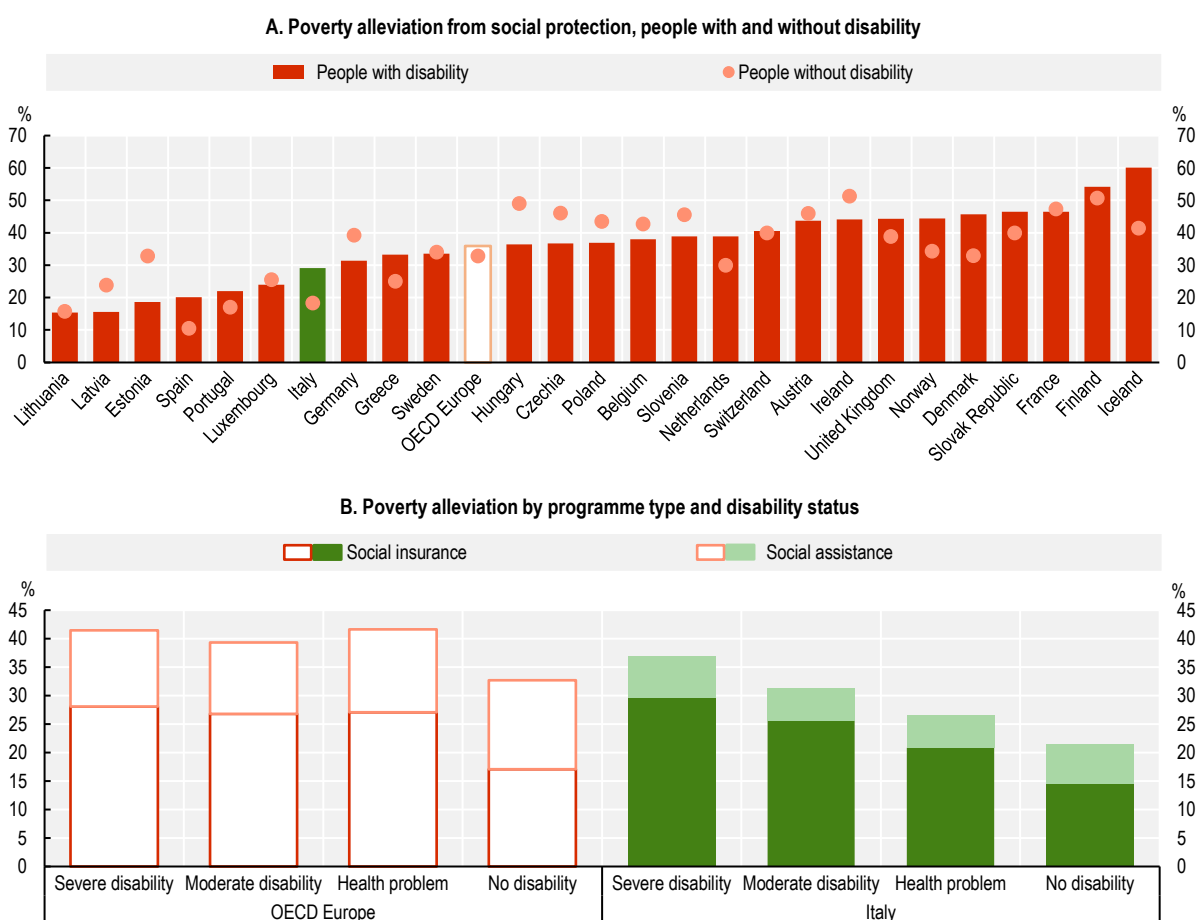
#### 4.4.1. The poverty alleviating effect of the social protection system

The capacity of the Italian social protection system to alleviate poverty is below European OECD average in general, but it is relatively better at supporting people with disability. Figure 4.4, Panel A, shows that across OECD European countries, social protection prevents over 35% of persons from falling into poverty, a share comparable for people with and without disability. In Italy, the social protection system reduces the incidence of poverty among people with disability by almost 30%, but that of people without disability by only 18%. It is a particularity of Southern European and Nordic countries that social protection systems do better in alleviating the poverty risk for people with disability than for people without disability. In most other OECD European countries, the opposite situation can be found, with social protection systems having a stronger poverty-alleviating effect for people without disability than for people with disability.

Disaggregating results by disability extent reveals that in Italy, poverty alleviation from social protection is particularly effective for people with severe disability (Figure 4.4, Panel B). The poverty alleviating effect of social protection declines gradually for people with moderate disability, people with health issues who have no disability, and people without disability. Instead, on average across OECD Europe, the poverty alleviating effect is similar for people with severe and moderate disability and only slightly lower for people without disability. Panel B also shows that social insurance has a relatively greater impact on poverty reduction in Italy than on average across OECD European countries. Many factors could explain this, including the relatively low take up of social assistance in Italy compared to other European countries, the relatively high replacement rate of contributory disability benefits, and, as discussed below, the importance of other social insurance programmes like old-age pensions and unemployment benefits.

**Figure 4.4. Social protection in Italy reduces the poverty risk of people with disability significantly**

Average over 2018-21



Note: OECD Europe represents the weighted average of the 26 European countries shown in Panel A.

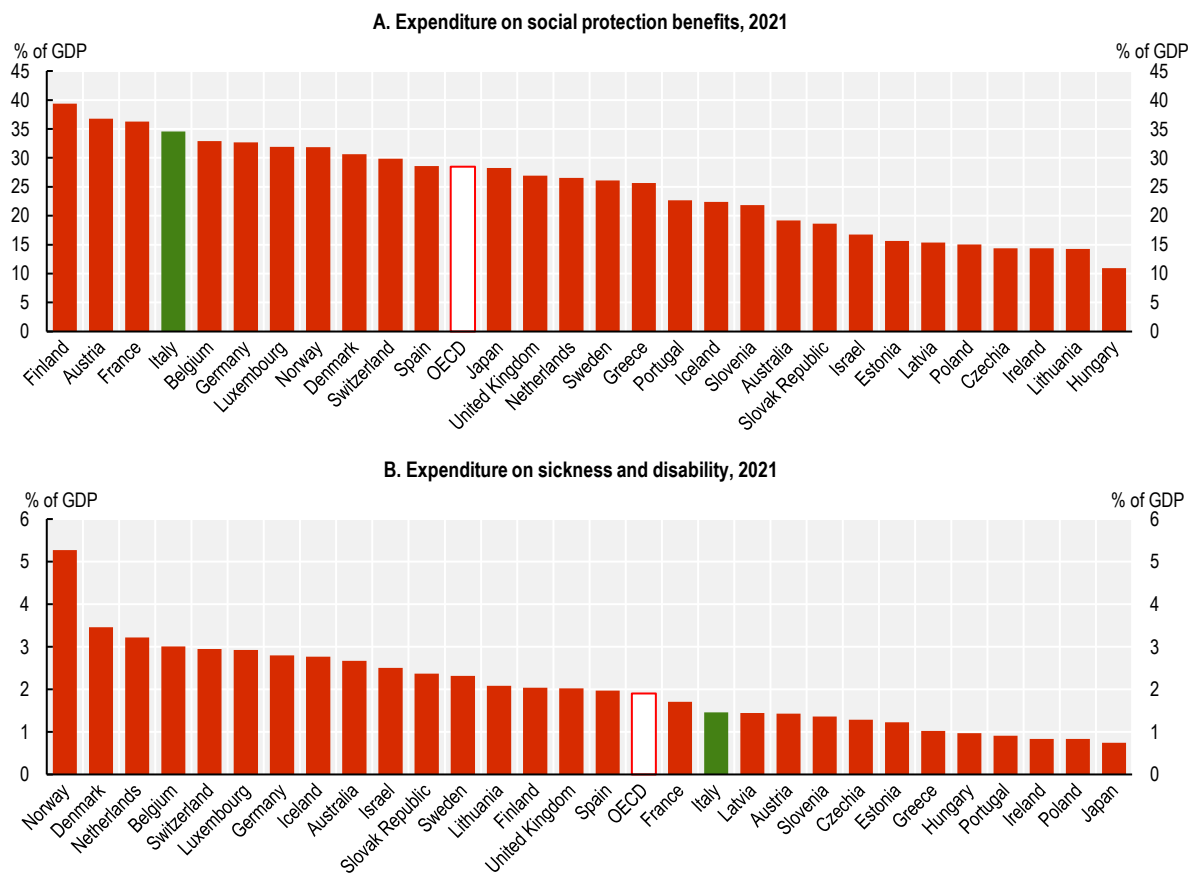
Source: OECD calculations based on the EU Statistics on Income and Living Conditions (EU-SILC).

StatLink  <https://stat.link/bxzyvq>

Public social spending is very high in Italy overall, compared to other OECD countries. Figure 4.5, Panel A suggests that total spending on social protection benefits is 35% of GDP in Italy, compared to 29% on average across the OECD. Large part of this spending comes from old age pensions, both in Italy and in many other OECD countries. On the contrary, spending on sickness and disability benefits is relatively low


in Italy, at 1.5% of GDP, lower than the OECD average of 2% and much lower than in some of the higher spenders in the north and west of Europe (Figure 4.5, Panel B). This suggests that the poverty alleviating effect for people with disability in Italy is to a considerable degree created by social programmes other than disability benefits, including retirement and early retirement programmes. When evaluating the efficiency of social protection for people with disability in Italy, it is thus critically important to include mainstream programmes such as old-age, unemployment, and social assistance benefits.

**Figure 4.5. Social spending is high in Italy but spending on disability programmes is below average**



Note: The OECD average excludes Chile, Colombia, Costa Rica, Korea, Mexico, New Zealand, Türkiye and the United States.

Source: OECD calculations based on OECD datasets: 11. Government expenditure by function (COFOG), [https://stats.oecd.org/index.aspx?QueryId=61325\\_SNA93](https://stats.oecd.org/index.aspx?QueryId=61325_SNA93); GDP and spending – Gross domestic product (GDP) – OECD Data, <https://data.oecd.org/gdp/gross-domestic-product-gdp.htm>; and Conversion rates – Exchange rates – OECD Data, <https://data.oecd.org/conversion/exchange-rates.htm>.

StatLink  <https://stat.link/z63yc2>

There are efficiency gains to be made in Italy as the large social spending – driven by old-age pensions mostly – does not translate into an equally large poverty alleviating effect of the social protection system. In countries where social spending is comparable to that of Italy, like France or Belgium, the poverty alleviating effect of social protection is well above OECD average. Instead, countries with a comparable average poverty alleviating effect, like Luxembourg and Portugal, spend less in social protection benefits. To improve the efficiency of the system, Italy may need to consider a stronger emphasis on working-age benefits which are relatively ungenerous, compared to retirement and early retirement entitlements.

#### 4.4.2. Duplications and missing links in the Italian disability system

In a system as complex as the Italian system of disability benefits and services, the lack of integrated information makes it impossible to clearly identify coverage gaps on the one hand and benefit and service overlaps, or duplications, on the other. Identifying and addressing gaps and overlaps would be essential for improving the effectiveness and efficiency of the system.

The Italian social protection system for people with disability is divided between a national component (mostly providing income replacement) and several subnational components (mostly providing in kind support). Overlaps and coverage gaps may occur because of the lack of exchange of data and information across stakeholders and government levels, including through the way in which assessments are conducted. As discussed in Chapter 2, predominantly medically driven disability status assessments which determine eligibility for most benefits are largely detached from needs assessments which take a broader view on disability and determine eligibility for services. This disconnection makes the system inefficient for both people with disability and the main actors in the system and contributes to the coverage gaps.

Major duplications of support occur within subnational systems. The main issue is that the co-ordination between the health and the social domain is limited in Italy, in most regions, and differently enacted across and even within regions. When it comes to supporting people with disability, however, the health and social domain offer services and benefits that not only can be similar in many cases (e.g. both offer rehabilitation and homecare services), but their separation can be detrimental to providing a holistic support to people with disability. As a result, some people with disability are covered under a multiplicity of individual plans (rehabilitative, educative, support to independent living) which rarely converge into a consistent long-term and tailored life plan for people with disability but rather follow the availability and eligibility criteria of regional, provincial, and local programmes and projects. Many more people with disability are left uncovered from any such service, given the high cost of these individual plans. Also, because of the large expenditure on oftentimes duplicated interventions, some crucial aspects to support people with disability are left uncovered. In Italy, both labour inclusion policies and poverty eradication policies (e.g. Inclusion Pact, inclusive work stages, measures for extreme poverty, social housing, regional and municipal income support, community-building projects, etc.) are limited.

## References

- ISTAT (n.d.), *Disabilità in cifre*, <https://disabilitaincifre.istat.it/>. [2]
- OECD (2021), *Pensions at a Glance 2021: OECD and G20 Indicators*, OECD Publishing, Paris, <https://doi.org/10.1787/19991363>. [3]
- OECD (2019), *Strengthening Active Labour Market Policies in Italy*, Connecting People with Jobs, OECD Publishing, Paris, <https://doi.org/10.1787/160a3c28-en>. [1]

# 5

## Piloting a new disability assessment in four regions of Italy

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This chapter discusses the results from a pilot in four regions of Italy of a new disability assessment tool that would add the perspective of functioning to the current medically based assessment of disability status in Italy, the WHO Disability Assessment Schedule (WHODAS). The analysis includes observations from 3 242 individuals participating in the pilot in late 2022 and early 2023 (of which 1 327 in Lombardy region, 1 223 in Campania region, 510 in the Autonomous Province of Trento and 182 in the Autonomous Region Sardinia). Using a statistical approach, the chapter evaluates the performance of the WHODAS questionnaire and concludes that the tool delivers valid, reliable, and scientifically robust distributions of WHODAS scores in all four pilot regions and that social workers in Italy are well placed to conduct WHODAS interviews effectively. The report also compares the WHODAS scores of the pilot sample with the corresponding civil invalidity percentages, as pilot participants had been assessed in both ways, and presents options on how the WHODAS questionnaire could be integrated into the current way of assessing civil invalidity in Italy.

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The assessment of civil invalidity in Italy which determines a person's rights and entitlements to benefits and services is outdated and incomplete as it is limited to the identification of a medical condition, or impairment, which determines the percentage of civil invalidity without consideration of the person's actual disability experience and the context in which the person lives. With the passage of the Enabling Act in 2021 (Law 227/2021), Italy has taken a first step towards a reform of its disability policies. The implementing decrees of the Enabling Act, which are currently being drafted and which will also benefit from the contribution of the project presented in this report, go in the direction of providing that the assessment of the disability condition and the revision of its basic assessment processes will be carried out in accordance with the provisions of the Convention of the Rights of Persons with Disabilities, also through the adoption of the WHO Disability Assessment Schedule (WHODAS) – the focus of the pilot project carried out in Italy – within the new basic assessment system provided for by the law.

To prepare the ground for reform, the WHODAS tool was piloted in four regions of Italy – Campania, Lombardy, the Autonomous Region Sardinia (henceforth, Sardinia), and the Autonomous Province of Trento (henceforth, Trentino) – testing the feasibility of the inclusion of functioning information into the current assessment of civil invalidity. WHODAS was developed by the WHO as a tool to identify the kind and nature of problems people are facing in their lives, in alignment with the International Classification of Functioning, Disability and Health (ICF). WHODAS has been tested successfully in many countries and different contexts. While Italy can draw on the experiences in other countries, it was also important to test the validity and reliability of the tool in Italy, and the ability of social workers to implement this tool. This chapter summarises the findings of the pilot that took place from October 2022 to April 2023.

## 5.1. Pilot sample and WHODAS responses and distributions

In the ICF framework, information about categories of Activities and Participation can be collected either from the perspective of capacity (reflecting exclusively the expected ability of a person to perform activities considering their health conditions and impairments) or the perspective of performance (reflecting the actual performance of activities in the real-world environmental circumstances in which a person lives). Information about capacity typically represents the results of a clinical inference or judgment based on medical information, while performance is a true description of what occurs in a person's life. The two perspectives are therefore very different, although capacity constitutes a determinant of performance.

The ICF understands “disability” to be any level of difficulty in functioning in some domain, from the perspective of performance. The WHO has developed, tested, and recommended WHODAS as a tool that can capture the performance of activities by an individual in his or her daily life and actual environment. The “actual environment” is represented in the ICF in terms of environmental factors that act either as facilitators (e.g. assistive devices, supports, home modifications) or as barriers (e.g. inaccessible houses, streets and public buildings, stigma, and discrimination). The WHODAS questionnaire is structured around six basic functioning domains: cognition, mobility, self-care, getting along with people, life activities, and participation.

The “clinical” version of the WHODAS questionnaire collects information about problems in functioning – i.e. disability – by means of a face-to-face interview conducted by a trained interviewer who asks a set of standardised questions and, if necessary, follow-up probe questions. WHODAS uses a 5-level response scale (1 = None, 2 = Mild, 3 = Moderate, 4 = Severe, 5 = Extreme or Cannot do) to rate each question. In extraordinary circumstances (e.g. COVID-19 lockdown), WHODAS can be administered in a telephone or video interview by the trained professional. Respondents are informed that their answers about each domain of functioning should adopt the perspective of performance, i.e. that they should describe what they do considering the experiences in their daily life and the environmental barriers and facilitators they experience. For the pilot, the 36-item version of WHODAS was chosen to create a full picture of the disability experienced by the respondent in their everyday life.

### 5.1.1. Sample characteristics

A total of 3 307 individuals participated in the pilot. The data for 65 individuals were not included in the analysis because of high missing values in their responses. The socio-demographic characteristics of the remaining N = 3 242 individuals are shown in Table 5.1, region by region. The proportion of male participants was below 50% for all four regions. Mean ages differed significantly across regions, with 52.2 years in Campania, 49.8 years in Lombardy, 50.7 years in Sardinia, and 48.8 years in Trentino. An average of about 11 years of education was reported for all regions. Most participants indicated their marital status as being married and most respondents were living independently in the community. The percentage of individuals living in assisted living was highest in Trentino.

**Table 5.1. Pilot sample – descriptive statistics for each of the four participating regions**

Distribution of the four regional samples across selected socio-demographic characteristics

	Campania	Lombardy	Sardinia	Trentino
N	1 223	1 327	182	510
Gender = male (%)	543 (44.5)	580 (43.7)	86 (47.3)	251 (49.2)
Age – mean (SD)	52.24 (10.89)	49.81 (12.25)	50.71 (13.08)	48.84 (12.48)
Years of education – mean (SD)	11.38 (3.81)	11.26 (3.59)	11.32 (3.99)	11.46 (3.29)
Marital status (%)				
Never married	260 (21.3)	356 (26.8)	66 (36.3)	172 (33.7)
Currently married	745 (61.0)	630 (47.5)	76 (41.8)	222 (43.5)
Separated	81 (6.6)	79 (6.0)	14 (7.7)	31 (6.1)
Divorced	64 (5.2)	124 (9.3)	12 (6.6)	39 (7.6)
Widowed	46 (3.8)	48 (3.6)	6 (3.3)	14 (2.7)
Cohabiting	26 (2.1)	90 (6.8)	8 (4.4)	32 (6.3)
Living condition (%)				
Independent in community	1 166 (96.6)	1 206 (90.9)	182 (100.0)	425 (83.3)
Assisted living	41 (3.4)	120 (9.0)	0 (0.0)	80 (15.7)
Hospitalised	0 (0.0)	1 (0.1)	0 (0.0)	5 (1.0)
Work status (%)				
Paid work	358 (29.3)	633 (47.7)	50 (27.5)	246 (48.2)
Self-employed	94 (7.7)	65 (4.9)	7 (3.8)	20 (3.9)
Non-paid work	2 (0.2)	4 (0.3)	0 (0.0)	3 (0.6)
Student	25 (2.0)	57 (4.3)	11 (6.0)	14 (2.7)
Keeping house	139 (11.4)	65 (4.9)	18 (9.9)	19 (3.7)
Retired	64 (5.2)	76 (5.7)	14 (7.7)	23 (4.5)
Unemployed (health reasons)	209 (17.1)	299 (22.5)	60 (33.0)	131 (25.7)
Unemployed (other reasons)	324 (26.5)	123 (9.3)	21 (11.5)	38 (7.5)
Other	7 (0.6)	4 (0.3)	1 (0.5)	16 (3.1)

Note: The table shows the number of people in the sample in each group while the values in parentheses shows either the corresponding percentage (%) or the corresponding standard deviation (SD).

Source: OECD calculations based on the pilot data.

StatLink  <https://stat.link/nfpwhm>

The data on employment was collected in different manners so that for some of the data collected in Campania detailed information is missing, i.e. it was not possible to determine if unemployment was health-related or not or if the work activity was for an employer or self-employed. Overall, participants indicated having paid work (39.7%) or being unemployed for either health reasons (21.6%) or other reasons (15.6%). The share in paid work was especially high in Lombardy (47.7%) and Trentino (48.2%).

Table 5.2 presents the frequency and percentages of observed ICD-11 diagnostic chapters, with the caveat that the data on health conditions were collected differently in the four regions. Health condition

codes were linked to the closest ICD-11 chapter; the latest version of WHO's International Classification of Diseases (ICD-11). Many people in the data set have more than one diagnosis. If several diagnoses would link to just one ICD chapter, the chapter was reported only once. The situation is different for people with more than one condition from different ICD chapters. Information regarding the priority of different diagnoses was unavailable for most data. It was therefore decided to include in the analyses by health condition all ICD-chapter diagnoses recorded for a person. Such, the total number of conditions presented in Table 5.2 is larger than the total sample as a person with two different conditions would be counted twice. This should not affect the findings by health condition.

**Table 5.2. Prevalence of diagnoses by ICD-11 chapter: Total sample and the participating regions**

ICD-Chapter	Total sample		Campania		Lombardy		Sardinia		Trentino	
	N	%	N	%	N	%	N	%	N	%
1 Infectious diseases	14	0.4	1	0.09	5	0.36	3	1.39	5	0.6
2 Neoplasms	558	15.93	234	22.1	229	16.4	14	6.48	81	9.72
3 Diseases of the blood	6	0.17	2	0.19	2	0.14	2	0.93	0	0
4 Diseases of the immune system	36	1.03	4	0.38	30	2.15	0	0	2	0.24
5 Endocrine and nutritional diseases	155	4.42	59	5.58	44	3.15	24	11.11	28	3.36
6 Mental or behavioural disorders	535	15.27	201	19	162	11.6	23	10.65	149	17.89
8 Diseases of the nervous system	281	8.02	38	3.59	139	9.96	18	8.33	86	10.32
9 Diseases of the visual system	87	2.48	16	1.51	34	2.44	5	2.31	32	3.84
10 Diseases of the ear	115	3.28	25	2.36	57	4.08	3	1.39	30	3.6
11 Diseases of the circulatory system	564	16.1	188	17.77	184	13.18	31	14.35	161	19.33
12 Diseases of the respiratory system	150	4.28	19	1.8	94	6.73	2	0.93	35	4.2
13 Diseases of the digestive system	138	3.94	26	2.46	68	4.87	12	5.56	32	3.84
14 Diseases of the skin	2	0.06	0	0	0	0	2	0.93	0	0
15 Musculoskeletal diseases	578	16.5	191	18.05	217	15.54	58	26.85	112	13.45
16 Genitourinary diseases	50	1.43	12	1.13	21	1.5	7	3.24	10	1.2
20 Development anomalies	14	0.4	3	0.28	6	0.43	2	0.93	3	0.36
21 Symptoms not elsewhere classified	51	1.46	10	0.95	23	1.65	6	2.78	12	1.44
22 Injuries or poisoning	22	0.63	4	0.38	13	0.93	1	0.46	4	0.48
24 Factors influencing health status	147	4.2	25	2.36	68	4.87	3	1.39	51	6.12
All diseases	3 503	100	1 058	100	1 396	100	216	100	833	100

Note: WHO's International Classification of Diseases (ICD-11).

Source: OECD calculations based on the pilot data.

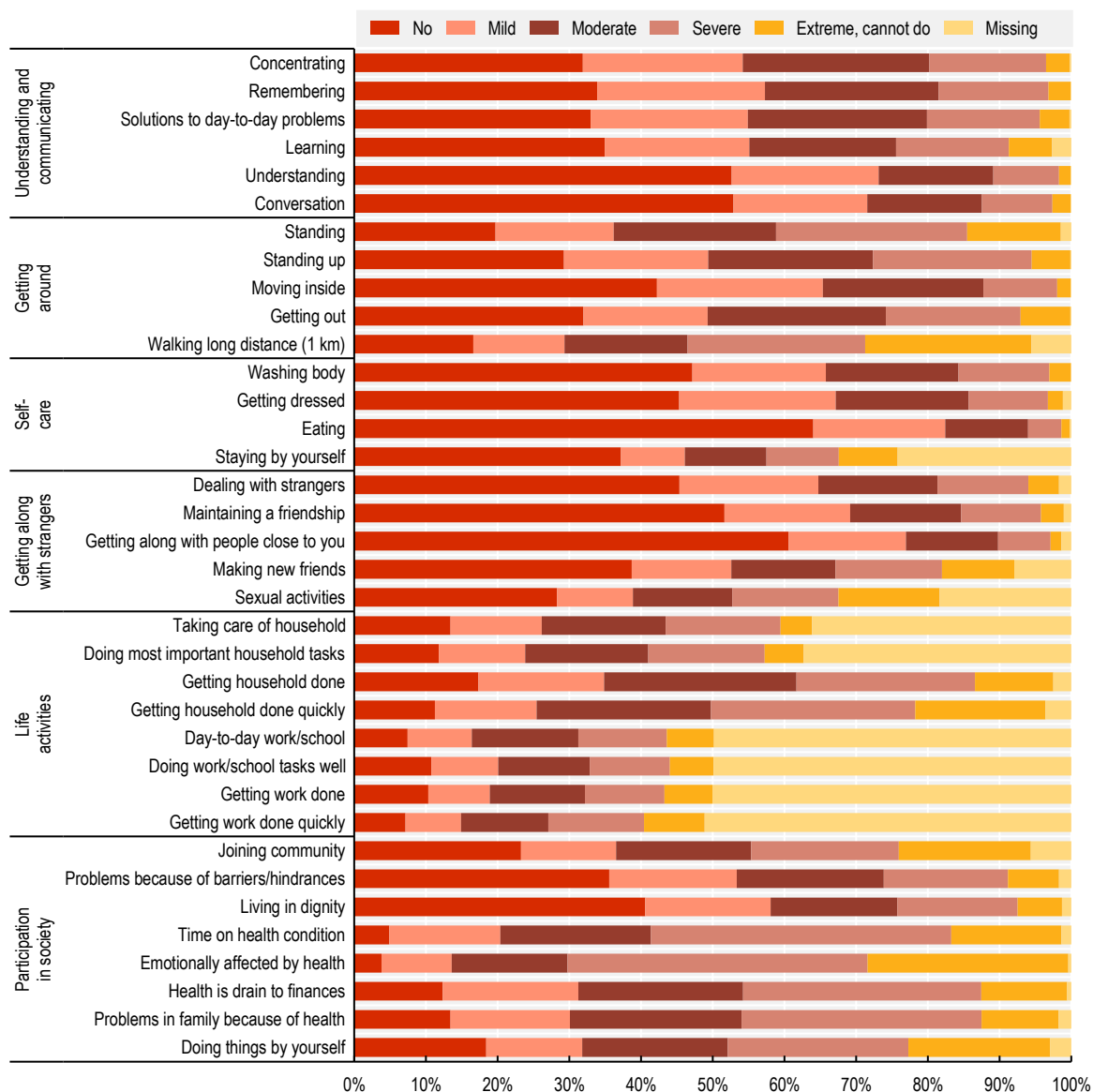
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### 5.1.2. WHODAS response frequencies

Figure 5.1 visualises how the 36 items of the WHODAS questionnaire have been rated. The percentage of missing values was highest, i.e. about 50%, for items D5.5 to D5.8 that assess difficulties at work (or in school). These four questions have been removed from the construction of the WHODAS score because of the high share of missing values. More than 30% of missing values were also found for two other questions, D5.1 (Taking care of household responsibilities) and D5.2 (Doing most important household tasks), as these two questions were not consistently assessed across all the regions at the start of the pilot.



**Figure 5.1. Percentage of ratings by degree of civil disability for each WHODAS item**

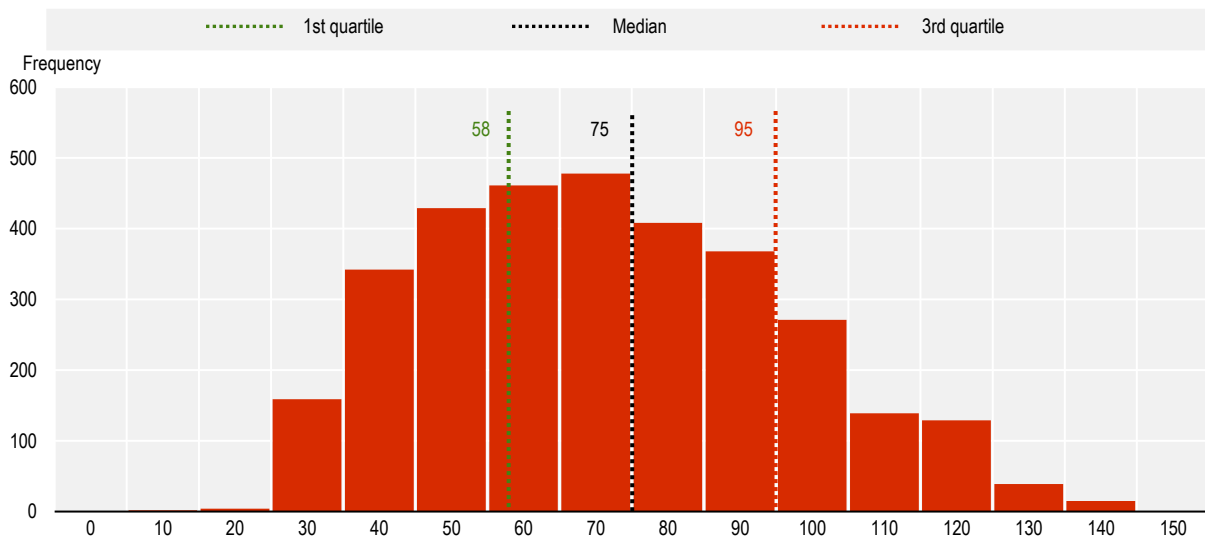


Note: WHODAS: WHO Disability Assessment Schedule.  
 Source: OECD calculations based on the pilot data.

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### 5.1.3. WHODAS score distribution

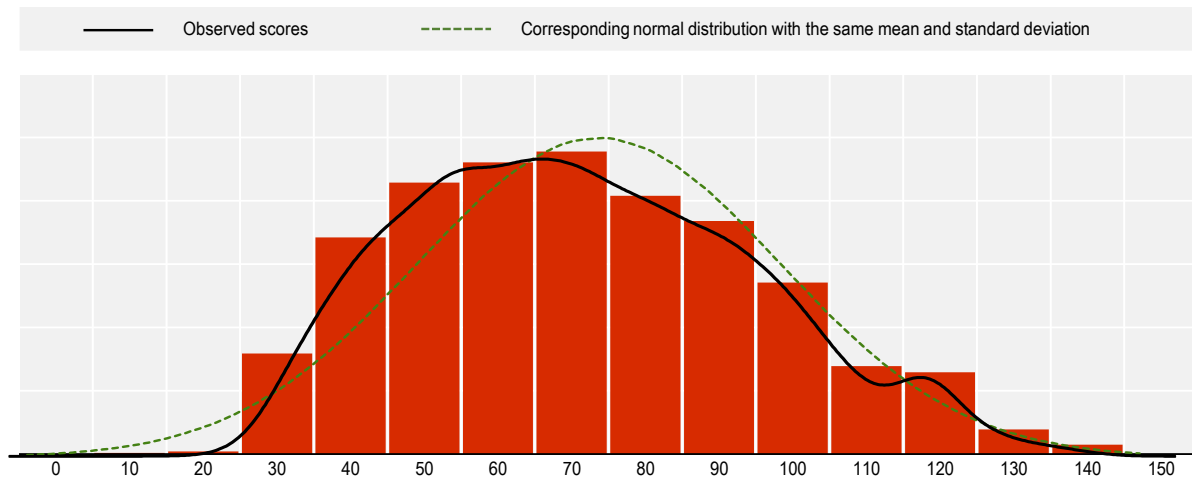
Figure 5.2 shows the distribution of the total raw scores obtained when adding up the 32 items of WHODAS. The total raw WHODAS score ranges from 32 to 160, although a few total scores below 32 are possible as the scores are computed on the raw data with some missing values (less than 20%). Coloured segments in Figure 5.2 indicate the position and value of the 1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> quartiles, with a median score (2<sup>nd</sup> quartile) of 75. The density lines in Figure 5.3 show the density of the observed scores (black line) and the corresponding normal distribution with the same mean and standard deviation (dotted line). Scores in this sample for Italy are distributed relatively normally, which was a common finding also in other countries where WHODAS was pilot tested (including Bulgaria, Greece, Latvia, Lithuania, Romania, Seychelles).

**Figure 5.2. Raw score distribution of the WHODAS**

Note: WHODAS: WHO Disability Assessment Schedule. Items D5.5 to D5.8 are excluded due to number of missing values.

Source: OECD calculations based on the pilot data.

StatLink  <https://stat.link/6djoxv>

**Figure 5.3. Score density: Observed density and random normal density**

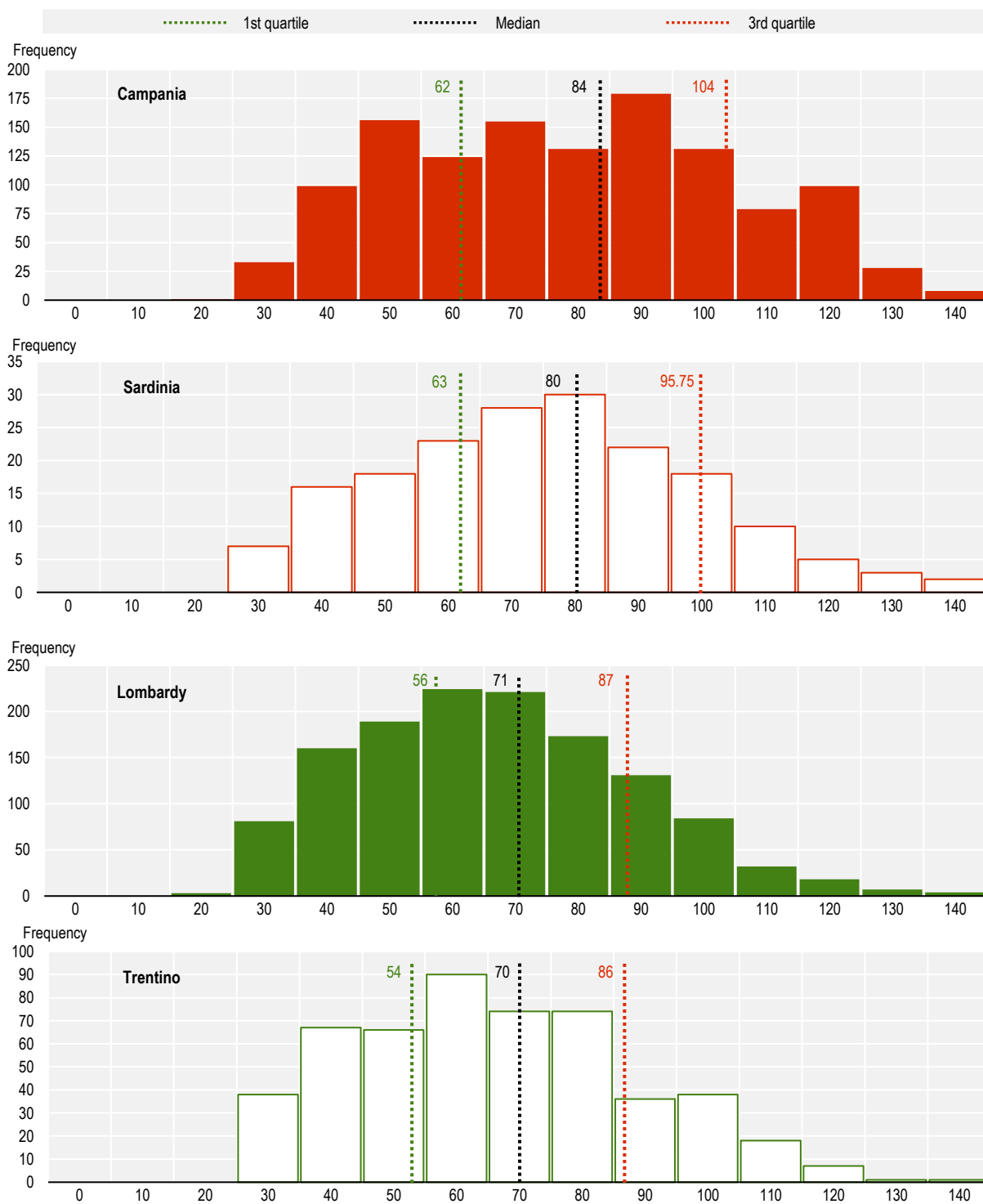
Note: WHODAS: WHO Disability Assessment Schedule. Items D5.5 to D5.8 are excluded due to number of missing values.

Source: OECD calculations based on the pilot data.

StatLink  <https://stat.link/u631i9>

The distributions of the WHODAS raw scores in the four regions that participated in the pilot present some but small differences (Figure 5.4). The highest median WHODAS score (blue dotted line) is found for Campania (Q2 = 84) and the lowest median score in Trentino (Q2 = 70). Higher WHODAS raw scores indicate higher levels of disability among those going through a disability assessment. Otherwise, however, the figures show rather normally distributed WHODAS raw scores for all four participating regions.

**Figure 5.4. Raw score distributions of the WHODAS in the four regions**



Source: OECD calculations based on the pilot data.

StatLink  <https://stat.link/w5ya1t>

## 5.2. Psychometric properties of WHODAS applied in Italy

One objective of the assessment pilot was to assess the validity and reliability of the WHODAS instrument in Italy. This is done through Rasch analysis, a statistical method from the field of probabilistic measurement first introduced by the Danish mathematician George Rasch (Rasch, 1960<sup>[1]</sup>). Rasch analysis is essentially testing several measurement assumptions (Bond, 2015<sup>[2]</sup>; Tennant and Conaghan, 2007<sup>[3]</sup>): (1) the targeting of a scale, (2) the model reliability, (3) the ordering of the items' response options, (4) the absence of correlation between items (so-called Local Item Dependencies, or LID), (5) the fit of the items to the Rasch model, (6) the absence of effects of person factors such as gender and age on item responses (so-called Differential Item Functioning, or DIF), and (7) the unidimensionality of the questionnaire. If these measurement assumptions can be met, a questionnaire can be considered psychometrically sound and derived total scores therefore be considered interval-scaled and operative for measurement.

For a well-performing questionnaire, it is expected that the difficulty of the items is matched to the level of ability of the measured population, i.e. the questionnaire should not be too easy or too difficult. Statistically, good targeting (*assumption #1*) is achieved if the mean item difficulty and mean person ability are approximating zero. A Person Separation Index (PSI) above 0.8 speaks for a good reliability of the scale and values above 0.9 for very good reliability (*assumption #2*). The PSI indicates how well the scale can discriminate levels of functioning in the population. The Cronbach  $\alpha$ , which is typically also reported, is a classical measure of the internal consistency of the data, i.e. how well the items work to describe one construct (Nunnally and Bernstein, 1994<sup>[4]</sup>). In the presence of disordered response options (*assumption #3*), an analysis of response probability curves allows to determine which response options cause problems and decide on strategies to aggregate disordered response options. For example, if for an item the response options 2 and 1 appear reversed and indicate that an increase of difficulty cannot be discriminated, the item responses can be recoded so that these options represent only one level of response. LID often occur when items are redundant and measure approximately the same aspect of a construct (*assumption #4*). The most widely reported statistic for the item dependencies is the correlation matrix of the Rasch residuals (Yen, 1984<sup>[5]</sup>). Residual correlations above 0.2 are considered as not acceptable and a way to address these local item dependencies, without deleting items, is to aggregate (i.e. to sum up) the correlating items into so-called testlets (Yen, 1993<sup>[6]</sup>). In item testlets, the ordering of the thresholds is not expected anymore. For good item fit (*assumption #5*), infit and outfit values are expected to be below 1.2 (Smith, Schumacker and Bush, 1998<sup>[7]</sup>). The outfit statistic is more sensitive to outliers as the infit statistic. Ideally, items of a questionnaire should be fair and not favour sample subgroups. The analysis of DIF allows to flag exogenous variables, or DIF variables (*assumption #6*), which conduct to a lack of invariance of the item difficulty (Holland and Wainer, 1993<sup>[8]</sup>). It is worthwhile to note that a DIF analysis is not always indicating a metric bias but can also simply represent subgroups with unequal underlying ability (Boone, Staver and Yale, 2014<sup>[9]</sup>). DIF analysis was conducted for age and gender, to determine the items which are sensitive to those external covariates. Finally, a questionnaire should measure only one construct. If a questionnaire shows to have several separate dimensions, the validity of one summary total score is not supported. Unidimensionality (*assumption #7*) was assessed with a principal component analysis of the Rasch residuals (Smith, 2002<sup>[10]</sup>). Typically, a first eigenvalue lower than 1.8 is deemed indicative of unidimensionality. Based on simulation analyses, Smith and Miao (1994<sup>[11]</sup>) suggested considering the size of the second component instead, with values below 1.4 indicative of unidimensionality.

The Rasch analysis for the Italian dataset showed that the scale is multidimensional, with a strong tendency of the items to load (i.e. to correlate with other variables) within WHODAS domains. Only a few items loaded across domains and, similarly, only a few items were free of dependencies. To solve the issues of multidimensionality and local-item dependencies, correlating items were aggregated by accounting for the domain structure of the WHODAS questionnaire. Findings can be summarised as follows:

1. The population included in this analysis presented a very good targeting to the scale.
2. The item reliability was high but also inflated at the beginning of the analysis because of item dependencies ( $PSI = 0.95$ , Cronbach  $\alpha = 0.95$ ). Reliability was still found to be good also after the adjustments were made ( $PSI = 0.88$ , Cronbach  $\alpha = 0.89$ ).
3. The response thresholds of 23/32 items of the WHODAS questionnaire presented disordering. Locally dependent items can be an explanation for the disordering, as well as a lack of discrimination between the two first response options, i.e. answer categories “None” and “Mild”.
4. The analysis of the residual dependencies showed strong local dependencies among most items of the WHODAS questionnaire, with a tendency of questionnaire items from the same domain to associate. To address these dependencies, items were aggregated considering the domain structure of the tool. The thresholds of the testlets are not expected to be ordered.
5. The item fit is good if the infit and outfit values are below 1.2. Three out of the 32 items showed misfit with infit or outfit above the cut-off: D1.5 (Generally understanding what people say), D6.4 (How much time did you spend on your health condition or its consequences), and D6.6 (How much has your health been a drain on the financial resources of you or your family). After aggregation of the items by domain, all testlets showed good infit and outfit values, below 1.2.
6. The DIF analysis indicated that all WHODAS domains are sensitive to age. Responses to domain 1 (Cognition – Understanding and communicating) and domain 5(1) (Life activities – Taking care of the household) are also affected by the gender of the respondent.
7. The principal component analysis indicated that the items cluster by domains which results in multidimensionality, with a very high 1<sup>st</sup> eigenvalue of 5.29 and a 2<sup>nd</sup> eigenvalue of 2.87. After adjustments, i.e. aggregation of items by WHODAS domains, the 1<sup>st</sup> eigenvalue dropped to 1.93 and the 2<sup>nd</sup> eigenvalue to 1.29, indicating unidimensionality according to the defined criteria.

In conclusion, statistical psychometric testing confirmed the validity and reliability of the WHODAS tool in the Italian context. Statistical analysis of the psychometric properties of WHODAS with the data piloted in Italy shows that functioning data collected with WHODAS display robust psychometric properties. It is important to keep in mind that the WHO developed WHODAS explicitly to statistically capture the construct of functioning from the perspective of performance – i.e. the experience of performing activities by a person with an underlying health problem in their everyday life environment. Based on satisfactory psychometric properties, one can confidently conclude that information collected with the WHODAS questionnaire is robust, viable, and relevant and that it validly represents the construct of disability as understood in the ICF and the UN Convention on the Rights of Persons with Disabilities (UNCPRD). Including the WHODAS questionnaire into disability status assessment in Italy would therefore (i) significantly strengthen the method of assessment currently in use (which is a medical assessment based on the existence of impairments) and align it with Italy’s general approach to disability; (ii) bring it closer to the ICF and UNCPRD understanding of disability; and (iii) harmonise the approach to assessment with the ICF functioning-based approach used in subsequent individual needs assessments.

### 5.3. Comparing WHODAS scores and civil invalidity ratings

#### 5.3.1. Meaningful cut-off points

There are no agreed and published cut-offs available for the WHODAS score that would be applicable to a population with diverse health conditions to categorise the severity of their disability. Having established cut-offs would allow to detect individuals with significant disabilities and to reflect and, eventually, reconsider attributed civil invalidity percentages. Some studies report the 90<sup>th</sup> or 95<sup>th</sup> percentile of the WHODAS score distribution as being the best cut-off to diagnose severe disability or dysfunctionality in some specific groups, such as post-partum women (Mayrink et al., 2018<sub>[12]</sub>) or the elderly population

(Ferrer et al., 2019<sup>[13]</sup>). A minimal clinically important difference in scores for the WHODAS has not been established yet (Federici et al., 2016<sup>[14]</sup>). However, based on several previous and comparable pilot projects conducted by the World Bank using the WHODAS questionnaire, in Greece, Latvia, Lithuania, and Bulgaria, meaningful WHODAS disability cut-off points for the Rasch-based 0-100 score are suggested as follows:

- Score 0-25: No functioning restrictions (i.e. no difficulties in performance/disability)
- Score 26-40: Moderate functioning restrictions (i.e. moderate difficulties in performance/disability)
- Score 41-60: Severe functioning restrictions (i.e. severe difficulties in performance/disability)
- Score 61-100: Very severe functioning restrictions (i.e. very severe difficulties in performance/disability)

A score of 40 would thus be a central cut-off for determining the presence of a disability and, thus, eligibility for services. In total, the sample presented N = 74 (2.3%) of individuals having no functioning restrictions, N = 972 (30.0%) of individuals with moderate functioning restrictions, N = 2 120 (65.4%) of individuals with severe functioning restrictions, and N = 76 (2.3%) of individuals with very severe functioning restrictions.

Later in this chapter, additional cut-offs are introduced to split the two middle groups in which most people are concentrated – thereby distinguishing lower and higher moderate functioning restrictions (with WHODAS scores of 26-34 and 35-40, respectively) as well as lower and higher severe functioning restrictions (with WHODAS scores of 41-48 and 49-60, respectively).

The civil invalidity percentages attributed to persons with health problems in Italy, following the assessment, can be divided into different categories in various ways. While there are no cut-off points for a discretionary assessment, entitlement for various benefits and supports suggest the following as a meaningful split:

- 0-33%: no invalidity
- 34-66%: moderate invalidity, of which
  - 34-45%: lower moderate invalidity
  - 46-66%: higher moderate invalidity
- 67-99%: severe invalidity, of which
  - 67-73%: lower severe invalidity
  - 74-99%: higher severe invalidity
- 100%: very severe invalidity

In total, the pilot sample presented N = 81 (2.8%) of individuals with no civil invalidity, N = 1 129 (38.8%) of individuals with moderate civil invalidity, N = 1 076 (37%) with severe civil invalidity, and N = 623 (21.4%) of individuals with very severe civil invalidity rated as 100%. There were N = 333 (10.3%) individuals in the data set with no reported civil invalidity percentage. The different levels of invalidity are key to obtaining supports from Italy's social protection system. For example, with a civil invalidity percentage above 46% individuals can request employment support, with more than 67% prostheses are provided free of charge, and with more than 74% people can receive a non-contributory disability allowance.

### **5.3.2. Sample characteristics according to cut-off points**

Table 5.3 presents the socio-demographic characteristics of the sample disaggregated by level of disability based on the WHODAS score. With 68.9%, the percentage of men was higher in the group with no disability and close to or below 50% otherwise. There is a statistically significant increase in mean age (p-value < 0.001) across disability levels from 45.7 years with no disability to 53.5 years with very severe disability. The average number of years of education decreases significantly with increasing disability status (p-value < 0.001) from about 12 years with no disability to about 11 years with very severe disability.

With regard to the living situation, 77.3% of participants with very severe disability lived independently in the community, with shares above 90% for all other groups. The percentage of persons in paid work decreased from 56.8% in the group with no disability to 21.1% for those with very severe disability.

**Table 5.3. Sample descriptive statistics by disability severity based on the WHODAS questionnaire**

	No	Moderate	Severe	Very severe
N	74	972	2 120	76
Gender = male (%)	51 (68.9)	491 (50.5)	884 (41.8)	34 (44.7)
Age – mean (SD)	45.74 (15.98)	49.32 (12.35)	51.29 (11.52)	53.45 (9.53)
Years of education – mean (SD)	12.05 (3.54)	11.75 (3.67)	11.14 (3.64)	10.96 (3.42)
Living condition (%)				
Independent in the community	73 (98.6)	936 (96.6)	1912 (90.7)	58 (77.3)
Assisted living	1 (1.4)	33 (3.4)	190 (9.0)	17 (22.7)
Hospitalised	0 (0.0)	0 (0.0)	6 (0.3)	0 (0.0)
Marital status (%)				
Never married	31 (41.9)	273 (28.1)	531 (25.0)	19 (25.0)
Currently married	33 (44.6)	506 (52.1)	1 094 (51.6)	40 (52.6)
Separated	4 (5.4)	54 (5.6)	142 (6.7)	5 (6.6)
Divorced	3 (4.1)	58 (6.0)	170 (8.0)	8 (10.5)
Widowed	0 (0.0)	27 (2.8)	86 (4.1)	1 (1.3)
Cohabiting	3 (4.1)	53 (5.5)	97 (4.6)	3 (3.9)
Work status (%)				
Paid work	42 (56.8)	474 (48.8)	755 (35.6)	16 (21.1)
Self-employed	7 (9.5)	71 (7.3)	107 (5.1)	1 (1.3)
Non-paid work	0 (0.0)	3 (0.3)	6 (0.3)	0 (0.0)
Student	5 (6.8)	46 (4.7)	56 (2.6)	0 (0.0)
Keeping house	1 (1.4)	68 (7.0)	167 (7.9)	5 (6.6)
Retired	8 (10.8)	38 (3.9)	119 (5.6)	12 (15.8)
Unemployed (health reasons)	4 (5.4)	122 (12.6)	540 (25.5)	33 (43.4)
Unemployed (other reasons)	7 (9.5)	142 (14.6)	349 (16.5)	8 (10.5)
Other	0 (0.0)	8 (0.8)	19 (0.9)	1 (1.3)

Note: WHODAS: WHO Disability Assessment Schedule.  
Source: OECD calculations based on the pilot data.


StatLink  <https://stat.link/io13ct>

Table 5.4 presents the socio-demographic characteristics of the sample disaggregated by the level of civil invalidity, following the above-proposed cut-off categories. The percentage of men is higher and above 50% only in the group of persons with no civil invalidity. Again, there is a statistically significant increase in the mean age ( $p$ -value < 0.001) across degrees of civil invalidity, from 45.2 years in the group with no invalidity to 52.9 years in the group with very severe civil invalidity. The average number of years of education is slightly above 11 years across all invalidity levels. The share of people living independently in the community is about 85.2% among those with very severe invalidity and above 90% for the other groups. Finally, the percentage of persons in paid work decreases from about 44.4% in the group of persons with no or moderate civil invalidity to 32.4% in the group of persons with very severe disability.

**Table 5.4. Sample descriptive statistics by impairment severity based on assessment of civil invalidity**

	No	Moderate	Severe	Very severe
N	81	1 129	1 076	623
Gender = male (%)	44 (54.3)	498 (44.1)	507 (47.2)	271 (43.6)
Age – mean (SD)	45.16 (14.20)	48.94 (12.38)	51.69 (11.59)	52.87 (10.72)
Years of education – mean (SD)	11.41 (3.22)	11.37 (3.61)	11.27 (3.78)	11.52 (3.64)
Living Condition (%)				
Independent in the community	76 (93.8)	1 074 (95.8)	996 (93.1)	529 (85.2)
Assisted living	5 (6.2)	45 (4.0)	73 (6.8)	89 (14.3)
Hospitalised	0 (0.0)	2 (0.2)	1 (0.1)	3 (0.5)
Marital Status (%)				
Never married	28 (34.6)	301 (26.7)	277 (25.7)	156 (25.0)
Currently married	35 (43.2)	583 (51.7)	557 (51.8)	326 (52.3)
Separated	2 (2.5)	79 (7.0)	73 (6.8)	39 (6.3)
Divorced	9 (11.1)	79 (7.0)	72 (6.7)	47 (7.5)
Widowed	1 (1.2)	32 (2.8)	47 (4.4)	24 (3.9)
Cohabiting	6 (7.4)	54 (4.8)	50 (4.6)	31 (5.0)
Work Status (%)				
Paid work	36 (44.4)	509 (45.1)	397 (36.9)	202 (32.4)
Self-employed	6 (7.4)	69 (6.1)	58 (5.4)	37 (5.9)
Non-paid work	1 (1.2)	5 (0.4)	3 (0.3)	0 (0.0)
Student	7 (8.6)	50 (4.4)	24 (2.2)	15 (2.4)
Keeping house	5 (6.2)	87 (7.7)	78 (7.3)	44 (7.1)
Retired	2 (2.5)	23 (2.0)	67 (6.2)	67 (10.8)
Unemployed (health reasons)	14 (17.3)	204 (18.1)	238 (22.1)	163 (26.2)
Unemployed (other reasons)	10 (12.3)	171 (15.1)	200 (18.6)	88 (14.1)
Other	0 (0.0)	11 (1.0)	10 (0.9)	7 (1.1)

Source: OECD calculations based on the pilot data.

StatLink  <https://stat.link/jdbvk1>

### 5.3.3. Pathologies, WHODAS scores and civil invalidity ratings

Table 5.5 presents the mean WHODAS score, on the 0-100 scale, disaggregated by health condition, and the distribution of the population across ICD-11 chapters. Individuals with “Symptoms, signs or clinical findings not classified elsewhere” presented the highest mean WHODAS score of 46.66. The least disabling conditions as measured by WHODAS are development anomalies with a mean score of 40.8. Among the four most frequent pathologies, the category “mental, behavioural or neurodevelopmental disorders” has the highest mean WHODAS score (44.95) while the other three main impairments (neoplasms, circulatory system diseases, and musculoskeletal system diseases) all have mean scores around 43.

**Table 5.5. Frequency of ICD chapters and mean of the corresponding WHODAS score**

	N	Mean (SD)
1 Certain infectious or parasitic diseases	14 (0.4%)	43.4 (9.75)
2 Neoplasms	558 (15.93%)	43.44 (8.08)
3 Diseases of the blood or blood-forming organs	6 (0.17%)	48.47 (8.07)
4 Diseases of the immune system	36 (1.03%)	45.13 (7.77)
5 Endocrine, nutritional or metabolic diseases	155 (4.42%)	43.85 (7.67)
6 Mental, behavioural or neurodevelopmental disorders	535 (15.27%)	44.95 (7.99)
8 Diseases of the nervous system	281 (8.02%)	45.09 (8.34)
9 Diseases of the visual system	87 (2.48%)	41.49 (8.56)



	N	Mean (SD)
10 Diseases of the ear or mastoid process	115 (3.28%)	42.02 (8.07)
11 Diseases of the circulatory system	564 (16.1%)	42.65 (7.94)
12 Diseases of the respiratory system	150 (4.28%)	41.38 (9.07)
13 Diseases of the digestive system	138 (3.94%)	43.16 (7.22)
14 Diseases of the skin	2 (0.06%)	43.12 (10.7)
15 Diseases of the musculoskeletal system and diseases of connective tissue	578 (16.5%)	43.51 (7.13)
16 Diseases of the genitourinary system	50 (1.43%)	41.64 (8.66)
20 Development anomalies	14 (0.4%)	40.80 (8.00)
21 Symptoms, signs or clinical findings, not elsewhere classified	51 (1.46%)	46.66 (11.39)
22 Injury, poisoning, or other consequences of external causes	22 (0.63%)	42.87 (5.99)

Note: WHO's International Classification of Diseases (ICD-11). WHODAS: WHO Disability Assessment Schedule.

Source: OECD calculations based on the pilot data.

StatLink  <https://stat.link/pol01g>

Table 5.6 disaggregates the sample by pathology and degree of civil invalidity. By and large, the results show that mean WHODAS scores tend to increase with the invalidity degree for most pathologies although the results must be interpreted with caution, due to the small number of cases in the group with no invalidity (N = 81). It is not the same condition that consistently receives the highest WHODAS rating across the different civil invalidity degree groups. Looking at the four main pathologies only, for which the sample size is large enough to draw reliable conclusions, the following can be observed:

- Diseases of the musculoskeletal system are the dominant pathology among people with a moderate level of civil invalidity (25.5% of those with degrees 34-66%). For those diseases, mean WHODAS scores clearly and gradually increase with the invalidity degree, from around 38.1 to 49.8.
- Neoplasms are the dominant pathology among people with very severe levels of invalidity (38.5% of those with a degree of 100%). Mean WHODAS scores are lower than for the other main diseases, at all invalidity levels with degrees above 33%.
- Diseases of the circulatory system are particularly frequent in the two middle invalidity categories, moderate and severe disability (i.e. degree 34-99%). Mean WHODAS scores generally lie between those for neoplasms and for diseases of the musculoskeletal system.
- The percentage of mental, behavioural, or neurodevelopmental disorders increases slightly with an increasing invalidity degree, with a high WHODAS mean compared to the other main diseases.
- The mean WHODAS scores increase with the invalidity degree for all four main pathologies.

**Table 5.6. Frequency of ICD chapters by civil invalidity degree and mean of the corresponding WHODAS score**

	No invalidity (0-33%)		Moderate invalidity (34-66%)		Severe invalidity (67-99%)		Very severe invalidity (100%)	
	N	mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)
1 Certain infectious or parasitic diseases	1 (1.25%)	43.67 (–)	5 (0.4%)	39.87 (13.52)	6 (0.43%)	43.87 (6.99)	2 (0.27%)	50.65 (9.53)
2 Neoplasms	5 (6.25%)	42.09 (18.48)	74 (5.86%)	38.7 (7.75)	190 (13.58%)	41.61 (7.35)	285 (38.46%)	45.91 (7.56)
3 Diseases of the blood or blood-forming organs			1 (0.08%)	44.41 (–)	2 (0.14%)	42.64 (1.8)	2 (0.27%)	50.53 (9.7)
4 Diseases of the immune system	1 (1.25%)	51.6 (–)	14 (1.11%)	41.74 (7.58)	16 (1.14%)	44.69 (4.91)	5 (0.67%)	54.73 (9.18)
5 Endocrine, nutritional or metabolic diseases	2 (2.5%)	32.31 (11.66)	44 (3.48%)	40.49 (8.85)	77 (5.5%)	44.33 (6.67)	30 (4.05%)	48.38 (5.19)
6 Mental, behavioural or neurodevelopmental disorders	8 (10%)	37.72 (11.26)	169 (13.38%)	42.79 (7.06)	258 (18.44%)	44.92 (7.98)	99 (13.36%)	49.34 (7.37)
8 Diseases of the nervous system	7 (8.75%)	39.03 (9.9)	87 (6.89%)	40.59 (7.48)	101 (7.22%)	45.03 (7.52)	85 (11.47%)	50.27 (7)
9 Diseases of the visual system	5 (6.25%)	32.28 (14.01)	35 (2.77%)	40.73 (8.42)	37(2.64%)	43.69 (7.66)	10 (1.35%)	40.62 (6.31)
10 Diseases of the ear or mastoid process	9 (11.25%)	40.8 (7.17)	64 (5.07%)	41.1 (7.94)	34 (2.43%)	43.97 (8.14)	8 (1.08%)	42.48 (9.6)
11 Diseases of the circulatory system	6 (7.5%)	42.14 (6.63)	220 (17.42%)	40.81 (7.42)	269 (19.23%)	42.98 (7.76)	65 (8.77%)	47.04 (8.48)
12 Diseases of the respiratory system	2 (2.5%)	39.82 (1.03)	86 (6.81%)	39.61 (10.05)	53 (3.79%)	43.31 (7.19)	9 (1.21%)	47.24 (4.91)
13 Diseases of the digestive system	2 (2.5%)	49.76 (2.59)	43 (3.4%)	40.73 (6.43)	68 (4.86%)	42.32 (6.88)	25 (3.37%)	49.1 (6.32)
14 Diseases of the skin					1 (0.07%)	50.69 (–)	1 (0.13%)	35.55 (–)
15 Diseases of the musculoskeletal system	20 (25%)	38.05 (5.72)	322 (25.49%)	42.3 (7.07)	183 (13.08%)	44.57 (6.45)	47 (6.34%)	49.75 (6.16)
16 Diseases of the genitourinary system	1 (1.25%)	35.97 (–)	14 (1.11%)	39.7 (5.58)	19 (1.36%)	38.79 (7.86)	16 (2.16%)	47.08 (9.82)
20 Development anomalies			5 (0.4%)	37.69 (6.71)	6 (0.43%)	39.95 (6.4)	3 (0.4%)	47.66 (11.25)
21 Symptoms not elsewhere classified	3 (3.75%)	27.98 (11.49)	9 (0.71%)	38.74 (7.04)	19 (1.36%)	45.95 (7.46)	20 (2.7%)	53.69 (10.79)
22 Injury, poisoning or other external causes	2 (2.5%)	42.87 (2.88)	9 (0.71%)	44.01 (6.94)	7 (0.5%)	38.72 (4.65)	3 (0.4%)	47.1 (1.88)

Note: WHO's International Classification of Diseases (ICD-11). WHODAS: WHO Disability Assessment Schedule.

Source: OECD calculations based on the pilot data.

StatLink  <https://stat.link/as9dp1>

Table 5.7 looks at the mean WHODAS score and the mean civil invalidity percentage per ICD chapter, comparing the situation when the linked health condition chapter appeared as standalone diagnostical information versus when it was reported in addition to other health condition chapters; thereby comparing cases of single morbidity with cases of comorbidity. The average WHODAS score per ICD chapter hardly changes whether it is a single diagnosis or part of multiple diagnoses. In contrast, the average civil invalidity percentage is in many cases higher when a person is diagnosed with multiple conditions. In other words, the WHODAS score per ICD chapter varies significantly less than the civil invalidity percentage: it appears that co-morbidity has an influence on the civil invalidity percentage but not on the WHODAS score. The data do not allow an interpretation of this finding but the discretionary freedom in the civil invalidity assessment could play a role, i.e. assessors perceiving people with co-morbidity as having a more severe disability – a finding that is not corroborated by the corresponding WHODAS scores.

**Table 5.7. Mean and standard deviation of the WHODAS score and the civil invalidity percentage per ICD chapter: comparing results for single diagnoses with cases of co-morbidity**

	Number ICD chapter linked = 1 (i.e. single diagnosis)			Number ICD chapter linked > 1 (i.e. multiple diagnoses)		
	N	WHODAS score mean (SD)	Civil invalidity percentage mean (SD)	N	WHODAS score mean (SD)	Civil invalidity percentage mean (SD)
1 Certain infectious or parasitic diseases	3	44.49 (0.76)	30 (27.84)	6	37.16 (11.01)	70.17 (8.68)
2 Neoplasms	430	43.78 (8.09)	86.38 (18.93)	58	41.51 (8.31)	72.26 (20.05)
3 Diseases of the blood and its organs	3	48.57 (7.64)	71 (27.22)	2	51.88 (11.62)	100 (NA)
4 Diseases of the immune system	12	40.85 (9.04)	60.33 (17.17)	15	47.37 (6.97)	74.53 (17.83)
5 Endocrine or nutritional diseases	67	42.91 (7.85)	67.38 (19.89)	52	44.93 (6.97)	76.15 (15.95)
6 Mental or behavioural disorders	316	44.47 (8.09)	68.61 (19.68)	97	45.22 (7.61)	70.94 (21.06)
8 Diseases of the nervous system	117	44.36 (9.43)	71.62 (27.01)	71	46.76 (7.67)	74.06 (20.83)
9 Diseases of the visual system	30	42.28 (10.32)	51.1 (26.68)	48	40.63 (7.94)	70.08 (22.25)
10 Diseases of the ear or mastoid process	30	40.73 (8.54)	34.6 (23.2)	65	43.13 (7)	65.14 (19.31)
11 Diseases of the circulatory system	236	41.71 (8.45)	63.13 (17.57)	186	43.56 (7.17)	72.55 (18.4)
12 Diseases of the respiratory system	55	39.81 (11.37)	48.15 (17.74)	57	43.11 (7.69)	66.91 (14.56)
13 Diseases of the digestive system	57	42.61 (7.67)	66.81 (20.39)	46	43.39 (6.62)	74.11 (22.28)
15 Diseases of the musculoskeletal system	299	43.08 (7.61)	54.37 (20.82)	177	44.42 (6.56)	68.04 (19.26)
16 Diseases of the genitourinary system	23	40.96 (9.74)	72.3 (26.43)	19	44.02 (6.73)	75.05 (22.96)
20 Development anomalies	4	40.33 (5.34)	58 (7.26)	4	41.26 (5.55)	59.75 (16.56)
21 Symptoms not elsewhere classified	21	47.78 (12.92)	68.05 (34.27)	19	46.35 (11.1)	77.63 (16.56)
22 Injury, poisoning, other external causes	7	42.79 (8.29)	49.86 (36.97)	13	42.41 (5.14)	68.5 (18.6)
24 Factors influencing health status or contact with health services	58	42.4 (6.58)	57.05 (23.5)	51	44.44 (8.31)	71 (23.61)

Note: WHO's International Classification of Diseases (ICD-11). WHODAS: WHO Disability Assessment Schedule.

Source: OECD calculations based on the pilot data.

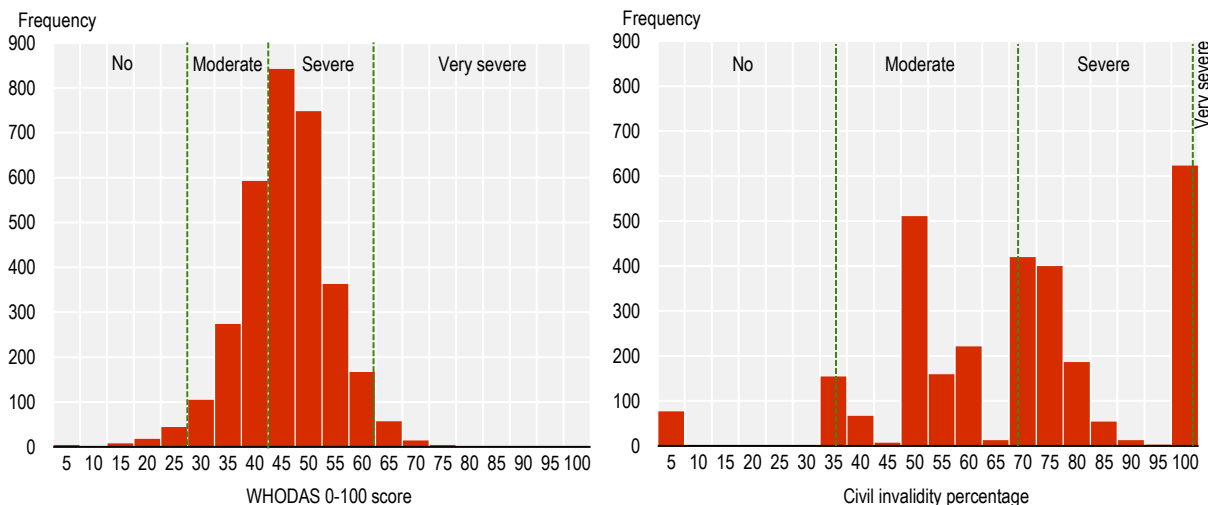
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### 5.3.4. Comparing WHODAS scores and civil invalidity ratings

The following figures pursue the comparison between the disability score based on the WHODAS questionnaire and the result of the civil invalidity assessment. Figure 5.5 looks at the distribution of WHODAS scores against the distribution of civil invalidity percentages. While WHODAS disability scores are distributed normally around a mean of 43.2, with a standard deviation of 8.5, civil invalidity percentages seem to be distributed erratically, with higher frequencies at distinct locations on the continuum linked with critical cut-offs for eligibility for specific social benefits and services. The discretionary method of assigning

invalidity percentages with limited guidelines and standards might explain the concentration at the cut-offs. In practice, this turns the invalidity scale into an ordinal scale with just a few possible outcomes.

**Figure 5.5. The pilot reveals large differences between assessing disability experience (WHODAS score) and impairment (civil invalidity percentage)**



Note: WHODAS: WHO Disability Assessment Schedule.

Source: OECD calculations based on the pilot data.

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Table 5.8 shows the four civil invalidity groups disaggregated by WHODAS disability groups. In interpreting these findings, it is important to keep in mind that a moderate civil invalidity level should not necessarily be understood to be equal to a moderate disability level. These are two different perspectives, correlated only modestly: WHODAS measures lived experience of disability in the person's everyday environment; civil invalidity assesses disability based on the person's impairment (medical approach). The table shows that the number of individuals that fall in opposite severity groups is negligible: there is only one person with a very severe WHODAS disability but no civil invalidity and no one with very severe civil invalidity and no WHODAS disability. However, less extreme seemingly contradictory cases are more frequent: there are, for example, 94 persons with very severe civil invalidity and only moderate WHODAS disability. Likewise, the data include 40 persons with severe WHODAS disability but no civil invalidity.

**Table 5.8. Frequencies of civil invalidity degree groups by WHODAS disability group**

		Civil invalidity degree groups				
		No	Moderate	Severe	Very severe	Missing data
WHODAS disability groups	No	10 (0.31%)	39 (1.2%)	14 (0.43%)	0 (0%)	11 (0.34%)
	Moderate	30 (0.93%)	434 (13.39%)	298 (9.19%)	94 (2.9%)	116 (3.58%)
	Severe	40 (1.23%)	646 (19.93%)	754 (23.26%)	481 (14.84%)	199 (6.14%)
	Very severe	1 (0.03%)	10 (0.31%)	10 (0.31%)	48 (1.48%)	7 (0.22%)
	Missing data	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

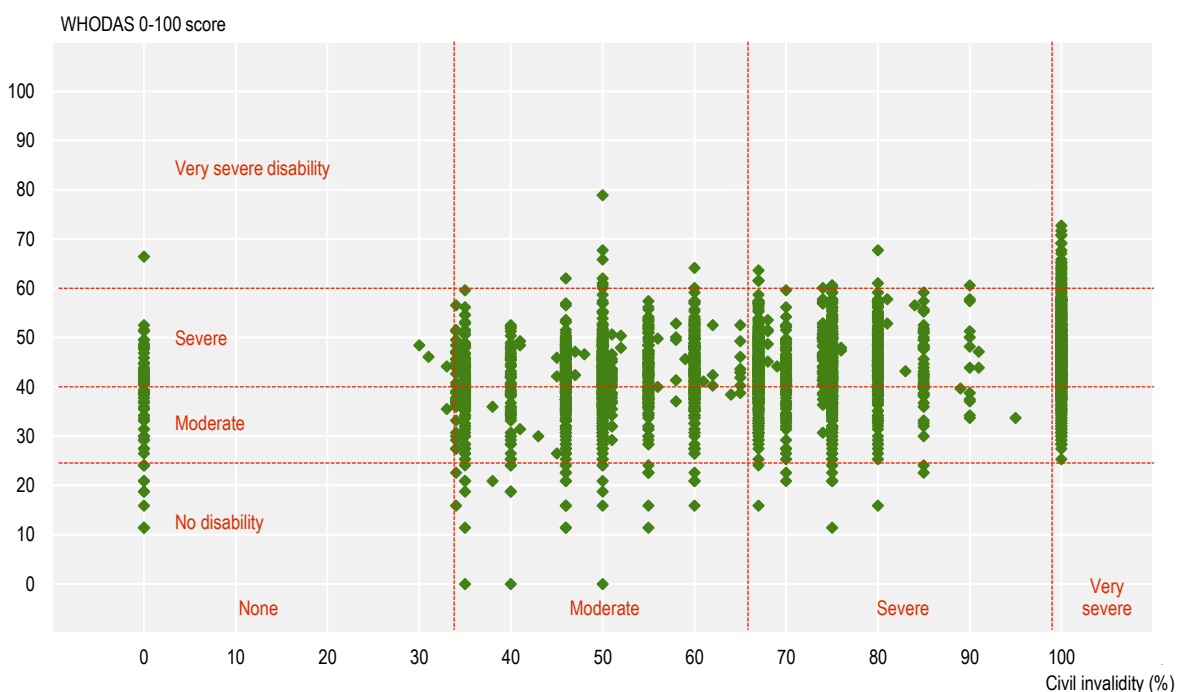
Note: WHODAS: WHO Disability Assessment Schedule.

Source: OECD calculations based on the pilot data.

StatLink  <https://stat.link/3skqon>

Figure 5.6 also compares the distribution of individual civil invalidity percentages and WHODAS scores. The figure shows the full distribution of data points for the WHODAS score (y-axis) and the civil invalidity percentage (x-axis). Horizontal lines represent the cut-offs for the WHODAS score, from no disability to moderate, severe, and very severe disability, and vertical lines represent the cut-offs for the civil invalidity percentage (again, no, moderate, severe, and very severe). The two scores show a positive correlation but only at a very moderate level ( $R = 0.33$ ). This is expected because disability cannot be inferred from medical conditions or impairment only: two individuals with the same medical diagnosis will be assigned the same percentage of disability based on medical criteria for the assessment. However, they may experience different levels of disability (functioning limitation and participation restrictions or performance in the ICF disability understanding) depending on their environment.

**Figure 5.6. WHODAS score distributions at respective civil invalidity cut-off**



Note: WHODAS: WHO Disability Assessment Schedule.  
Source: OECD calculations based on the pilot data.

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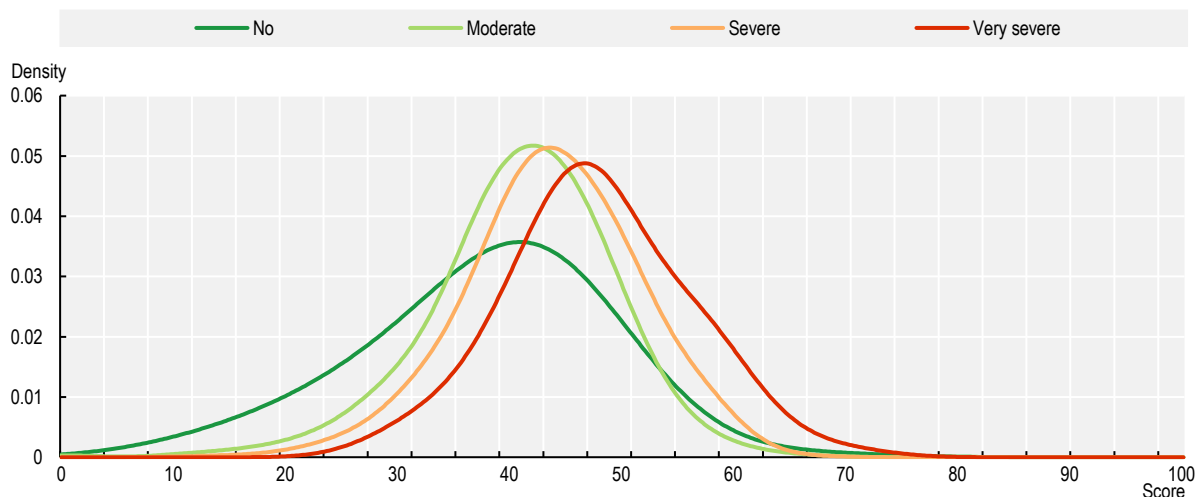
Some notable exceptions can be observed on the plot, such as individuals having 0% of civil invalidity while reporting moderate to very severe disability according to the WHODAS questionnaire looking at their functioning levels across different life domains. Similarly, some individuals with a civil invalidity percentage above 66% (i.e. with severe or very severe invalidity) are found not to have any disability based on their WHODAS score.

## 5.4. Including functioning elements into the assessment of civil invalidity

### 5.4.1. General considerations on the inclusion of functioning

WHODAS functioning scores by current levels of civil invalidity demonstrate that medical assessment alone does not differentiate well between different levels of disability, also suggesting rather low reliability and precision of the civil invalidity ratings in Italy today. Figure 5.7 shows the density lines for the WHODAS scores for the four levels of civil invalidity. While WHODAS scores for very severe functioning restrictions stand out at least a bit (red line), the difference between severe and moderate level of civil invalidity (orange and light green line, respectively) appears to be very small. These density lines suggest the presence of both false positives (cases with high invalidity percentage and low WHODAS score) and false negatives (cases with low invalidity percentage and high WHODAS score). Also, a more accurate assessment would show the density line of the group with no or very low level of civil invalidity (dark green line) positioned more towards the left-hand side of the figure. Again, this suggests that the medical information alone may misrepresent the true extent of individual disability experienced in daily life.

**Figure 5.7. WHODAS-score density lines by percentage of civil invalidity (four categories)**



Note: WHODAS: WHO Disability Assessment Schedule.  
Source: OECD calculations based on the pilot data.

StatLink  <https://stat.link/a2y6dz>

The results in Figure 5.7 come as no surprise as WHODAS was designed explicitly to assess so-called whole-person disability, while the medical approach to assessing disability used in Italy does not directly assess disability but *infers* disability based on the underlying health condition or impairment. Sometimes there is a close correlation between the severity of health conditions and the severity of resulting disability; but sometimes there is no such correlation. The latter is best seen in the case of mental health problems where the impact of the person's environment may greatly increase the impact of the experience of, say, depression. This is the basic validity problem with medically based disability assessment. As pointed out above, although the presence of a health condition and associated impairment is a precondition for disability, inferring the level of disability from the presence of the underlying health condition is scientifically problematic. The level of disability that an individual experiences, as the ICF argues, is determined by the interaction between the person's health condition and associated impairments and the environment in which the person lives. WHODAS was designed to directly capture this disability experience while assessment of disability based solely on medical grounds cannot do so validly or reliably.

### 5.4.2. Options for including functioning into civil invalidity assessment in Italy

The WHODAS pilot in Italy has shown that it performs well in capturing the actual experience of disability. The question is how best to include the functioning information captured by WHODAS in the system of disability status assessment in Italy. Medical information will remain relevant to disability assessment; the ICF makes it clear that without an underlying health condition and associated impairments, disability does not exist. Information about health status provides the basis for identifying specific physical and mental dimensions of activities and areas of participation vulnerable to disability, which can then be directly confirmed by the findings received from the WHODAS questionnaire. Medical information provides essential guidance on the medium and long-term trajectory of disability that the individual will experience, including whether the person faces a progressive decline in health capacity resulting in more and more disability, or the reverse, a progressive improvement. While medical information remains an essential component of disability assessment, the medical review must also change with better standardisation and methodological guidelines and possibly using the ICF body functions and body structures.

As medical information is essential, this section of the report discusses possible options for combining medical and functioning information in the assessment of disability in Italy – rather than replacing the current medical approach altogether by the WHODAS questionnaire. Several methods were tested on the pilot dataset to address this question. These methods can be grouped here into three principal strategies: (1) *averaging* the medical assessment percentage with the WHODAS score to arrive at a final disability assessment score, (2) *flagging* persons whose WHODAS score and disability severity are different from the severity group based on the percentage determined by medical information alone, and (3) *scaling* the civil invalidity percentage by a certain coefficient ‘x’ when the WHODAS-score exceeds or falls below a certain threshold or reference value. It is important to add that as WHODAS is used in Italy, more data are collected. This data can be analysed using the techniques from this report to continually update and recalibrate parameters and cut-off points. In more detail, the three approaches work as follows:

1. *Averaging* – averaging in some predetermined way the attributed civil invalidity percentage and the WHODAS score. This approach is based on the theory that, together, medical information and functioning scores contribute, to different degrees, to a realistic and valid assessment of disability.
2. *Flagging* – identifying persons whose WHODAS score differs from the medically determined civil invalidity percentage and flagging these individuals to request from them additional information or even a full reassessment. When an individual has a WHODAS score over or below some cut-off value, this suggests that the medical score alone does not adequately capture the experience of disability and a second-level assessment should be conducted.
3. *Scaling* – the civil invalidity percentage can be altered (i.e. raised or lowered) to reflect the WHODAS score by means of a score-based coefficient. This approach assumes that at the core of disability and civil invalidity assessment is the medical problem that the individual experiences, but at the same time, that the performance is modified (to some extent) by environmental factors that need to be understood to augment or diminish the medical score.

Averaging, flagging, and scaling are three of several potential approaches to bringing together two scores that measure different phenomena but which, together, constitute our best assessment of disability. Each approach is grounded in the ICF’s understanding of disability as the outcome of an interaction between a person’s underlying health condition and impairment on the one hand and the physical, human-built, interpersonal, attitudinal, social, economic, and political environment in which the person lives on the other hand. The three approaches differ, however, in how they weigh the impact of the respective medical and environmental determinants of disability. The next section describes the results of applying strategies that were tested using different weighting combinations.

## 5.5. The impact of different policy options including functioning elements

This section presents in more detail the three options to include functioning into disability assessment in Italy. Each option follows the ICF in recommending a combination of medical and functioning assessment (with the latter provided by WHODAS). Option A is the situation in which WHODAS scores are considered, or disregarded, in a purely discretionary manner. Options B (averaging strategies), C (flagging strategies) and D (scaling strategies) are quantitative. Each option has advantages and disadvantages.

The framework for evaluating the pros and cons of every approach draws on key scientific principles that determine the credibility of any disability assessment process: *validity* (the extent to which the option relies on a true assessment of disability); *reliability* (the ability of the option to arrive at the same assessment of the same case by different assessors); *transparency* (the degree to which the assessment process and outcomes can be described and understood by all stakeholders); and *standardisation* (the extent to which the process resists distortion or alteration over time and across locations).

Option A is the option in which an individual or committee reviews medical scores and the WHODAS scores and makes a judgment about the extent of disability as the individual or committee sees fit. This is a purely discretionary option, surprisingly common in practice. This approach is subject to manipulation, lacks validity and reliability, and is utterly non-transparent. The option is given here as a contrast to the remaining options B, C, and D, but also, in fairness, because some countries continue to rely on this option for disability assessment (strategy #1). The authors of this report do not recommend this option. Numerous interactions with officers involved in disability assessment in different countries suggest that medical professionals involved in the assessment of disability are confident they can consider functioning and the experience of disability as part of the medical description of the applicant's situation. One often hears medical assessors claim that they take functioning fully into account when examining medical records. One implicit result from the pilot is, however, that this assumption is not grounded in evidence.

Averaging, flagging, and scaling are quantitatively driven options, very different from Option A. In different ways and for different reasons, they satisfy not only the basic psychometric assumptions of validity and reliability but each, to different degrees, strives to achieve transparency and standardisation.

### 5.5.1. Using an averaging algorithm

In the Italian pilot WHODAS data set, there is a relatively small percentage of persons indicating no functioning problems at all (only 2.3%), among which the majority had a moderate or severe degree of civil invalidity. Weighting the civil invalidity percentage with the WHODAS score would adjust levels of invalidity by accounting to some degree for the observed and experienced disability level assessed by the WHODAS questionnaire. To get a full sense of the range of possible approaches under Option B, four weighting schemes are shown: (i) 75% civil invalidity percentage and 25% WHODAS score; (ii) 50% each; (iii) 25% civil invalidity percentage and 75% WHODAS score; and (iv) 0% civil invalidity percentage and 100% WHODAS score (represented by strategies #2 to #5). Option #5 shows the result of WHODAS alone.

*Advantages of averaging:* (i) An assessment of the level of functioning plays a significant role in the determination of eligibility for disability benefits so that the eligibility for benefits is not solely based on purely medical criteria. (ii) The averaging approach minimises the impact of the inherent psychometric problems with the civil invalidity percentage based on the Barema-based medical assessment. (iii) The assessment of the level of functioning is empirically and statistically verified. (iv) This option yields high levels of validity and reliability. (v) Merging the results of two assessments scaled by means of “weighted averages” is fully objective, transparent, and non-discretionary. (vi) The method is not sample-dependent.

*Disadvantages of averaging:* (i) There are, potentially, an infinite number of combinations of weighting schemes (i.e. “strategies”), each of which affects the set of eligible applicants differently and has different budgetary and political consequences. This is an unavoidable fact about the nature of disability as a



continuum and the fact that there are not yet scientifically verified or objective cut-offs for severity on a 0-100 continuum. (ii) Any strategy selected will be objectionable to individuals who, under that strategy, will not be certified as having a disability and thus not eligible for any benefits. This signals the need for clear and transparent information dissemination and a solid grievance redress system that may include using tools for clinical testing and determination of functioning.

### **5.5.2. Using a flagging algorithm**

Six different flagging strategies are represented by strategies #6 to #11. The idea of this strategy is to highlight individuals whose civil invalidity percentage is unexpected in view of the WHODAS score. A conservative approach would be to flag individuals with scores in the upper (or lower) extremes of the WHODAS score distribution of the sample, who have a very small (or large) civil invalidity percentage (#6). The next four approaches do not use the sample distribution but the distribution of scores within civil invalidity degree groups to increase or decrease the invalidity percentage. The approach #11 combines strategies #7-10 and considers all cases that fall into one of these groups.

*Advantages of flagging:* (i) Scientifically robust and based on actual data. (ii) Shows that the purely medical approach to disability assessment may not accurately assess disability in many cases – in which, as reported in the WHODAS score, a person is experiencing more, or fewer, functioning problems in their lives than what the health condition is thought to imply. (iii) High levels of validity and reliability.

*Disadvantages of flagging:* (i) WHODAS cut-offs for different degrees of functioning problems are based on the experiences from past pilots and some evidence from the scientific literature. Sensitivity analyses are not available to this point. More precise cut-off values specific to Italy may be introduced at later time points when more information on functioning is collected (assuming WHODAS will be introduced into the existing system). (ii) Technically robust methodological and procedural instructions will have to be developed to guide the reassessment process to ensure transparency.

Even with the caveat on the cut-off points for disability severity, the flagging method may be introduced through a specifically designed two-step administrative procedure.

### **5.5.3. Using a scaling algorithm**

The scaling approach, represented by strategies #12 and #13, reproduces an approach that is in some form used in some countries (e.g. Lithuania) though generally in a rather opaque way, namely, modifying the civil invalidity percentage assigned by a disability assessment committee by means of a coefficient representing functioning information (e.g. generated by a WHODAS score). The idea behind this approach is to avoid relying on a medical determination of disability exclusively, as such an approach undervalues the actual impact of health conditions on a person's life and functioning performance.

Two strategies to illustrate the scaling approach are used (there are, in theory, many other possibilities). The first strategy would look for individuals with high disability, according to their WHODAS score, above the WHODAS cut-offs of 40 and 60 to augment their civil invalidity percentage, either by a coefficient of 1.25 (with WHODAS scores above 40) or 1.5 (with WHODAS scores above 60). Reversely, in the second strategy used, individuals with a very low disability according to their WHODAS score, below the WHODAS cut-offs of 40 and 25, are selected to reduce their civil invalidity percentage either by a coefficient of 0.95 (with WHODAS scores below 40) or 0.9 (with WHODAS scores below 25). The choice of coefficients here is to some extent driven by the objective to achieve similar impact in both directions.

*Advantages of scaling:* (i) Using a coefficient value generated statistically is a common and widely used approach. (ii) A coefficient approach (increasing or reducing the medically-determined civil invalidity percentage considering the corresponding functioning score) is the most intuitive way to combine the scores of very different assessments – medical and functioning – into a single score. (iii) This option incorporates the insight that a medical determination alone can often miss instances where people have

only moderate or very high disability needs. (iv) This option, because of the psychometric properties of WHODAS, would have high levels of validity and reliability.

*Disadvantages of scaling:* (i) As with other options, there are many possible variations of approach D with different outcomes – in this report only two possibilities are presented, as an illustrative example. Although the scaling approach itself is intuitively understandable and can be made transparent to the public, the scientific and statistical justification for Option D is therefore somewhat technical and may not be easily understandable by a lay public.

Table 5.9 provides an overview of the testing strategies that were considered and gives the number of individuals who would have a moderate, severe, or very severe disability after adjusting for the WHODAS score. Further, and maybe most importantly, the table also shows the number of individuals who would have their civil invalidity severity ranking changed towards a higher degree (total upshifts) or a lower degree (total downshifts). In brief, the results are as follows:

- The four *averaging* strategies show that the use of WHODAS generally generates more upshifts to higher invalidity degrees than downshifts. Giving WHODAS a weight of 25% (strategy #2) changes little, as it affects only 2.5% of the sample and of those, most would see a downshift – these are people just above one of the invalidity thresholds who seem to function well, maybe because the environment is supportive, and their needs are addressed. The more weight WHODAS receives, the more people are affected and the more upshifts occur. With a 50% weight to both WHODAS and civil invalidity (strategy #3), 8.5% of the sample would be affected, with an equal number of upshifts and downshifts. With WHODAS only (strategy #5), 42% of the sample would see a change in the invalidity severity, with two-thirds seeing an upshift. Most upshifts are a shift from moderate to severe invalidity, potentially generating more eligibility for a disability allowance. On the contrary, the number of people with very severe invalidity considered to be non-self-sufficient and, thus, in need of constant care would fall drastically, from over 20% to only 2% of the sample. This suggests that current medically based disability assessment may be overestimating the degree of disability and policies may be setting the wrong priorities, and incentives.
- The six *flagging* strategies show that very few people currently receive an invalidity rating that is drastically different from their actual disability experience, as measured by WHODAS. Only 2% of the sample have extremely low or extremely high WHODAS scores (strategy #6) and only 5.5% of the sample would be flagged as having an invalidity rating very different from their WHODAS score (strategy #11). Among those 5.5%, two-thirds would potentially see a downshift in their current severity rating depending on the result of the indicated second assessment and most of them would be people classified with 100% civil invalidity although experiencing much less disability. (For supplementary flagging variants, see section 6.3).
- The coefficients chosen for the two *scaling* strategies generate a situation in which over 8% of the sample would see their invalidity rating increased because of (very) severe disability according to WHODAS (strategy #12) and, similarly, close to 8% would see their invalidity rating lowered because of no or only moderate disability experience according to WHODAS (strategy #13). The large difference in the size of the coefficients is a result of the current invalidity assessment and rating, with so many people found just above the next invalidity threshold. A clear disadvantage of strategy #12 is that it increases the already large number with a very severe invalidity rating. Combining strategy 12 and strategy 13 would imply that 16% see their rating changed.

**Table 5.9. Overview of strategies and changes in group sizes based on the selected approaches**

	#	Description	No civil invalidity	Moderate civil invalidity	Severe civil invalidity	Very severe civil invalidity	Total upshift	Total downshift
A. Discretionary	#1	Civil Invalidation cut-offs	81	1 129	1 076	623	0	0
B. Averaging	#2	Civil Invalidation 75%, WHODAS 25%	82	1 157	1 047	623	21	51
	#3	Civil Invalidation 50%, WHODAS 50%	87	1 131	1 068	623	116	130
	#4	Civil Invalidation 25%, WHODAS 75%	52	1 059	1 176	622	337	209
	#5	Civil Invalidation 0%, WHODAS 100% <sup>1</sup>	63	856	1 921	69	768	459
C. Flagging	#6	Extreme WHODAS scores: < 24 or > 63	118	1 102	1 064	625	7	53
	#7	WHODAS score > 40, Civil Invalidation < 33%	40	1 170	1 076	623	41	0
	#8	WHODAS score > 60, Civil Invalidation < 66%	80	1 120	1 086	623	10	0
	#9	WHODAS score < 25, Civil Invalidation > 66%	81	1 143	1 062	623	0	14
	#10	WHODAS score < 40, Civil Invalidation 100%	81	1 129	1 170	529	0	94
	#11	Sum of approaches #7-#10	40	1 174	1 166	529	51	108
D. Scaling	#12	if WHODAS indicates Severe disability then Civil Invalidation x 1.25 Very severe disability then Civil Invalidation x 1.5	78	889	1 125	817	243	0
	#13	if WHODAS indicates Moderate disability then Civil Invalidation x 0.95 No disability then Civil Invalidation x 0.9	105	1 205	1 070	529	0	218

Note: This approach uses the WHO Disability Assessment Schedule (WHODAS) cut-offs: WHODAS scores < 25 indicate no disability, 20 to 40 moderate disability, 40 to 60 severe disability, and > 60 very severe disability.

Source: OECD calculations based on the pilot data.

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## 5.6. Reflections and conclusions

The pilot evaluation suggests that the current disability assessment system in Italy would benefit from the inclusion of functioning information into the assessment method in at least three ways:

- the assessment of disability would be more precise and accurate, reflecting the real-life experience of disability and identifying some people who are not well identified by a purely medical approach;
- the assessment would be in line with today's interdisciplinary understanding of disability to which Italy has committed already 14 years ago when it ratified the UN Convention; and
- the assessment would be harmonised with, and provide more valuable input into, any subsequent individual assessment of the actual support needs of people with disability.

The approach suggested for disability assessment is to combine medical and functioning information in some transparent form. While there are in principle many alternative methodological options for doing this, for Italy *flagging* the need for a second assessment seems to be the most meaningful and realistic way forward. This is so because the current process of civil invalidity assessment through which applicants are assigned an invalidity degree, or percentage, is strongly influenced and biased by the various thresholds in place for eligibility to various entitlements, benefits, and services. Therefore, while in theory people could be assigned any percentage, in practice most applicants for a civil invalidity assessment return with a degree close to, or at, one of the critical thresholds. Technically speaking, the current assessment returns ordinal scaled disability degrees determined by the existing thresholds rather than interval-scaled degrees that reflect the degree of the person's impairment. The consequence of this is that quantitative approaches like *scaling* or *averaging* can generate undesirable results on both ends of the spectrum. People sitting just at a threshold would easily fall below the threshold and, thus, lose critical disability entitlements; people far away from a threshold might receive a significantly higher invalidity percentage but without any change in the type of service or benefit they are entitled to.

A related reason for the limited applicability in Italy especially of the averaging approach is the discretionary nature of Italy's civil invalidity assessment. While the assessment is intrinsically medical in nature, assessors can take people's actual situation into account if they wish: in a discretionary and untransparent way, they can increase the assigned invalidity percentage in line with any "perceived" functioning limitations – perceived, because this is done without any basis or tool to assess functioning. This problem is related to the problem that system thresholds seem to influence the assessment outcome. On the contrary, averaging would be a highly promising and adequate approach if it was used to average two independent pieces of information: the medical and the functional aspects of disability. Such a situation could be achieved also in Italy if information on these two aspects would be collected independently, and the medical part of the assessment would be performed in a standardised manner with methodological guidelines applicable across the entire country.

If Italy chooses to move on with the introduction of a flagging algorithm, two aspects have to be addressed: the weight given to functioning information relative to medical information, and the structure of the entire assessment process. The first question on the relevance attached to functioning, i.e. the WHODAS score, is equal to asking how many cases "should" be flagged. Even with strategy #11, the combined result of strategies #7-#10, only about 5.5% of all applicants would be considered for a second assessment – while the remaining 94.5% would not be affected by such a reform. That is a very low share which (i) does not do justice to the importance of people's actual disability experience, (ii) hardly justifies a comprehensive reform, (iii) would likely fail in changing everyone's mindset towards a modern view on disability and functioning and, eventually, (iv) would hardly affect the adequacy and effectiveness of disability supports.

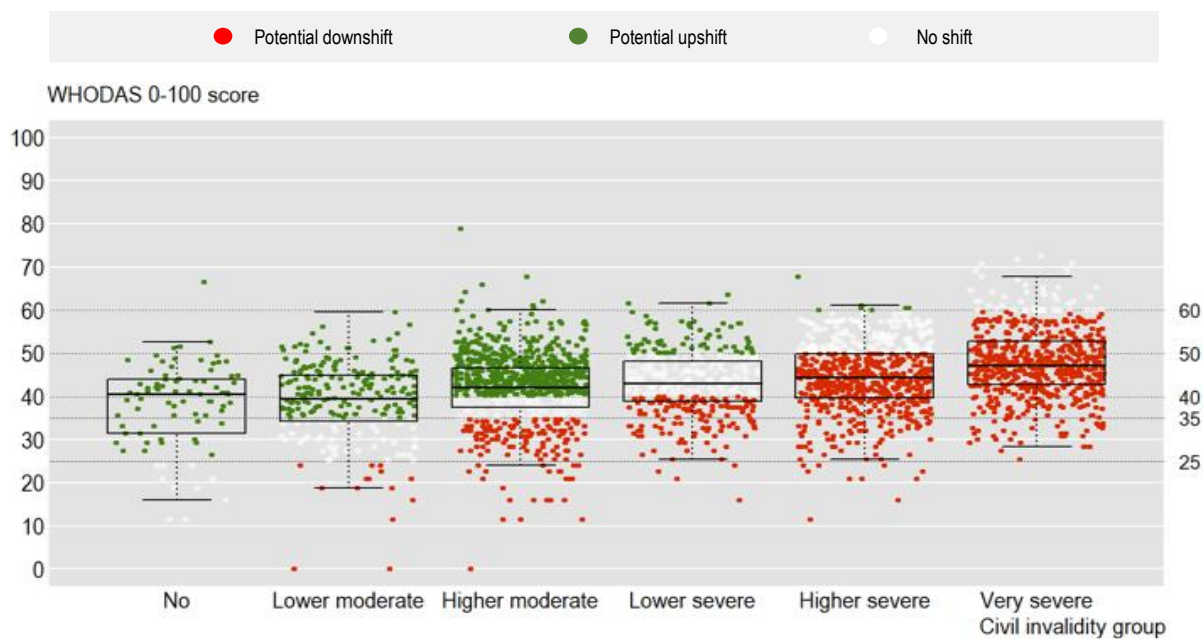
It is, therefore, useful to think about ways to increase the number of flagged cases by not only questioning and thus reassessing extreme differences between the civil invalidity percentage and the WHODAS score but also smaller differences between the medical and the functional view. For this purpose, it is useful to use the finer grid of civil invalidity thresholds, which also distinguishes lower from higher moderate invalidity and lower from higher severe invalidity, thereby creating six different invalidity categories. Similarly, the following exercise splits the moderate and severe disability groups, as measured by the WHODAS score, into two subcategories each, thereby also creating six different disability categories. The following two supplementary strategies show the range of options which Italy has.

The first supplementary strategy selects all those cases for a second assessment for which the medically determined civil invalidity percentage on the six-category invalidity scale differs from the functionally determined disability score on the six-category WHODAS scale. Figure 5.8 shows the corresponding result: cases marked in red and green are those for which the WHODAS score would imply a reassessment, with a potential downshift for the cases marked in red and an upshift for those marked in green. About one in four of the total pilot sample falls in the same category under both scales (cases marked in grey) while all others would be considered for a reassessment, with two-thirds of the flagged

cases potentially considered for a downshift to a lower invalidity rating and one-third for an upshift. Most potential downshifts concern people with a 100% civil invalidity rating (very severe) or a rating between 74% and 99% (higher severe). On the contrary, most potential upshifts are people with a higher moderate invalidity rating (46%-66%).

### Figure 5.8. Flagging about 75% of all civil invalidity applications for a secondary reassessment

WHODAS-scores by degree of civil invalidity, with potential downshifts and upshifts for cases for which the civil invalidity percentage deviates from the WHODAS score by at least one category on a six-by-six scale



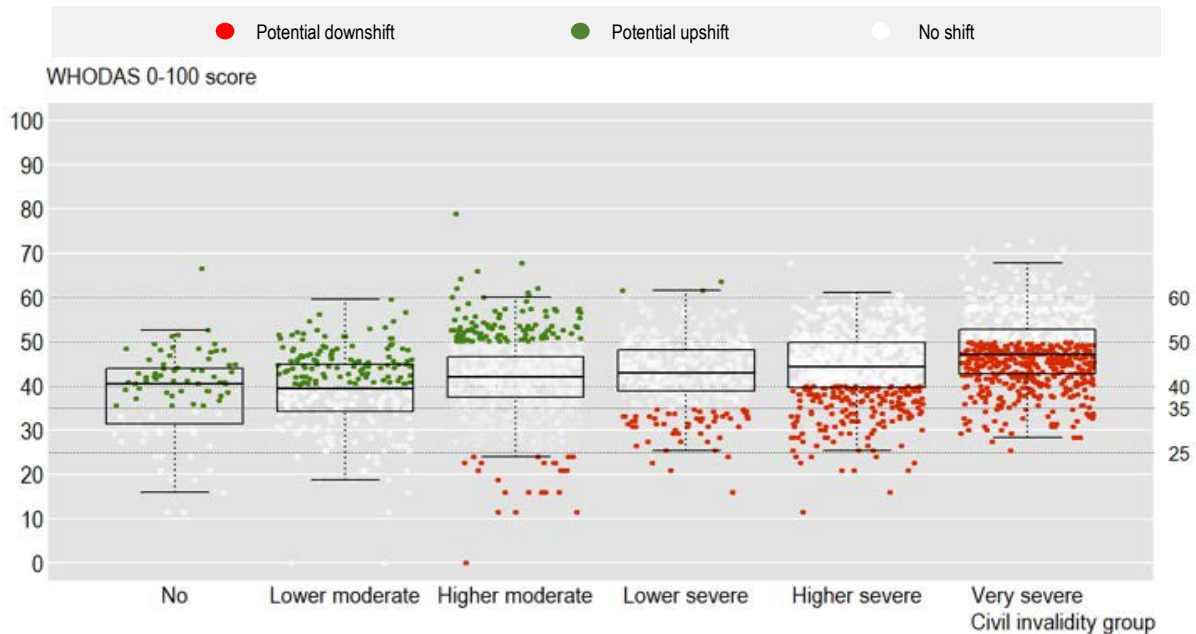
Note: WHODAS: WHO Disability Assessment Schedule.

Source: OECD calculations based on the pilot data.

The second supplementary strategy is less strict and allows deviations in the two scales by one category and only selects those cases for a second assessment for which the medically determined civil invalidity percentage differs from the functionally determined disability score by *at least two* categories. Figure 5.9 shows the result of this middle strategy, again marking in red and green cases with a negative or positive discrepancy between the civil invalidity rating and the WHODAS score. In about 70% of the total pilot sample, the difference between the two scales is so small that the assigned civil invalidity rating would remain untouched, while 30% would be selected for a reassessment. Of those 30%, again, about two-thirds are candidates for a potential downshift and one-third candidates for a potential upshift. In this case, most potential downshifts concern people with a 100% civil invalidity rating (very severe) while potential upshifts concern people with a lower or higher moderate invalidity rating (34-45% or 46-66%).

### Figure 5.9. Flagging about 30% of all civil invalidity applications for a secondary reassessment

WHODAS-scores by degree of civil invalidity, with potential downshifts and upshifts for cases for which the civil invalidity percentage deviates from the WHODAS score by at least two categories on a six-by-six scale



Note: WHODAS: WHO Disability Assessment Schedule.  
Source: OECD calculations based on the pilot data.

There is no right or wrong in the choice of the flagging approach but, the higher the importance attached to the WHODAS score, the more cases will be considered for reassessment. While the two supplementary strategies are illustrative in nature, the 30% identified in the second supplementary strategy could be a meaningful middle way for the Italian Government to consider. The thresholds underlying the selection of cases for reassessment are somewhat arbitrary initially but would become more and more robust over time, as more and more data is being collected through the new assessment process.

The second aspect to consider for the introduction of a flagging algorithm is the structure of the assessment process, i.e. the question who is assessing and deciding at what stage of the process. In this context, the Italian system has a great starting advantage as the final disability rating is approved and assigned by INPS already today. This lends itself to a natural process. In a first step, medical information is assessed by the regional assessment committee, just like today, and functioning information by local social workers, as was done in the regional pilots. These two independently collected pieces of information – the person's impairment score and the person's WHODAS score – are forwarded to INPS (or any other supervisory authority) which evaluates and compares the results and decides in which cases a reassessment is needed. This echoes today's process except that it would be done in a more transparent way and must include everyone for whom the medical and functional score deviate more than the legislation allows. If the two scores are close enough, the determination is essentially automatic and a decision on disability, by INPS, is issued. People for whom the two scores deviate are considered for a second assessment. In this case, medical assessors and social workers should sit together, examine the case, and make a new joint proposal to INPS. These could be done by the medical assessors and social workers responsible for the initial evaluation, or medical assessors and social workers from INPS (or the supervisory authority).

Of course, there are additional aspects to consider within the various components. For instance, better technical and methodological guidelines would be needed for assessing doctors on how to translate

impairments (via body functions and body structures) into invalidity percentages, to eliminate the current level of discretion and ensure that people with the same type and level of impairment always receive the same invalidity percentage from the assessors. Similarly, one could consider moving away from the interval scale and instead only consider groups of impairment levels, such as those used in this report.

Italy certainly has the administrative capacity to implement such a change smoothly. Italy has a cadre of experienced social workers in both the health and the social sector who could be engaged in administering WHODAS. Most Italian regions also have an advanced information system that could easily accommodate the collection and use of the information on functioning, derived from a WHODAS questionnaire, in addition to the information on the impairment. If instead of a flagging approach, which will result in a second combined medical-functional assessment in selected cases, an averaging or a scaling approach would be chosen as the method for the future, the procedure would be even easier as much of the process could be automatic. Whichever the ultimate choice might be, the result is that information on functioning will be systematically included in disability assessment using a standardised approach, and the administrative process itself will become more rigorous, standardised, and objective.

In implementing change, the Italian Government will have to consider two additional, political aspects. First, any new method adopted should probably be applied to new applicants only, to make sure the change is accepted by the population. Across the OECD, only very few countries (in particular, the Netherlands and the United Kingdom) have chosen to reassess current beneficiaries according to any new, reformed assessment method. Most OECD countries would, in such situations, choose to grandfather existing recipients; generally, it is considered fairer to leave existing entitlements unchanged despite the apparent inequality such an approach creates between those who were assessed before and after reform.

Second, it will be important to anticipate and manage the outcome of any reform. Whatever approach is chosen, there will be some individuals who benefit from the reform and others who will lose entitlements when compared to the current situation. As one of the conditions for reform is cost neutrality, this issue is unavoidable. The importance given to the functioning component, relative to the medical information, will determine the size of the two groups. Instead, Italy could also choose to produce winners only and to use functioning information only to identify people for whom the current system fails to identify their needs adequately. Such an approach would ensure that no one is left behind but would not be cost neutral.

In conclusion, this evaluation shows that the concept of disability based on functioning (via WHODAS) and the concept of civil invalidity currently in use in Italy based on impairment are hugely different. This is not surprising because one approach tries to assess the level of activity and participation and the kind and nature of problems people have in a scientifically tested way, while the other limits itself to assessing the existence, or discretionarily perceived existence, of a medical condition. The considerable difference between the two concepts demonstrates the critical importance of the inclusion of functioning into Italy's disability assessment. This will contribute to a better identification of the group of people needing support, better targeting of costly benefits and services, and a better link with regional and local needs assessments. The pilot has shown that Italy's regions are very able to implement the necessary change.

## References

- Bond, T. (2015), *Applying the Rasch Model*, Routledge, <https://doi.org/10.4324/9781315814698>. [2]
- Boone, W., J. Staver and M. Yale (2014), *Rasch Analysis in the Human Sciences*, Springer Netherlands, Dordrecht, <https://doi.org/10.1007/978-94-007-6857-4>. [9]
- Federici, S. et al. (2016), "World Health Organization disability assessment schedule 2.0: An international systematic review", *Disability and Rehabilitation*, Vol. 39/23, pp. 2347-2380, <https://doi.org/10.1080/09638288.2016.1223177>. [14]
- Ferrer, M. et al. (2019), "WHODAS 2.0-BO", *Revista de Saúde Pública*, Vol. 53, p. 19, <https://doi.org/10.11606/s1518-8787.2019053000586>. [13]
- Holland, P. and H. Wainer (1993), *Differential item functioning*, Lawrence Erlbaum Associates, Inc. [8]
- Mayrink, J. et al. (2018), "Reference ranges of the WHO Disability Assessment Schedule (WHODAS 2.0) score and diagnostic validity of its 12-item version in identifying altered functioning in healthy postpartum women", *International Journal of Gynecology & Obstetrics*, Vol. 141, pp. 48-54, <https://doi.org/10.1002/ijgo.12466>. [12]
- Nunnally, J. and I. Bernstein (1994), *Psychometric Theory (3rd edition)*, McGraw-Hill, New York. [4]
- Rasch, G. (1960), *Probabilistic Model for Some Intelligence and Achievement Tests*, Danish Institute for Educational Research, Copenhagen. [1]
- Smith, E. (2002), "Detecting and Evaluating the Impact of Multidimensionality Using Item Fit Statistics and Principal Component Analysis of Residuals", *Journal of Applied Measurement*, Vol. 3/2, pp. 205-31. [10]
- Smith, R. and C. Miao (1994), "Assessing Unidimensionality for Rasch Measurement", in *Objective Measurement: Theory into Practice: Volume 2*, Greenwich, Ablex. [11]
- Smith, R., R. Schumacker and M. Bush (1998), "Using item mean squares to evaluate fit to the Rasch model", *Journal of Outcome Measurement*, Vol. 2/1, pp. 66-78. [7]
- Tennant, A. and P. Conaghan (2007), "The Rasch measurement model in rheumatology: What is it and why use it? When should it be applied, and what should one look for in a Rasch paper?", *Arthritis Care & Research*, Vol. 57/8, pp. 1358-1362, <https://doi.org/10.1002/art.23108>. [3]
- Yen, W. (1993), "Scaling Performance Assessments: Strategies for Managing Local Item Dependence", *Journal of Educational Measurement*, Vol. 30/3, pp. 187-213, <https://doi.org/10.1111/j.1745-3984.1993.tb00423.x>. [6]
- Yen, W. (1984), "Effects of Local Item Dependence on the Fit and Equating Performance of the Three-Parameter Logistic Model", *Applied Psychological Measurement*, Vol. 8/2, pp. 125-145, <https://doi.org/10.1177/014662168400800201>. [5]



# 6

## Disability policy challenges in Italy: Conclusions and recommendations

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This chapter summarises the conclusions and recommendations of a project that supports the Government of Italy in its efforts to renew, strengthen and harmonise disability policy. The analysis is based on available evidence and in-depth conversations with policy makers and other key stakeholders in four regions of Italy – Campania region, Lombardy region, the Autonomous Region Sardinia, and the Autonomous Province of Trento – as well as a pilot conducted in those four regions of an alternative disability assessment with a focus on peoples’ actual life situation. The chapter provides detail on why the system of disability assessment and of social protection for people with disability needs reform and what elements a comprehensive reform should include, to strengthen system efficiency and effectiveness and to address long-standing inequalities.

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Disability policy is a complex and sensitive matter, not least because it addresses a population that is diverse (in terms of the nature and the degree of disability) and an issue that is variable for the people concerned (as disability can improve or worsen over time) and for society (as new types of disability arise and are better understood such as, e.g. highly prevalent mental health conditions). Consequently, disability reform is often controversial and deeper structural reform is politically difficult, not least because it requires a cultural change among key stakeholders and institutions, people with disability themselves, and society at large. Disability reform therefore is an ongoing and never-ending process.

Since Italy's ratification in 2009 of the UN Convention on the Rights of Persons with Disabilities (CRPD), an international treaty aiming for a truly inclusive society, Italian Governments of the time were confronted with a need for a structural change in disability policy, to align policies with the ideology of the CRPD. The current Government of Italy has engaged in a reform process which started with the enactment of a framework legislation – the so-called Enabling Act that delegates the responsibility for reform to the national government – and aims to address at least three long-standing policy issues: first, discrepancies with the CRPD calling for a new way to define and assess disability and thus eligibility for support; second, the fragmentation of disability assessments and disability supports; and third, resulting inequalities across Italy's regions in the provision of disability services and the take-up of disability benefits.

This report is the result of a project, funded by the European Union, which aims to support the Government of Italy in its efforts to update disability policy and increase the efficiency of disability benefits and services. The project has supported the government in three ways: by i) piloting a new disability assessment in four regions which represent the social and economic diversity of Italy, discussed in Chapter 5; ii) analysing disability status and needs assessments in use in Italy, discussed in Chapters 2 and 4; and iii) analysing the system of social protection for people with disability in Italy, i.e. disability benefits and disability services available, discussed in Chapters 3 and 4. This final chapter summarises the conclusions from these analyses and provides actionable policy recommendations for Italy to consider.

## **6.1. Conclusions and policy recommendations on disability assessment**

### **6.1.1. Main issues for disability assessment in Italy today**

Disability assessment is critical in the Italian system of social protection, as in most OECD countries, as it regulates entry into the system and eligibility for and access to all available disability supports. People with disability in Italy are confronted with a fragmented legal landscape. Several definitions and corresponding assessments of disability (status) coexist, reflecting the historical evolution of the legal framework. A piecemeal approach to legislation on disability created a system that is complex to navigate, with unclear or lacking links between the different types of assessment and a disability status assessment practice that looks at the individual from a rather narrow medical perspective.

Italy operates five different disability status assessments in parallel (civil invalidity, civil blindness, civil deafness, handicap, and disability for employment support), which look at different dimensions of disability, but all share a medical approach. General practitioners have a considerable responsibility in the process, as their documentation of the health situation forms the basis for the assessment decision. This decision is proposed by, and after a visit to, a medico-legal commission (with varying composition for the various status assessments, often referred to as baseline assessments), but in most cases the commission follows the opinion of the general practitioner. The assessment uses outdated correspondence tables to perform disability determination, thereby creating problems especially for mental health conditions which are the predominant health conditions today, especially for young adults, for whom a purely medical approach fails to correctly assess disability and, subsequently, to match needs with available resources.

In addition, Italy operates a contributory disability insurance system which operates its own assessment to determine a person's remaining and permanent work capacity. While the co-existence of a contributory

and a non-contributory system is common in OECD countries, the disconnect between the two systems and the heterogeneity of assessment practices are particularly salient in Italy.

Baseline or disability status assessments give people access to certain cash benefits that depend on the severity of their disability, or civil invalidity, measured as a percentage (100%=maximum disability). It is then mostly left to the person to follow up with regional and local authorities for other in-kind benefits (mostly health and social services) and corresponding needs assessments at the regional or local level.

Over the past decade, legislative efforts have been made to overcome fragmentation in both disability status and needs assessments, by introducing the concept of single points of entry at the local level to provide information and conduct a pre-assessment of applicants. These single points of entry should, in theory, guide users through the system and perform a triage into multidisciplinary and multidimensional assessments, playing an extensive role in taking charge of the client. In practice, however, the implementation of single points of entry varies considerably across and within regions, and – where such points of entry exist – there are considerable limitations in the degree of integration they achieve between social and health matters, as well as in the functions they perform.

Mirroring the situation with disability status assessments, the Italian situation is also characterised by a multitude of needs assessments at the regional and mostly local level. Needs assessments are performed in several contexts and tend to be driven by the service offered (i.e. provider driven) and shaped by the divide between the health and the social domain. The multitude of assessments remains a weakness in the passage to access regional and municipal programmes and services. A single multidisciplinary evaluation accepted by the health and social domain would simplify service access for vulnerable people and improve eligibility for different services available, according to the person's individual needs, and thereby reduce the large variation and inequality in service access across the regions of Italy.

Not only are there several parallel needs assessments in place within and across regions, but there is also a multitude of tools used in those assessments, ranging from a very discretionary to a more structured and systematic approach. Several regions use a variant of the 'multidimensional assessment card for people with disability', an instrument developed in Veneto to standardise the provision of essential levels of social and health supports. None of the tools, however, have been tested in a scientifically sound way for their validity and their ability to identify the needs associated with a person's functioning problems.

Finally, there is a large apparent disconnect between disability status assessments and subregional needs assessments, with the information of the former being of limited utility to the latter due to the purely medical perspective, the format of the output and limited data sharing. This results in duplication of efforts at all levels of governance, with needs assessments for example yet again often requiring initial input by the general practitioner rather than building on the information provided for the disability status assessment.

The Enabling Law, enacted in late 2021, addresses several of the weaknesses of the disability assessment system in Italy, and suggests moving away from the narrow medical view on disability and achieving some system simplification and harmonisation across the country, also as a basis for a corresponding change and harmonisation in the social protection system for people with disability. The Law remains quite general on forthcoming social protection reform while being quite precise on the forthcoming disability assessment reform, including a call for a single national entity to run disability status assessments.

### ***6.1.2. Policy recommendations for a more accurate and fairer disability assessment***

Partly echoing the reasoning behind the Enabling Law, and partly going beyond it, this report finds several reasons why, and areas where, the system of disability assessment in Italy is in urgent need of reform. Italy would be well advised to take reform steps in the following directions.

**Include functioning and performance in disability status assessment.** Disability assessment in Italy still uses a largely medical approach, not in line with the latest international view on, and definition of,

disability. The focus on impairment in determining civil invalidity percentages does not consider the actual environment in which people live and their ability to function, thereby failing to assess the true extent of disability and not supporting equity and inclusion. In addition, the use of 30-year-old tables to translate impairment information into a civil invalidity percentage implies that many disabilities are covered poorly, especially mental health conditions which are frequent and often quite disabling. Including the WHO Disability Assessment Schedule (WHODAS) into the current assessment process would result in a more accurate assessment of a person's disability.

**Use WHODAS scores to flag the need for a more in-depth assessment.** Evidence from the pilot in the four regions of Italy shows that a purely medical assessment identifies a rather different group as having a disability than the ICF-based WHODAS instrument. Policy makers will have to decide on the weight given to the information from WHODAS relative to the information from the medical files. The evaluation of the WHODAS pilot concluded that WHODAS scores are best used in Italy to flag the discrepancy between medical and functional assessment, thus requiring a more in-depth assessment of the person's situation. The OECD would recommend to flag about one-third of all cases. While the government is committed to reform, to fulfil one of the central criteria of the CRPD which Italy had ratified more than 12 years ago, implementing change is likely to face resistance. It will therefore be important to communicate this change very clearly, to win the key stakeholders and the public over the reform.

**Bring more social workers and other professions into the assessment process.** Related to the medical orientation of disability assessment in Italy, the involvement of professionals other than medical doctors is limited. General practitioners initiate the process, collect the medical evidence that the applicant must provide for the case, and submit the medical file to the assessing authority. The medico-legal commissions, which are dominated by medical doctors with different specialisations, usually decide based on the medical file submitted by the general practitioner. This setup contributes to the overarching use of medical criteria and the limited consideration of the environment and peoples' actual life. There is a strong case for giving social workers a greater role in the initiation and preparation of the documentation for disability assessments. The WHODAS pilot has demonstrated that social workers are well placed to implement the WHODAS questionnaire and to assess people's life situation and disability.

**Address the fragmentation and duplication of disability status assessments.** Italy is currently running five different disability status assessments in parallel, with different criteria, procedures, and assessment commissions but a very similar purpose: to determine eligibility for a range of economic benefits. Such system fragmentation, and duplication, is neither efficient nor justified. Moving forward, this fragmentation should be eliminated by replacing the five disability status assessments with one assessment that has its focus on the capacity of a person to perform life activities and participate in social life (which is affected by both the health condition/impairment and the environment in which people live). This requires a unification of the various coexisting definitions of disability. The Enabling Act is slightly vague about this issue, but reform should not shy away from radical change. Keeping five different definitions and assessments and moving to a functioning approach within each of them, in different ways and to a different extent, would mean perpetuating difference, lack of transparency and inefficiency.

**Address the fragmentation and duplication of needs assessments.** Mirroring the inefficient multiplicity of disability status assessments, Italy's regions and municipalities are also operating an array of needs assessments to determine eligibility for special services and in-kind benefits. These assessments often differ between and within regions – with the within-region variation reflecting two problems: first, the total disconnection between the health domain (which is under regional authority) and the social domain (which is under municipal authority); and second, the service-driven approach of needs assessments in Italy, where a different assessment is often used to determine eligibility for every service that is available. Maintaining a two-tier system, with a needs assessment following a disability-status assessment, is a practical way forward and an approach applied in many OECD countries. However, ideally both disability status assessment and needs assessment would be unified. A single needs assessment should be used across and within regions and municipalities to identify people's needs and determine entitlement to

different health and social services; this assessment should focus on people's needs only, avoiding any bias related to the availability and capacity of specific services.

**Improve the connection between disability status assessment and needs assessment.** In the current assessment structure, not only are disability status and needs assessments fragmented but there is also no connection between the two. In a more effective and efficient system, disability status assessment would provide meaningful input for the subsequent needs assessment, and the information collected in the baseline assessment would be shared with the authorities responsible for needs assessment. Such an approach requires data to be collected and shared systematically, and ideally electronically. In this way, persons whose situation is assessed will not have to provide the same information repeatedly. Overcoming the fragmentation of disability status and needs assessments will facilitate the flow of information between the responsible assessment authorities. Data should not only be shared but some data should also be made publicly available, to foster transparency and promote an objective public debate. For instance, periodic reports on the number of people applying for and receiving a disability status, by age, gender, and region, could provide up-to-date evidence on the implementation of the legislation across Italy.

**Reconsider the planned change in the governance structure for disability assessment.** With the constitutional reform in Italy about 20 years ago, more responsibility for disability status assessment was devolved to the regions, even though the ultimate decision remained with INPS and some regions, or provinces, have chosen to delegate their new responsibility back to INPS. The Enabling Law foresees a change in the governance structure by appointing a single entity to run disability status assessments in the whole country in a coherent way. It is questionable if this is the best answer to the large difference across regions in the share of people of working age who apply for a disability status assessment – a phenomenon related to the large regional variance in the state of the economy and the labour market. An alternative to recentralising disability assessments would be strengthening the capacity of regions, especially as regions will continue to have core responsibilities in fields such as health and social services. Keeping disability status assessment in the hands of the regions at least to some degree, would facilitate structural reform and prevent a further disconnection between disability status and needs assessment.

**Strengthen objectivity and reduce discretion in disability assessments.** Both disability status and needs assessment decisions in Italy carry considerable discretionary elements, in turn potentially creating considerable inequity across similar life situations. This is explained by the lack of a standardised approach to assessments, and the lack of scientific testing of the features of the assessment tools in place. In the case of disability status assessment, including WHODAS would be a way to reduce discretion and achieve fairness and equity in the decision. Adapted versions of WHODAS could also be used for the disability status assessment for minors and for the elderly. For needs assessment, unifying assessments across regions, provinces, and municipalities, and for the health as well as the social sector, would be the only way to reduce discretion. This could be done by comparing and evaluating tools currently in place in the regions and choosing the best-performing of all available tools, or by developing and pilot-testing a new tool agreed by all regions and municipalities.

**Help people with disability navigate the complex system.** In the current system, the degree to which people with disability receive all the national, regional, and local benefits and services they could potentially be entitled to, depends to a considerable extent on their ability and staying power to navigate the system. This situation was also the starting point for the implementation of the single points of entry (PUA) in many regions and municipalities. PUAs are a sensible idea that is poorly implemented in practice, especially because the disability system remains complex and opaque to people who are not experts in administrative matters. A simplification and unification of disability status and needs assessments would facilitate the tasks and role of the PUAs considerably. Until then, the status of the PUAs should be enhanced so that they can be what they are meant to be: the first and only point of entry to the entire disability system, including all assessments (and thus all benefits and services) at both the national and the subnational level. It will also be important to achieve a higher degree of unification in the setup of PUAs and improve their human capacities across the territory.

**Think about systematic reassessment of disability rights and entitlements.** The Enabling Law makes no reference to two important issues. First, it does not address the issue of reassessment (on which also data is entirely absent) of a person’s disability status and needs. Reassessment is an important aspect of an effective and fair disability policy because disability can improve or deteriorate – in line with changes in the health condition and/or the social and supporting environment. In many cases, therefore, regular reassessment is justified and can strengthen the credibility and affordability of a generous social protection system. A second and partly related question that is also marginally addressed in the Enabling Law is the treatment of existing entitlements. A country can choose to either grandfather all existing entitlements or reassess everyone or certain groups in line with the new rules, tools, and procedures; either of the two approaches can be seen as “fairer” than the other, in different ways. Reassessing existing entitlements will be particularly appropriate if and as the social protection system also changes.

## 6.2. Conclusions and policy recommendations on social protection

### 6.2.1. Key issues for social protection for people with disability in Italy today

Evaluating the social protection system for people with disability in Italy and understanding the interaction between national policies (mostly various types of social benefits) and regional and local policies (mostly in-kind benefits and services) is difficult, for two reasons: first, because of the complexity of the system – which is a challenge for people with disability – and second, because of the lack of evidence in all areas to measure the effectiveness and efficiency of disability policies in place. It is therefore difficult to assess the actual impact and performance of the system. Policy conclusions and recommendations thus rely on limited, very partial, and often anecdotal evidence.

It appears that disability benefits and disability services available in Italy are quite comprehensive, with a suite of contributory and non-contributory payments to cover income loss and additional costs related to a person’s disability and, equally, a comprehensive menu of interventions provided by municipal social assistance authorities, regional health authorities, and employment services to address the varied needs of people with disability. On the surface, there is no indication of a particular service gap or a lack of services commonly available in other OECD countries. However, beyond this general observation, there are several important issues of potential concern.

Comparative cross-country data show that public social spending on disability policy in Italy is well below OECD average, and that most spending is used for disability benefits. The Enabling Law foresees that all changes must remain within the current budget envelope. Restructuring, simplifying, and unifying disability assessment should make the system more efficient, and free up resources. However, in the longer run the level of disability-related spending might not be sufficient to achieve the envisioned switch to a more personalised approach to disability, based on individual life plans and focussed on self-sufficiency. Already today, many people with disability in Italy lack access to support and with a stronger focus on functioning in assessing disability, this group could turn out to be larger than is currently known.

The adequacy of disability payments and services provided in Italy is difficult to assess, as it depends very much on the package of support that people receive – an area on which very little is known. The level of non-contributory disability payments is very low, for example, but many people will receive additional payments, such as attendance allowance, to cover their needs and costs. Data on income sources of Italian households suggest that people with disability rely on social benefits to a larger degree than on average across OECD Europe. However, this finding is driven by benefits other than disability benefits, including (early) retirement payments, unemployment benefits and social assistance. Poverty levels in Italy for households in which people with disability live are comparable to those in other countries and those for people without disability. In Italy, contrary to other countries, the broader benefit system (not just disability benefits) seems to reduce poverty risks more for people with disability than for other people.

The adequacy of disability services available in Italy is even more difficult to assess, lacking any systematic information on the number of service users and the number of people waiting for or in need of services but not currently receiving any. The limited data available suggest that per-capita spending for service users is quite high, be it for homecare services and services aimed at improving self-sufficiency or for more recently introduced employment services. The number of users of any of these services, however, is very low compared to the potential group of users, however defined. Italy therefore seems to face an access challenge, not a generosity challenge, as those who can access services seem well supported.

There are also two more general issues across the Italian system of disability benefits and services. First, there is a massive North-South divide. Poorer regions in the south of the country lack the capacity and resources to provide services in sufficient number; hence, both the number of service users and per-capita spending on services is lower than in the wealthier part of the country. In turn, the number of recipients of disability benefits, especially non-contributory benefits, is much higher in the South than in the North, with the benefit reciprocity rate varying between less than 2% of the working-age population in some regions and more than 7% in others. This difference is the result of two characteristics of the benefit system: first, the fact that all benefits are funded from the national budget and, second, that non-contributory payments are more attractive in regions with fewer jobs and lower wages and eligibility for means-tested payments much more likely. Any reform of disability policy will have to address these equity issues.

Second, there is also a significant divide in Italy between severe disability and moderate disability. By and large, disability payments and disability services in Italy cater for people with severe disability (e.g. 50% of them receive a disability benefit) while people with moderate disability and people with highly prevalent mental health conditions will in most cases rely on the general social protection system (e.g. only 10% of them receive a disability benefit) and find it difficult to access disability services. Even disability employment services are reserved for people with a rather significant level of disability. In turn, disability mainstreaming in all policies and practices is a key issue for Italy, pointing to more general reform issues to boost social and employment outcomes for all people, which would also benefit people with disability.

Lastly there are also significant systemic issues that Italy could address, related to the complexity and the fragmentation of a system that involves many actors with shared responsibility between the national level (benefits), the regional level (health services) and the local level (social services). The decentralised nature of the state and the distribution of responsibilities requires a significant degree of information sharing and co-operation to avoid duplication of services on the one hand and service gaps on the other. At the subnational level, health and social authorities provide distinct supports that in many cases overlap, e.g. regarding homecare, but co-ordination between the two sectors is limited. Similarly, there are overlaps between national and regional efforts, e.g. for support of self-sufficiency and long-term care, covered by cash benefits and family leave at the national level and in-kind benefits and services at the regional level.

### **6.2.2. Policy recommendations for more effective and efficient social protection**

This report finds several strengths and weaknesses in Italy's social protection for people with disability, and several reasons why reform is needed to strengthen system efficiency and effectiveness and address long-standing inequalities. Italy would be well advised to consider reform steps in the following directions.

#### *Improving the evidence base by implementing better data sharing practices*

Very little is known in Italy about which programmes are serving which groups of the population, making it difficult to assess the performance of the system (coverage, adequacy, and efficiency). Much could be done to improve the evidence base through systematic data collection and data sharing.

**Invest in modern data management systems.** At present, local services are not recorded in a single IT system at the individual level, which makes it very difficult to map the set of benefits and services that a person is receiving, particularly when services are received from both the social and the health realm. A

solution that allows recording these data and storing them in data warehouses to later be linked across institutions and data sets, is essential to identify key areas for reform, and to facilitate the administrative work of public employees. The initiative of the social sector to implement a single IT system (SIOSS) is welcome, but efforts should be made to ensure the system does not impose technical barriers to linking the data from the social sector with data from the health sector or with national-level benefits data.

**Use a single central authority to link and store administrative data.** Linking administrative data across institutions poses technical and legal challenges many countries have overcome by establishing a single central authority responsible for data-linking. This also avoids the need for bilateral data exchange agreements and having to build technical capacity in every institution. In most countries, this single central authority is the national statistical institute. Italy's National Statistical Institute (ISTAT) is well positioned as it has the necessary technical and analytical capacity.

**Address privacy concerns.** In addition to technical barriers stemming from a lack of a single IT system, Italian authorities experience difficulties in sharing and receiving data across institutions due to privacy concerns. Data protection regulation is often used as a shield to prevent any data exchange, in many cases applying stricter regulations than the European legislation (GDPR). Exchanging data across institutions requires establishing legal frameworks to ensure the protection of personal data and developing sound guidelines around using and sharing such data.

#### *Promoting co-operation across institutions and levels of government*

System inefficiency in Italy is related to a lack of co-operation across levels of government and associated financing mechanisms. Promoting co-operation and streamlining funding could increase transparency for users and delivery institutions alike, thereby ensuring better use of national and subnational resources.

**Enforce regulations that foster co-operation.** The regulatory landscape includes promising initiatives to promote co-operation across institutions, but their implementation is weak. This is particularly the case for the co-operation between the health and the social sector. The regulation lays out the importance of a single point of entry to deliver co-ordinated health and social services, with a single needs assessment to determine individualised plans. Concerted efforts are needed to make single points of entry a reality. The national government could take a stronger role through systematic monitoring and evaluation and the provision of financial incentives for regions to achieve a higher degree of service integration.

**Create a forum to share experiences and learn from each other.** Learning from good practices of other stakeholders – across regions, across municipalities and provinces within regions, and between the health and the social sector – can be beneficial to building administrative capacity, improving programming, and fostering co-operation. Systematic cross-institutional learning should be facilitated and promoted.

**Develop financing mechanisms that promote better co-ordination of supports.** A consolidation of subnational programmes with a similar purpose would best be achieved through a consolidation of funding sources. With consolidated national funds for sub-nationally provided in-kind benefits and services, it would be easier for regions to decide where to complement national funds with their own resources. Alternatively, national funds could be targeted at certain broader objectives (such as inclusion, independent living, or accessibility) without being earmarked to specific programmes, thereby giving regional bodies more control over the efficient use of these funds. Lastly, better co-ordination and service integration between the health and the social sector – on residential, semi-residential and most importantly homecare services – could be achieved, and service duplication prevented, through integrated and transparent budgeting.

#### *Decreasing territorial differences in access to benefits and services*

Large territorial income differences and the current financing of the system results in poorer regions relying heavily on nationally funded social benefits and providing only limited support to the functioning of a person



through in-kind benefits and services. Rectifying this situation and improving the capacity of economically weaker regions to provide effective services will be critical but this is not an easy exercise.

**Address structural labour market weaknesses and spatial divides.** Poorer regions in Italy have weaker labour markets, lower wages, and higher levels of informality. These factors influence the reliance on social benefits and also reinforce each other, as a high dependence on means-tested benefits promotes informal work. Addressing these structural economic and labour market issues across Italy is crucial. Over the past decade, the OECD's Economic Surveys for Italy have identified some of the key areas to address, including improving skills and education, introducing active labour market programmes, boosting job creation, and rethinking the tax system, to break the North-South divide.

**Promote the harmonisation of services through a focus on performance.** To harmonise the delivery of health and social services, the national government has imposed minimum service standards. However, many regions fail to meet these standards, without much consequence. The current monitoring of minimum standards focuses on a series of line-item indicators, rather than focusing on the performance of the system as a whole. Using the existing regulation to harmonise the delivery of services, and making it binding and focused on performance, would help strengthen service quality in underperforming areas.

**Prioritise the delivery of services over the provision of social benefits.** The necessary shift in focus away from benefit provision towards the delivery of services for inclusion will not be achieved without financial incentives for regions and municipalities. Following the example of Denmark, and turning around the logic in the system today, the Italian Government could ensure full cost-coverage for services delivered at the subnational level, while imposing significant regional co-payments for non-contributory disability benefits, to make it attractive for regions and municipalities to shift their focus towards service delivery.

#### *Making employment integration of people with disability a policy priority*

Labour market inclusion of people with disability is low in Italy, although not necessarily lower than for other vulnerable groups of the population. Moving forward, employment inclusion should become a key priority, implying a shift in the focus to in-kind benefits and services and a change in regulations to promote work.

**Focus on early intervention.** Effectively promoting the employment of people with disability requires intervening as soon as barriers to employment materialise. In Italy, where disability certifications play such a major role for receiving support, when people with disability receive financial and employment support, it is often too late. This implies that much more should be done for people with health conditions – many of which could turn into disability – at an earlier stage and before seeking disability certification, i.e. at a time when people are seeking help through general social protection programmes, in particular sickness benefits and unemployment benefits.

**Develop effective and accountable Public Employment Services.** Despite recent improvements, public employment services in Italy have a limited role in supporting job search through active labour market programmes. This general weakness affects the employment support provided for people with disability. There is an urgent need to improve the capacity of public employment services to deliver active labour market policies in general, and to increase the accountability for vulnerable jobseekers such as people with disability. There is also a need to expand services from only helping people who are listed for disability employment quota purposes to a wider group, with a particular focus on mental health conditions.

**Link disability benefit to activation provisions.** Many OECD countries have introduced comprehensive rehabilitation pathways for disability benefit claimants and/or temporary programmes preceding the claim of a disability benefit (e.g. Austria, the Netherlands, Norway, Switzerland), and many provide financial incentives to those working while receiving benefits. In Italy, receipt of a disability pension discourages work, especially for people with partial disability and partial work capacity. There is an urgent need to revisit the complementarity of disability pensions with work, and to consider introducing rehabilitation pathways and capacity-adjusted activation provisions.

# Disability, Work and Inclusion in Italy

## BETTER ASSESSMENT FOR BETTER SUPPORT

One in seven working age adults identifies as having a disability in OECD countries. Many of them are excluded from meaningful work and have low levels of income and social engagement. Governments can help create an environment that supports social and labour market integration for people with disability. This report reviews the effectiveness of the social protection system for people with disability in Italy and summarises the results of a pilot carried out in four regions testing an alternative disability assessment. The current assessment process can sometimes deny services to people in need of support while being generous to people with significant health problems but who are not experiencing severe disability. A disability assessment that takes medical and functional aspects into account helps to direct services and resources to those most in need and to harmonise access to disability support across the country. Implementing disability reform has proved to be difficult in Italy in the past decade. This report provides evidence that reform can improve outcomes for people with disability.



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