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# The Regional Implementation of Socio-Health Integration 20 years after l. 328 and the Welfare Impact of the PNRR

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The current growth in chronicles and life expectancy poses new challenges for welfare in ensuring care in the face of the increased spread of fragility in the territory. This contrasts with the progress of research and technological innovation, which can ensure a different organization of personal assistance services. In this context, the integration of services to the person in the dual dimension of health and social assistance is to be considered not only as an objective but as a means by which to guarantee well-being at the territorial level.

However, widespread forms of organizational inefficiency in personal services related to individual segments of care affect the welfare system in terms where they do not provide an adequate response to the growing demand for care on the ground.

My article is oriented to analyze in a diachronic and comparative way the welfare system in Italy through the filter of L. 328/2000, at twenty years in order to highlight the application obstacles and possible prospects in ensuring the development of services to the person adapted to the growth of welfare demand.

The social protection system has changed from a centralized approach to a decentralized welfare state, which promotes citizen participation. At a comparative level, welfare was originally characterised by the downsizing of public intervention in the field of social welfare and the limited financial resources allocated to this sector. These shortcomings have led to a lack of local assistance for the community.

In contrast to the above, L. 328 has reformed the model of social assistance, through the regulation of the integrated system of social services. The universalistic approach (art. 2) is extended through priority access to services and services provided by the integrated system of social interventions and services. The objective of promoting well-being is extended both to "normality in people's lives" and to "situations of crisis and discomfort" [1].

The river of the reform is constituted by the introduction of the community care that is of taking care of the territory through a network of territorial services. In this context, subsidiarity has been the principle to be applied in achieving the public interest of an integrated system of social services, through a distribution of competences and roles, based on the skills of public and private actors involved in the programming, implementation and evaluation of services to the person.

The implementation of this reform has come up against the critical issues regarding the way in which funding for social services is distributed, the lack of specificity of which has led not only to a fragmentation of the allocation of resources, but also a dispersion of the same. The restriction of funding such as the National Fund for Non-Self-sufficiency (1.220/2010) has made the provision and subsequent enforceability of services to individuals critical in practice.

Another obstacle to implementation has been the lack of provision of control and enforcement tools, able to ensure the effective delivery of essential levels of performance on the ground according to the universalistic principle. The biggest shortcoming was the management of the services to the person on the territory due to the lack of organization of technical bodies, the lack of reporting of the Area Plans and the shortfall in forecasting and implementation of sanctioning measures. In practice, these findings have made it impossible for recipients to make such services available.

The reversal of the department of powers envisaged by the federalist reform gave the State the "determination of the essential levels concerning civil and social rights" to be guaranteed on the territory, while the Regions were given the functions of direction and coordination. This approach, if on the one hand it has made it possible to adapt the regulatory application to the territory, on the other hand has favored a regional implementation differentiation.

In Sicily, the implementation of the integrated system of personal services has been pursued through a will aimed at affecting the level of well-being and quality of services provided to the person, through the integration between the health and social area. The l.reg. 22/1986 "Standards for the management of social welfare services in Sicily" introduces key guidelines for the sector. L.r.n. 5/2009 has reorganized the Health Service in Sicily, through the regulation of both social and health integration (Art.2, 9, 12, 17), and the 'integrated social and health services with social benefits' (Art. 12).

This implementation legislation of 128/2000 is in contrast to the planning of the Regional Health Plan, which every two years indicates the channels within which to guide the social and health integration and the guidelines of the integrated socio-health system in Sicily that note the need to optimize the rice available through a planning of the same. In this sense, DGR 12/2012 regulates the integrated socio-health regional system, through an organic regulatory system capable of overcoming the current problems of coexistence between the social and health systems. The "Guidelines for the implementation of the socio-health plan of Sicily 2002", implementing L. 328/2000 constitutes a three-year programmatic document, able to define social policies, regulating their impact at the local level in a unified way, in order to arrive after the trial to the regional social-health plan.

Guidelines for the implementation of regional social policies 2019-2020" aimed to ensure greater continuity to social policies in the territory, through the forecast of FNPS resources allocated to Sicily for 2018 and those planned for 2019. This policy document aims to overcome the critical issues arising from the application of territorial social policies, in accordance with national macro-levels, in order to optimize the allocated resources, avoiding overlaps or duplication of interventions.

Like this, the current development of welfare in the medium and long term is to be directed in dealing with the growing fragility of communities, in which preventive strategies are to be prioritised over a restorative or sanctioning logic. In this way, my analysis is designed to identify the tools and measures that can implement integration aimed at ensuring the best way to care for the person through a fair, comprehensive and comprehensive social health care response.

The first objective is to overcome the inter-sectoral intervention, which has not allowed to overcome the current dichotomy between social and health care, through the strengthening of domiciliary services through innovative models of organization, able to put in place the contribution of technological innovation. In order to ensure greater care capilarization, greater continuity and coordination between hospital care and outpatient specialist services is needed, which can optimise prevention and long-term treatment that are lacking in the current welfare network.

The prospects of community welfare require to adapt to the evolution of social determinants and to ensure greater coherence between the planning phase and the implementation phase. This participatory path involves a constructive dialogue between policy makers in their respective roles and responsibilities and the target audience, stakeholders and the third sector, which is not in the planning and management phase in ensuring constant individual territorial realities. This implies even before the planning, the start of reporting and investigation of the fragilities present in the territory.

In the planning phase, the current public role in the programme agreements is to be overcome by identifying cooperation models, able to balance solidarity and economic interests through coordination between the two. local communities and economic operators, in a comparison not only competitive, but to be adapted to the evolution of welfare demand. This participatory path involves a constructive dialogue between policy makers in their respective roles and responsibilities and the target audience, stakeholders and the third sector, in the planning phase and in management in ensuring a adjustment to individual territorial realities, through a constant verification of the planned objectives and those achieved.

This change in support of the viability of the services of the integrated system to the person implies a regional and local planning that can be molded, in which the participatory extension is aimed at ensuring greater completeness and specificity in allocating financial resources, also alternative to public ones and individual professional contributions, are to be adapted to the fragility of the ever in this context, the implementation of PNRR through regulatory reforms and financial support in strategic axes for health care oriented to to exsurev a welfare definided at european level but to be implemented in a scalar manner at different levels the governance of individual Member States. in particular, the substantial European funding from the EU to be implememnted by 2026, in the medium and long term will have the socio-economic impact of ensuring innviative form of social and innovation especially in health. The targets are aimed both at the implementation of exiting tools and techonology and identification of innovative paths of social assistance in the territory through the creation of specific structires for existing person [2-5].

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