Care Of The Elderly. Aging and New Demands for the Development of Care Work in Italy

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Abstract

The increasing incidence of the older age groups on the working age population, the transformation of the families models and their implications on the redefinition of care, as well the progressive spread of the chronic diseases and non self-sufficiency in old age, are leading different institutions to question the effectiveness and sustainability of the welfare system in developing the quality of ageing (NNA 2017; UNECE 2017; ILO, 2018).

This happens in a context in which even the families, traditionally considered a leading resource in the fulfilment of care functions, are also affected by transformations. In relation to the increasing participation of women in the labour market, and the investment in policies aimed at the early retirement, the relationship between family responsibilities and work makes critical the position of caregivers within the labour market. An increasing number of households identify informal caregivers as a support in the management of care, giving rise to a transformation of the domestic and private care work. Despite an increasing relevance on the labour supply, informal care jobs are affected by a nuanced definition of the professional competences' profiles. In the context of changing organizational models of healthcare services, the regulation of the working conditions and the perspectives for the integration of the chain of social professions are still referred to the relationship between families and services, even within the debate on the recognition of the caregivers function. Retracing the mentioned scenario, this paper aims to explore the demand for the development of the care professions and services, deepening the relationship among the demand for care, the gender distribution of paid and unpaid care work, and the development of the social mandate in relation to the care jobs. Using the available national literature and statistics (Inps; Istat; Inapp) on care loads, recourse to support services, and finally on gender, aging and professional needs, the contribution

analyses the process of “re-familiarization "of the functions of care within the relationship between families and services, reflecting on limits and resources that can be identified in the current Mediterranean welfare model, characterized by prevalence of pension expenditure and monetary support to families compared to that for services. The hypothesis of a possible paradigm shift of the mandate towards care professions is proposed: from individualized policies, based on a diagnostic-rehabilitative and substitutive-compensatory approach, towards an integrative and community-oriented approach to the questions posed by non self-sufficiency.

Keywords: Ageing, domestic workers, care professions, social mandate, substitutive vs integrative approach, individual vs relational approach.

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1 Introduction

The social system is changing, among the emerging changes: the consistent increase of the older age groups on the working age population, the transformation of families and the redefinition of care functions traditionally entrusted to them, the prolongation of life, the progressive spread of chronic diseases and the condition of self-sufficiency that follows. All events that call for reflections on the welfare system capability to develop the quality of life and coexistence[1] (NNA 2017; WHO 2016; UNECE 2017; ILO, 2018).

In Italy, an increasing disabling ageing is leading to a growing demand for care in a scarce resources scenario both in terms of professionalism and availability of "informal" caregivers (OECD, 2011a and 2017); more generally, of financial and social security resources to guarantee the quality of life (Carrera et al. 2013; ISTAT 2015a; NNA 2017; Fosti and Notarnicola, 2018).

This happens in a context in which even the family, traditionally considered a leading resource in care functions, is affected by profound changes (Bizzotto and Villosio 2011; Scialdone 2015; Maino and Ferrera 2017; Canal 2017; ISTAT 2018a).

On the other hand, while several studies foreshadow the care work as one of the most developed employment opportunities in the years to come (Unioncamere 2018, ILO 2018), today, the panorama of health and social professions appears unbalanced on a polarization: a significant prominence of specializations and a proliferation of a myriad of less qualified professions. These last jobs require less specialized technical skills, but were born from attempts to respond to the new emerging mandate in taking charge of non-self-sufficiency: not only rehabilitation and specialist support to compensate deficits, but development of skills to deal with the contexts in which non-self-sufficiency is experienced (caregivers, family assistants, but also support administrators, etc.) (Pasquinelli and Rusmini 2013 a/b; Casadei and Franceschetti 2011; Franceschetti 2016; NNA 2017; Di Pasquale et al. 2018).

Retracing the aforementioned scenarios, the contribution proposes an analysis of the process of "re-familiarization" of care functions within the relationship between families and health and social services. Our aim is to understand how this process affects the development of a new mandate with regard to new competences and professionalism to develop in services.

[1] Here we consider the coexistence system as themed form Carli R. e Di Maria F. in Di Maria F., 2000. It is referred to the subjective and relational dimension of the human relationships as the foundation of the organizational dimensions of social systems. It is referred to different possibile representations of the relationships in their constitutitive aspects: belonging systems, outsiders and rules of the game (Carli R., 2000).

The article is composed of three parts. The first part traces the dimensions of the population aging, and of the ongoing social transformations, as they translate into problems and expectations that orient the relationship between the elderly, families, local communities and services within the production and coexistence systems. A second part will analyze the characteristics of long-term care services in Italy and the demand for informal care work. The third section offers a reflection on the implications of these transitions in the development of professionalism and care services and on the cultural premises underlying policy interventions. Finally, we will try to identify new policy development lines.

1.1 The dynamics of aging: longevity, chronicity and coexistence

The Italian population is aging faster than other European countries. While the mean number of children per woman is among the lowest in Europe, reaching 1.34[2] in 2017 (compared to the average of 1.59 in European countries), the aging index has grown over the time (168.7% in 2018 compared to 157.7% in 2015), and exceeds of 30% points the EU average (165.3% in 2017 compared to the 125.5% in Eu28). So that, Italy is one of those countries where the aging process is demographically more evident (ISTAT 2017a/b and 2018a/b).

Last year, people aged over 65 were over 22.3% of the population, mostly women (24.1% vs 19.6% men), and their incidence could reach 33.7% in 2045 (ISTAT 2018c). The combination of factors such as medical-hospital treatments, the quality of prevention services, the improvement of nutrition and housing conditions has been reduced the risk of death; the incidence of old age is gradually increasing. At 1st January 2018, people aged over 80 were 6.9% of the Italian population (4.207.000), exceeding the European mean of 5.6%, with a growing incidence of the over 90 and centenarians. (ISTAT 2018c).

If longevity is a trend characterizing the Italian population more than the European one, aging does not always take place in conditions of good health[3], enough to ensure significant levels of quality of life and social participation. About one in two elderly, in Italy, suffers from at least one serious chronic disease or is multichronic[4]. Over 30% of the elderly consider reduced their autonomy in the domestic work (preparing meals, shopping, taking medicine, do the cleanings)[5], or in one or more of the basic activities for the personal care (11.2%), with a particular disadvantage for older women living alone[6] (ISTAT 2017c).

[2] This amount results from the contribution of foreign women residing in Italy, whose had 1.96 children in 2016, compared to the mean of Italian women, stable at 1.27 since 2015.

[3] Life expectancy at age 65 years-old is at 83 compared to 81 in Eu28 (OECD 2018), but the healthy life expectancy is lower: 7.5 years compared to a European average of 9.5 (ISTAT 2017c).

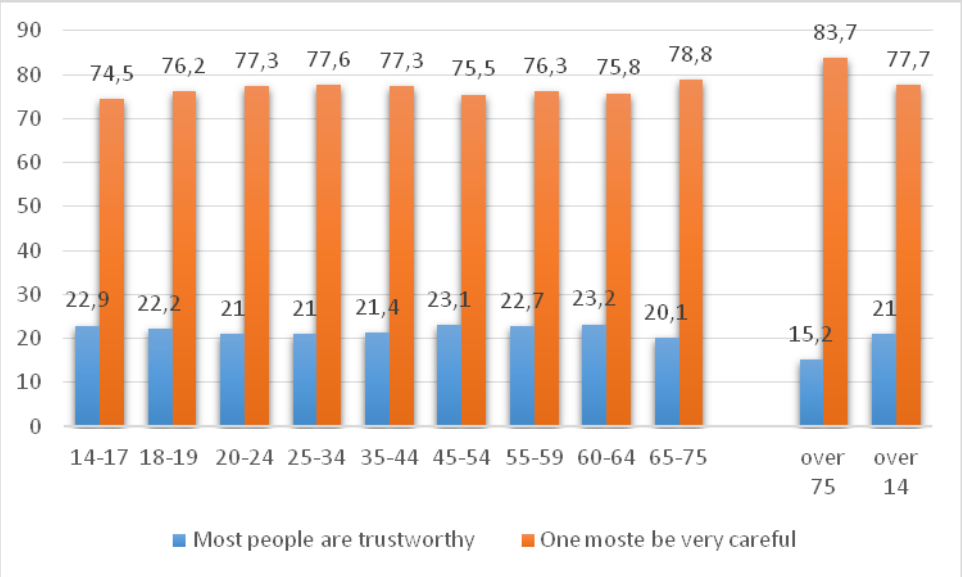
[4] These quotas rise 59% and 64% among the octogenarians (ISTAT 2017c).

[5] The quota rises at 47% among over 75s.

[6] When living alone one woman in two reports serious difficulties in both instrumental and basic activities of daily living.

Even though 25.9% feel they can count on a solid network of social support, over time, in the context of the economic crisis, a growing number of elderly people experience a feeling of isolation and mistrust (Figure 1), that can constitute a risk factor in expanding the relationships network on which one can rely (ISTAT 2018a).

Figure 1 – People aged 14 and over by interpersonal trust, year 2016 (v%).



Source: Elaborations on ISTAT data, Aspects of daily life, 2016

Among the elderly with severe reduction in autonomy 58.1% declares that they need help or have insufficient assistance (Table 1), especially in the southern regions (67.5) and in the islands (56%), among the less affluent elderly (64.2%), in the most densely populated areas, and among those living alone (53%) or in couples without children (65%).

Table 1: People aged 65 and over with serious difficulties in personal care and daily life activities (ADL) or in instrumental domestic activities (IADL) who claim to need help or need more help, by the main context variables. Year 2015 (per 100 people with the same characteristics)

Context variables		*Serious difficulties in ADL**	*Serious difficulties in IADL**
Sex	*Men*	*64,3*	*45,6*
	Women	*55,6*	*50,0*
Educational Attainment	*Low*	***59,8***	*50,3*
	Medium	*46,1*	*41,3*
	High	*38,2*	*28,8*
*Income Quintiles**	*I (Lower)*	***64,2***	*53,3*
	II	***62,1***	*53,1*

	III	*56,6*	*47,4*
	IV	*56,3*	*43,9*
	V	*51,2*	*44,7*
Geographic Area	*North-west*	*53,0*	*37,1*
	North-east	*48,7*	*39,1*
	Centre	*59,5*	***51,2***
	South	***67,5***	***59,2***
	Islands	***56,1***	***54,1***
Household	*Single person*	***53,2***	***49,6***
	Couple without children	***65,0***	***50,5***
	Couple with children	*62,0*	*43,7*
	Other families	*63,0*	*43,2*
	Aggregated member of a family	*53,4*	*48,5*
Total		***58,1***	***48,7***

**ADL= Activities of Daily living; IADL= Instrumental Activities of Daily Living*

Source: ISTAT, Elderly, health conditions in Italy and European Union (EHIS), 2017

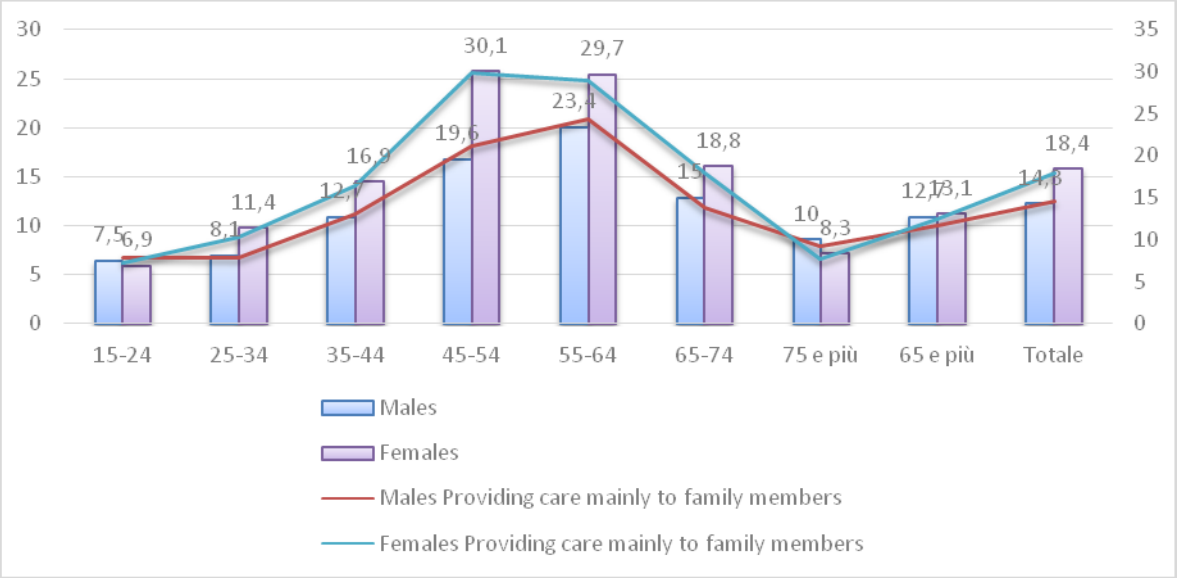
The progressive chronicization of many diseases (heart disease, stroke, neuropathies, neoplasms, etc.) followed by the transformation of cohabitation, thus, leads a growing number of elderly to live in a condition of fragility with even diversified needs for care. Especially in situations where incurable pathologies are accompanied by precarious economic and housing conditions, the demand for care becomes particularly complex (AGENAS 2012; Olivetti Manoukian)[7].

1.2 Families and care responsibilities

In Italy, it is estimated (ISTAT 2017c) that over 17.4% of the population take care, at least once a week, of people, generally the closest family members, with health problems related to aging and chronic illness. Most of them are women, of working age in the labor market - therefore with difficulty in balancing work and family life, or close to retirement if not out of the labor market (Figures 2 and 3).

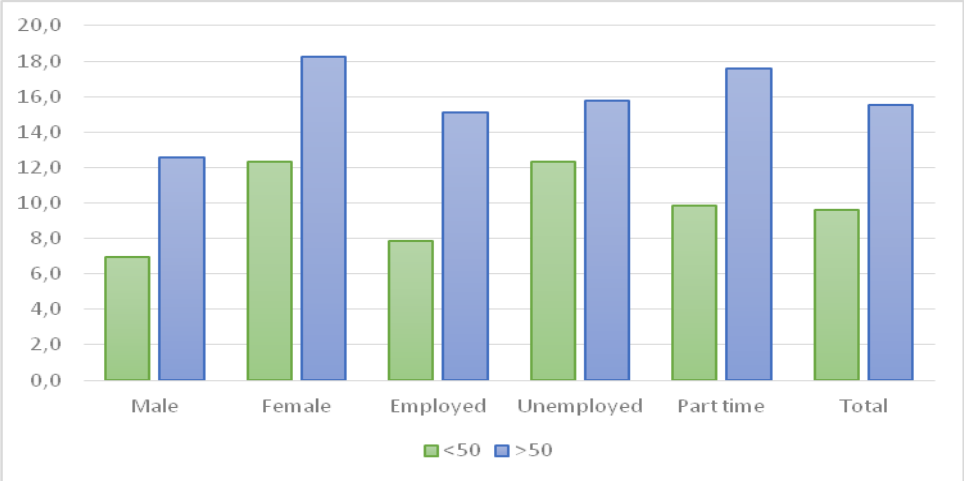
[7] Various authors reflect on disability in old age as a new "social emergency", also in view of the exponential increase in disability rates in the last phases of life - starting from 5.1% among 65-69s, to 43.3% among octogenarians (disabilitaincifre.it). It is related to a new health demand, less resulting from the diagnostic processes parameters, rather deriving from the contextual variability in the modes of construction of the experience of illness-disability (AGENAS 2015).

Figure 2 - People aged 15 and over providing care at least once a week to people with problems due to aging, chronic illness or infirmity, by gender and age class. Year 2015, per 100 people with the same characteristics



Source: Elaborations on ISTAT data, Health conditions and use of health services in Italy and in the European Union – EHIS Survey 2015

Figure 3- People aged 15 and over providing care, at least once a week, to people in conditions of reduced autonomy, by age group, sex and occupational condition. Year 2015 (v%).



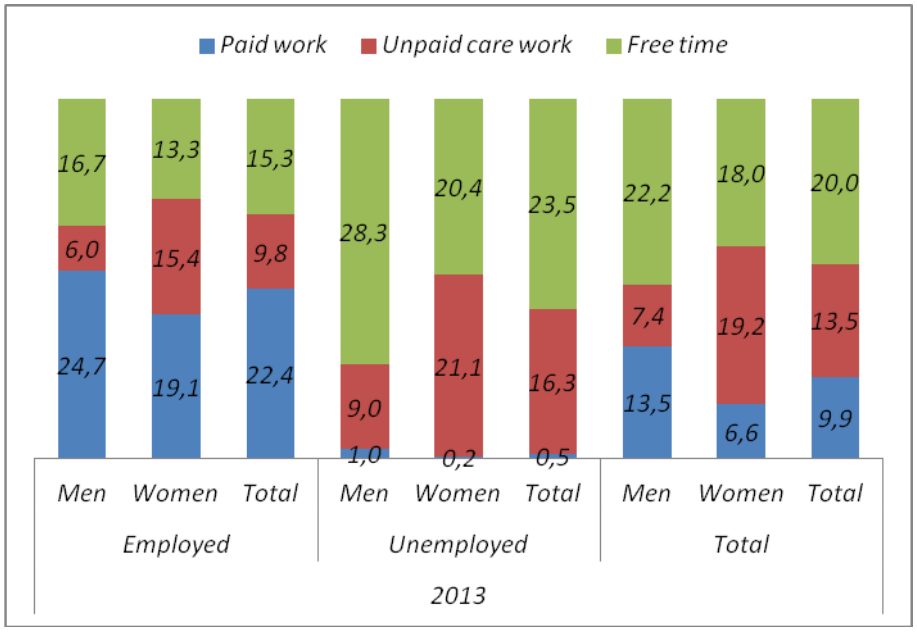
Source: INAPP, Plus Participation, Labour, Unemployment Survey 2016

If family networks constitute the main resource for the elderly (ISTAT 2018a, Ongaro 2018), it does not seem clear yet how to find a balance between taking care and consolidating an intergenerational or community solidarity system that considers the care function as a social resource: many caregivers still experience the care-work balance as an individual burden more than a possible choice (Vogliotti and Vattai 2015, Pasqualotto 2016, Fontana 2017).

Unlike the past, being alone is today the main cohabitation context of the Italian elderly so that over 48,7% of elderly "lives alone"[8], while over 48% of the elderly households is composed by "couples over 65 aged without children" up to 84 years of age. After the age of 85, over 52% lives in solitude, especially the women (ISTAT 2017c). New family models are emerging in Italy as in Europe (Dykstra 2010, OECD 2011, Bramanti and Garavaglia 2016) with some further implications for the care demand.

The multigenerational family was the most widespread model of cohabitation in Italy; it implied a continuity of relations between the household members, and a relatively cogent gender distribution between paid work and care functions (Pugliese 2011b). This model appears drastically reduced today (ISTAT 2018a). Nevertheless, the family and women still seem to be the main referents for the care (Figure 4); both directly (Da Roit 2007, Bramanti and Carrà 2011; Naldini, Pavolini and Solera, 2016) and taking on a role in the management of domestic work entrusted to family assistants (Bizzotto and Villosio, 2011), especially in old age (from 45 to 64 years)[9].

Figure 4 - Use of time by gender and employment condition (% of dedicated hours per 24 hours). Year 2013.



Source: Elaborations on ISTAT data, Multi-purpose survey on families: use of time, 2016

From the work-life balance point of view, the caregivers, in particular women, tend to have a lower probability of a regular permanent and continuous employment. The more intensive is the care

[8]This tendency characterizes the Italian population in general. In 2018, about one household out of three is made up of single people, while units of 2.4 members, in couple or parent-child relationships represent the majority (64.9%)(ISTAT 2018a).

[9] In 2011, the "young elders"(over 55s) more than others took care of children (36.4%) while the age group 45-54s was the most involved in the care of elderly/other non-self-sufficient (30%). Conversely, the younger generations performed under 20% in the childcare and 10% for the elderly care (ISTAT 2015b). The intensity of care tends to increase with age. Even though the number of caregivers is lower, the number of hours for care work increases: around 48% of 65-74 year olds provide support for over 20 hours a week, compared to 25% of the average population (ISTAT, 2017c).

commitment, the lower the likelihood of re-entering the labour market in the event of unemployment and higher the risk of poverty and deterioration in the quality of life (OECD 2011; Crespo and Mira 2012; European Commission 2017; Aversa et al. 2018).

Care commitments to non-self-sufficient persons are not necessarily associated with the leaving of the labour market by caregivers, who may rather consider convenient to maintain resources and income also useful for accessing care services (Da Roit et al. 2015). However, the degrees of freedom within which family considers the engagement as a compatible choice rather than as a necessary alternative to paid work are also related to the possibility for caregivers to access care support services (Aversa et al 2018).

2. Facing self-sufficiency: the Italian welfare system and care professions

From the public policies and services point of view, the interventions to deal with non-self-sufficiency have changed over the years also in relation to the hypotheses of social development[10] that guided public spending choices and mutual expectations intervention between State and civil society (Saraceno 2008; Ferrera 2012; Leon, Ranci and Rostgaard 2014; Ranci and Pavolini 2015; Olivetti Manoukinan 2015).

Until the '90s, in Italy and in most European countries, the care of non-self-sufficiency was mostly entrusted to intergenerational family and civic solidarity networks, from associations to charitable institutions, to health care and social assistance for specific categories of social marginality (economic poverty, absence of family members, severe disability).

From the Second World War until the 1990s, the so-called "Mediterranean" welfare model consolidated. It assigns a central function to the families, as a subject called to produce and redistribute - financial, relational, care - resources among its members (Da Roit 2007, Pugliese 2011a, Ciarini 2011, Fosti and Notarnicola 2014, Ranci and Pavolini, 2015, Vogliotti and Vattai 2015).

Regulator of this model is a system of "family and parental solidarity" expectations and obligations (Naldini 2003), and the rigid gender division of labor within the "male breadwinner" model that follows (Pugliese 2011a, Naldini et al 2016). In this respect, the expenditure for pensions, but also the tax

10 We refer to the concept of Welfare State discussed by Ferrera (2012) and Ranci and Pavolini (2015): a set of public policies outlined by State, families/society and the market, to regulate the coexistence and protect citizens from the social risks of developing productive systems. It embodies the provision of assistance, insurance and social security measures, in the face of specific social rights and financial contribution duties.

exemption of care costs, play a leading role in improving the elderly conditions. They represent 95% of public spending for non-self-sufficiency, while the development of services stands at 2.6% (Bertoni 2018), mainly in the long-term care and social care area - with the development of residential care[11] and both the health[12] and social[13] home care-; only recently with carer' leaves[14]. All these devices aimed at "healing" the main risk situations connected to the loss of productive capacity of the family or of the non-self-sufficient individual or the situations of social exclusion.

2.1 The development of care work in the health and social field

Within the aforementioned scenario, the formalization of care and assistance work took place concomitantly with the reorganization of social and health services aimed at treating the social integration of groups at risk of marginality: migrants, women, children, people with a diagnosis of disability, the elderly themselves (Olivetti Manioukian 2015; Ranci and Pavolini 2015; Bisogni and Pirrotta 2018).

Until the '80s in several European countries, the hospitalization was considered the most appropriate and economic solution to treat these margins, even if the main the responsibility of care was largely left to the families. From the '90s, expenditure-curbing instances, new risk profiles related to the perception of insecurity aroused by changes in lifestyles and economic scenarios (ISFOL 2009)[15], as well as the institutionalization opposition movements, made unsustainable the idea that the State, with the sole support of the mutualistic systems and the families' solidarity, could have tackled the emerging social issues. It was necessary, therefore, the overall reorganization of services and the approach to disability itself, considering the daily life and the living environment as a resource to promote autonomy and socialization. Within this orientation, the possibility of keeping people in their living environment resulted as cost reduction and led to the improvement of homecare services and

[11] The range of residential care goes from specialized units for pathologies with high medical assistance, to independent living solutions integrated with community services, for autonomous or semi-autonomous people (NNA 2017).

[12] The Integrate Home-Care (ADI) provided by the National Health system. It is a coordinated set of medical-nursing services, aimed at cure, rehabilitate and assisting the sick person at home, to avoid inappropriate hospital admissions and long-term care. It can be provided in three forms:

- Occasional: a few hours per week for people unable to reach the general practitioner due to the health conditions, without a complete taking charge or multidimensional evaluation;
- Integrated home care of I and II level (5/6 days out of 7) for chronic or post-acute disabling conditions;
- III Level and palliative care (7 days out of 7) for degenerative, end-of-life or severely debilitating conditions.

[13] The social home-care (SAD), provided by local councils. Established in the 70s to deal with elderly with slight impairment of self-sufficiency, offering domestic support, transport services, company or commissions, to prevent situations of social distress (poverty, isolation) of the most needy.

[14] There are two types of leave linked to the medical certification of the condition of severe disability: short permits (3 days per month) of law 104/92, or extraordinary leave (up to 2 years) of law 388/000.

[15] The authors address new vulnerability groups emerging from the spread of the "atypical" work and globalization: low-income workers, young people with difficulties in access and stabilization in the labor market, migrants.

measures to support the families, increasingly considered as direct interlocutor of assistance processes.

Within the two consolidated cultural paradigms of healthcare and assistance to the needy, public intervention and the development of social and health professions in services, has thus resulted on two patterns. On one hand there were a wide area of high-skilled technical specialists and professionals (physicians, physiotherapists, nurses, but also social workers, psychologists), aimed at defining parameters of prevention-diagnosis-treatment and cure of deficits. On the other hand, a myriad of professionals with low specialization (social-health operators, educators, family mediators etc.), still with a view to recovering the deficits, dedicated to support services for the condition of particular “need” of elderly and families (Casadei and Franceschetti 2011; Olivetti Manoukian 2015). Within 10 years, the reform of the health system[16], and subsequently the Laws n.104/92[17]and n.328/2000[18] (reform of social services), established the main references for the elderly, disabilities and non-self-sufficiency service system.

The social mandate that accompanied the reforms defined a new approach to disability and handicap[19] - not yet to self-sufficiency. It extends the within range of public intervention beyond the limits of the cure of the organic disease, to consider complex phenomena of relationship between the health condition and the personal and contextual circumstances of life. In particular with the law 328/2000, an attempt was made to promote a "widespread" approach to intervention by overcoming the sectorization of policies (social-assistance, labor, training, health), and recognizing the family context[20] as one of the key interlocutors of territorial services.

This resulted in a process of "de-institutionalization" of taking charge of the non-self-sufficiency, which, through an opening to the free market and the Third sector, led to the development of a

[16] The main references for the healthcare reform are the legislative decrees n. 502/1992, "Reorganization of the discipline in health matters”, and n. 517/1993 "Amendments to the Legislative Decree of 30 December 1992, n.502, reorganizing the health regulation”, see *References*.

[17] Law n.104/1992, “Framework law for assistance, social integration and the rights of disabled people”, see *References.*

[18] The Law n.328/2000, ensured an integrated system of services aimed at guarantee quality of life, equal opportunities, non-discrimination and citizenship rights, by preventing, eliminating or reducing the conditions of disability, need and individual and family hardship, deriving from income inadequacy, social difficulties and conditions of non-autonomy, excluding only those ensured by the social-security system and the health system. It was a significant step in the reorganization of the welfare, coming from an historical dualism between insurance institutions founded on labor and residual social assistance left to families and religious mutuality institutes.

[19] The Law 104/92 defines “disabled person” one who has a physical, mental or sensory impairment that cause learning, relationships or work integration difficulties representing social disadvantage or marginalization.

[20] Law 104/92 governs the relationship with services, equating the family with the disabled person in the role of "client", and a subject of law. Furthermore, the law 328/2000 promotes the family role as co-implementer of the intervention, calling the services to support the care and work responsibilities assuming a replacement function in the critical situation of the life course.

differentiated services supply and to a first definition of the chain of care work (Olivetti Manoukian 2015, Franceschetti 2016).

2.2 Clues on the families' demand in the elderly homecare

The situation of "gravity" and "functional limitation in the autonomy" of the individual, certified by the national healthcare system, remain in Italy the main reference criterion to access most of the devices of public intervention. Nevertheless, the way in which the elderly and families are reorganizing their relationship with the services seems to offer interesting insights.

Considering the way in which the State supports the social development of family care functions, we can distinguish three types of measures (Vogliotti and Vattai 2015):

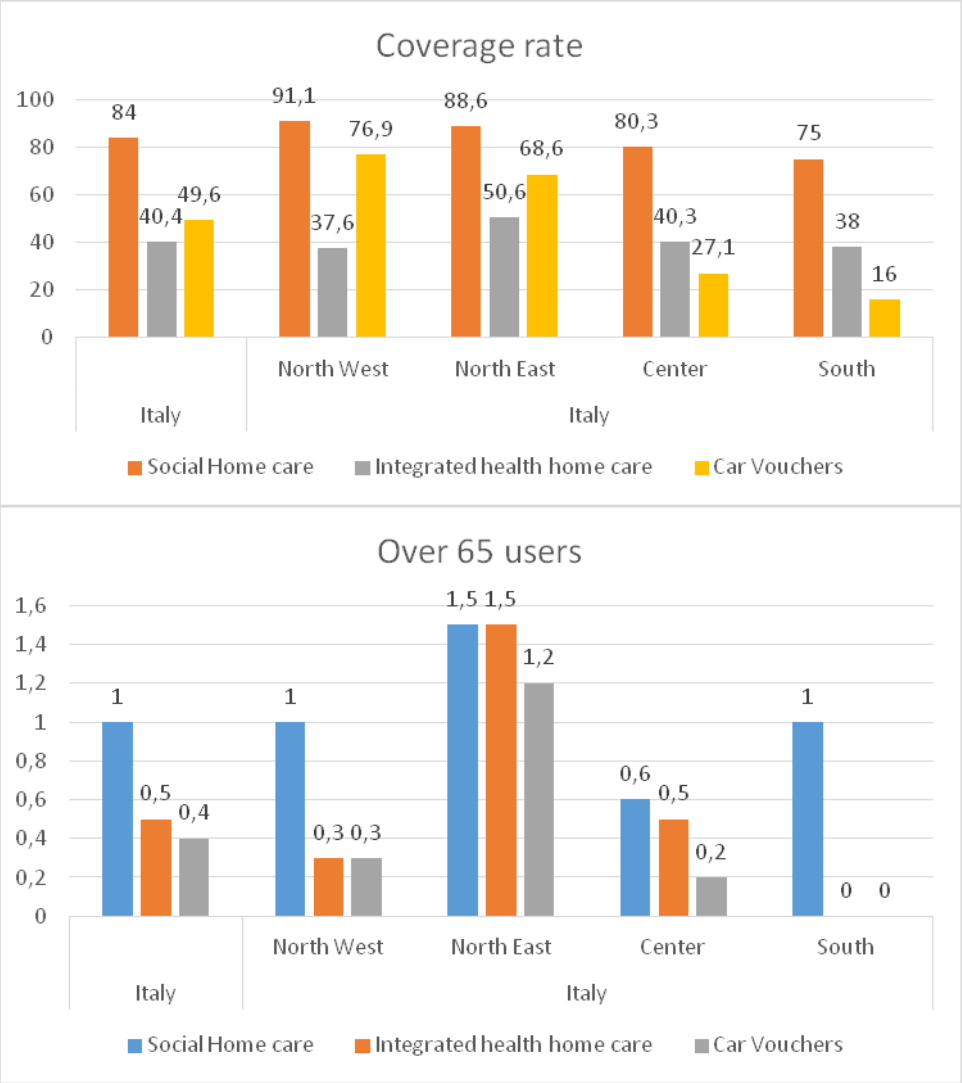
a) *Enabling policies*: monetary transfers to support income or care costs. In this area, we find the Care Allowance (*Indennità di accompagnamento*), a non-earmarked universal benefit, for individuals who have been certified a total "incapacity to walk without the permanent help of a companion or to carry out daily activities", and, where available, care vouchers, means tested and bounded to the purchase of care services.

b) *Replacement policies*: When services and institutions carry out part of the family functions. In this area, we place the residential and home-care services in both the healthcare and social form.

c) *Integrative or promotional policies:* those services that aim to promote and develop the resources available within the relational context of the non-self-sufficient elderly (e.g. conciliation measures, family associations, training services...).

Faced with a constantly growing proportion of people with functional limitations, the supply of services has a good territorial coverage (Figure 5) but the capacity to take care of the elderly seems to have decreased (Falasca 2017, NNA 2017). Although supply has increased over the years, access rates to local services remained low and very different between regions.

Figure 5 - Territorial coverage rate and over 65 users of home care services, by type and geographical area. Year 2015 (v%)



Source: INAPP elaborations on ISTAT data, dati.istat.it

Even considering the use of residential facilities, national statistics report high territorial variability of the supply (prevalent in the North), and a negative trend for lodgings, following the de-institutionalization process. The national rate of non-self-sufficient elderly hosted was 1.7% in 2012, reaching 2% in 2015 with the development of low-intensity residences, but with a coverage rate also decreasing (from 2.3 % in 2011, to 2.1% in 2010) (NNA 2015; ISTAT 2018e).

Up until the 2012, monetary transfers, in particular disability pensions and care allowances (Indennità di accompagnamento)[21], have remained the main tool that families benefited to address the care needs of non-self-sufficient elderly. Despite this, while the expenditure for the care allowance has

[21] We remind that the Indennità di accompagnamento is paid to the person needing care, who have been certified a total "incapacity to walk without the permanent help of a companion or to carry out daily activities". It is independent by the context of care, caregiver's and other family needs, and tends to not consider the specific non self sufficiency needs of disabilities that don't match the allowance requirements.

increased, there has been a drop in the percentage of people over 65 receiving it (from 12.7% to 12%) (INPS 2016).

Finally, even considering parental leave (from 291.455 in 2010 to more than 408,000 in 2014, according to INPS 2016), there is a lack of integrative measures. Just like the old age appears to be "inscribed" in the non-self-sufficiency condition, families and caregivers seems also asked to be "self-sufficient" in remaining productive and dealing with care as they can.

2.3 The informal caregiver and the re-familiarization of the care work

Many studies highlight an emerging phenomenon that has transformed the relationship between caregivers and services. After a great investment in the spread of the home care services, the care is "returning" to the families. A "re-familiarization process" of the informal care is taking place, with a wide diffusion of private in-home caregivers (*badante*) that could be considered as result of a specific way of a lacking de-familization of care in Italy (Sgritta 2009, Noci 2010; Ciarini 2011, Fondazione Leone Moressa, 2011, NNA 2017, Pugliese 2011b, Scialdone 2014, Paniccia, Giovagnoli and Caputo 2014, Censis 2015, INPS 2018).

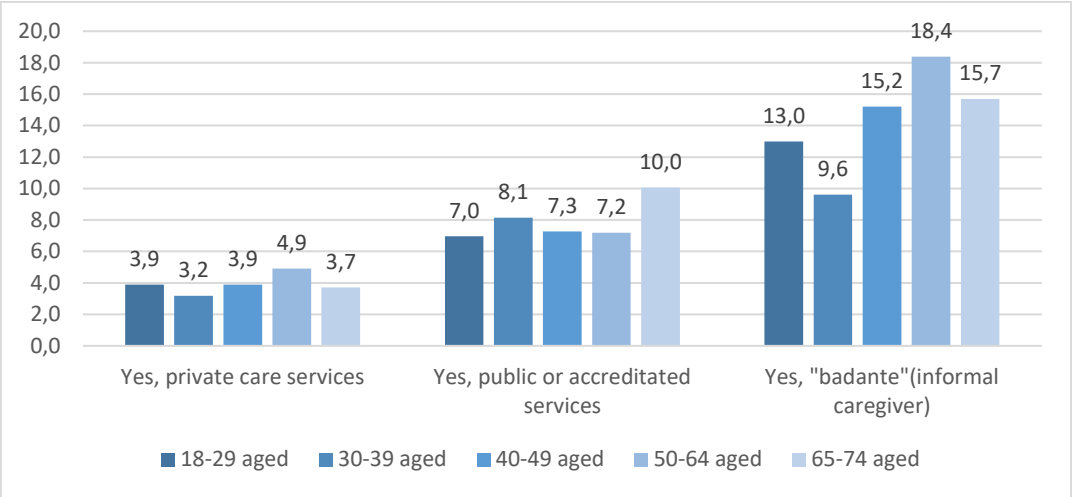
Public home care services are often considered "*rigid, absent or of less useful*" (CENSIS, 2015, pp. 204-210 and 224-232); most families, especially those on low-income, resort to public or private professional assistance services, mainly in case of emergency, with high costs for both families and the National Health Service (NNA 2015 and 2017).

When the costs of cure are too high or the condition of the elderly person is not recognized as invalidating as the access to the welfare system ask, the families prefer to assume directly upon themselves the care or to delegate it to "informal caregivers"[22]. As highlighted by the ISFOL Plus survey (Figure 6), when caregivers choose external support (26% of cases on average)[23], the most common choice, after the family, falls on "informal caregiver/badante", particularly among the generations of older caregivers.

[22] The term informal caregivers is generally referred both to carers privately employed by families, and unpaid family members, friend and volunteers. We use the term "informal" to underline the professional functions that come out from the process of non paid work, very close to identification choices of the family as job customer.

[23] Around 74% of caregivers within families choose to deal with care without any support of services or personal assistants. Instead, 54% of older caregivers and 69 % of younger caregivers prefer to use work leave.

Figure 6 - Care giver choices. Do you use support services to care for a dependent relative? By age of care giver, year 2014 (v%)



Source: ISFOL-INAPP, Participation, Labour, Unemployment Survey, 2016

Who are the informal caregivers, and how do they participate to the relationship between user's demand and public services response? The current INPS estimates suggest that, in Italy, the domestic workers hired with a regular contract are around 864.526[24]. Around 43% (39.478) has a contract as a personal assistant. In 88.3% of the cases they are women, over 73% are of foreign nationality and, in 43% with ages between 50 and 64 years. It is also estimated that there are around 1 million "informal" undeclared domestic workers (INPS 2018), mostly foreigners, whose working instability puts the same residence permit at risk (Pasquinelli and Rusmini 2008)[25]. Household spending is estimated at around 9352 billion euro (Pasquinelli and Rusmini 2008), around 29% of family income (INPS 2018); in half of the cases the costs are covered by the income of the assisted person, sometimes using the Care Allowance, the rest is covered by the family members (Fondazione Leone Moressa 2011, NNA 2015). The salary ranges from €500 to €1000 per month, plus room and board; they are generally asked to live in the same home of those they assist and to work 16 hours a day to offer a multi-demanding care (Fondazione Leone Moressa 2011)[26]. What happens is that the family gets "bigger" assimilating the

[24] The INPS estimates refer to workers who provide services for the needs of the employer's family life in the form of domestic workers, family assistants, babysitters, housekeepers, waiters, cooks, etc. (INPS 2018).

[25] The domestic work has developed in Italy with poor regulation. This means not only that the jobs tend to under-protected, but also that the tense situations typically present in providing informal care tend to be reproduced in the working relationship (Da Roit 2007, Bizzotto and Villosio 2011, Scialdone 2014).

[26] When the care is in charge of the family, many variables come into play: work commitments, family conflicts, health conditions of the caregiver, presence of a support network. Care tasks, therefore, vary in intensity according to the conditions of the elderly and may include support in personal care (nutrition, hygiene, surveillance and mobility support), paramedical aspects (drugs administration) and instrumental activities such as house cleaning, housework or simple

badante as a family component without a clear difference between itself and the external aid (Pugliese 2011).

The high bid and low costs have allowed access to this type of assistance for families of middle and lower-middle class, low-income households tend to resolve by themselves the need for care (Casula 2011, Pugliese 2011, NNA 2015 and 2017).

The *badante*'s choice, in a context of lack of trust in public services, seems to be consistent with traditional representation of family roles. The informal caregiver seems the choice that guarantees the perpetuation of relatives' and women' role in care, preserving the identity values of families in transition (Da Roit 2007, Sgritta 2009, Pugliese 2011b, Bramanti and Carrà 2011 Paniccia et al. 2014).

In this regard, there is a connection between the Italian families' culture and the welfare replacement function, which leads to the maintenance of a "status quo". As social relationships within families are changing, the welfare system focuses on the individual. The diagnosis of pathological functioning in old age remain as fundamental criteria for accessing most welfare measures, while relational contexts in which aging occurs remain largely out of reach of services.

The sectoral organization of care services imposes an operational model on categories of people with more or less intense levels of need, and often focuses on the elderly without considering family ties and the dynamics of relationship with caregivers. Where provided, the service mainly outlined for the elderly without a family and deals with survival needs; the prospect of integrating primary family ties is absent or irrelevant and does not seem to play an effective support role for the management of care burdens (Bramanti and Carrà 2011).

3. Toward new policies: prospects for the development of care work

Toward what direction?

Today, people employed in social and health and social services are around 8.5% of total employment in Italy (INAPP/ISTAT 2018[27]). Due to the aging, several studies anticipate that in the near future (2018-2022) the health and personal care sector will contribute to employment with an average annual rate of + 3.8%. In 2022 there will be a great contribution from specialists in life and health sciences (69,000, + 3.1%), a sustained growth in the need for technicians in social services (15,700, + 4.2%), and in health

accompaniment of the person at home. When one turns to external aid, all the needs of elderly people are progressively delegated, even if the family and the relative caregiver maintain the overall responsibility of coordinating the care (Noci 2010).

[27] http://professionioccupazione.isfol.it/datifol/index.php?id=5.3.1.1.0

services - nurses, professional educators, physiotherapists - (129.400, + 3.4%). Finally, there will be a particularly significant contribution from the qualified professions in the personal services area (856000, + 7.5%) (Unioncamere 2018).

In other words, the demand for highly specialized labor will increase, but also, and predominantly, it will rise the demand for those professional skills which, although appear less qualified, arisen from the development of the alternative services to hospitalization. Skilled job profiles not only to support the reduction of deficits, but also in dealing with the contexts in which non-self-sufficiency takes place, families, local services, local communities, schools (*badante*, family assistants, healthcare workers, but also support administrators).

From the labor market point of view, these trends expose the welfare system to some risks, within which, however, some resources can be identified. On the first side, the qualified professions in care work are affected by some structural criticalities of the sector, as historically developed.

By virtue of a "cultural" closeness, care professions have been assimilated to the care functions of women. Within the paradigm of care and assistance, these professions are characterized by high segmentation of gender (over 88% of social professions are held by women), by a high incidence of foreign staff[28], of advanced age[29], and by significant pay gaps compared to other sectors.

Both for the greater discontinuity of career paths in the Third sector and for the public spending cuts on services, these will be professions which, without specific policy reflections, could be affected by a further deterioration in the quality of work as much in terms of a reduction in wages as in working conditions (Unioncamere 2018). Especially in the case where families constitute themselves as employers, without specific intermediation interventions, the employment relationship is, for example, exposed to a higher rate of irregularities (47.6% of employment created within the of personal services, compared to the average 15.9%) (ISTAT, 2018d).

On the resource side, instead, the development of a new mandate on care work, expressed by recent policies since 2012, paves the way to a new demand for skills that these professionals could invest in.

Next to diagnosis-cure and rehabilitation, the families and caregivers commitment role as clients of new job profiles, seems to point out a development demand. It does not concern the improvement of the professional identity of the provider, but the possibility of activating an integrative function to the

[28]Although not comprehensive of the entire sector, Unioncamere reports that in 2017 there were about 46% of social workers, not counting the pre-eminence of other nationalities in the nursing professions and among the aforementioned family assistants (Unioncamere 2018).

[29] According to the ISTAT information system of the professions, up to 2016, the average age of qualified professionals in social and health services exceeded 40years in 69%, compared to the national average of 64% in total employment.

role already held by families, to support them in defining the problems of everyday life, mobilizing resources in the relational context of intervention, by the exploration of the situations for which care work is required.

The compensatory approach, on which policy devices for families and elderly are set up, seems to have found its limit in splitting interventions aimed at guaranteeing the assistance of the individual within protected contexts (home, family, hospital), and interventions aimed at promoting the construction of productive perspectives in the relationship between caregivers and local communities, for example in the workplace.

The shift towards the development of integrative functions seems to be the one that could most effectively contribute to deal with the little-explored demand of the elderly and families, arising from the complexity in building reliable relationships with the services, precisely because set on splits (elderly or caregivers, hospital or territory, family or associations).

In this direction, a set of policy initiatives, activated to cope with aging in recent years, at different levels of government, could represent a resource.

Even not yet with a systematic focus on aging, as a process that develops over the life span, the condition of frail elderly people has begun to be considered within a new welfare mandate that different stakeholder express as *age friendly social innovation culture* (NNA 2017; ILO 2018).

Within this scenario, a new method seems to emerge in categorizing support for non-self-sufficiency: not only to guarantee survival and individual care in critical times of need, but to ensure the development of coexistence relationships and quality of life of the elderly and families within the broader social system.

Several proposals have gradually contributed to delineate new service configurations both in terms of health care interventions and social and family policies. On the health side, a few years after the approval of the **National Plan for the Family**[30]**,** between 2014 and 2016, the Presidency of the Council of Ministers approved, in agreement with the Regions, the **National Plan on dementias** - and later the **National Plan for Chronicities**[31]. They aim to promote the development of a culture of early management of problems associated with chronicity and dementia, not only in terms of the

[30]Approved on 7 June 2012, the Plan aims to create public interventions based on a cross-sector approach to implement the family 'competence in producing and sharing care resources with other families, associations, the services themselves. Focusing on the elderly, it promoted the creation of "Family Centers" and also: measures to guarantee fiscal fairness; subsidized rents and loans for innovative forms of social housing; family leave, flexible parental leave, community oriented services for caregivers; vouchers for nursing purchasing, intermediation services for informal caregivers; incentives for entrepreneurship in care work.

[31] See Presidency of the Council of Ministers (2014) and Ministry of Health (2016) in *References*.

improvement of specialized services for the function of diagnosis, rehabilitation and treatment, but also for increasingly precise and contextualized consideration of the relational implications of disease management processes.

From a substitutive and resolutive approach based on the delegation of the care relationship to the technical capacity of the services to "predict" the outcomes of the interventions in terms of reducing the deficit conditions, the Plans propose a re-orientation of the service towards the improvement of a widespread and shared taking-charge competence, within a "Customized care plan".

On the regulatory side, this cultural orientation has thus translated into further legislative initiatives, from 2012 to 2018, that attempt to integrate the development of health policies, with those of the social and labor sphere. We refer to the debate on the recognition of the caregiver's function launched by some regional experiences[32], followed by some bills currently under discussion in the Senate, as well as the establishment of the *Fund to support those who carry out family care*, as part of the 2018 Budget Law, refinanced in the 2019 Budget Law[33]. Despite the lack of a national shared reference legislation on the initiatives, the integrative value of the function of caregivers is recognized as a key element of the network of welfare services.

Furthermore, some devices introduced by the mentioned Budget laws, as well as by the Law 232/2016 have presented new measures to promote Corporate Welfare, allowing in some cases the conversion of productivity bonus into care-conciliation measures, as well as an early retirement scheme[34] for care responsibilities.

Conclusions

A system of relationships is in crisis. The frail condition of elderly highlights the failure of a key organizer of the social relationship among families. Non-self-sufficiency evokes a strong dependence on the affiliative relationship, which culturally refers to the family as the first social structure tasked with the care of its members. Unlike childcare, however, long-term care undermines the "generativity"

[32] E.g. Regional law 2/2014 in Emilia Romagna and law 43/2016 in Abruzzi Region. The regional laws inscribe the caregiver as co-designer and co-implementer of the social and health services so that they play an active function in the definition of the care plan in the home-care services provision. They promote a set of training, consulting, insurance services and financial support, to provide coaching and qualification in carrying out nursing duties, as well as the work-life conciliation or caregivers' reintegration into the labor market.

[33] The 2018 Budget Law (Law 205/2017, paragraph 257), establishes the Fund in the Ministry of Labor and Social Policies, with an endowment of €60 million for the period 2018-2020. The Law 145/2018 (Budget Law 2019) implemented the resources of €5 million per year.

[34] ‘‘Anticipo Pensionistico Sociale" is an experimental measure in force until 31th December 2019, within spending limits. It is an allowance paid for 12 months a year, up to the retirement age, reserved also to the caregivers of non-selfsufficient people.

of family relationships. It is a condition of dependence, associated with the disease, that confronts the family with the feeling of loss of the social role of the elderly, but also with feelings of loss of initiative of the family itself, making critical the participation to the broader productive context. If the family does not find outward resources for care, it tends to withdraw and remain in a state of isolation. That affects the development prospects and leads to a loss of the function of the family as symbolic system aimed at build safe conditions to deal with the "outside": the social and productive system[35] (Bramanti e Carrà 2011, Paniccia, Giovagnoli e Caputo 2014).

In coping with the illness and the non-self-sufficiency, health and home care system and the family assistant are both resources on which families can rely on. However, a diagnosis–cure-rehabilitation approach, can deal with only individuals, not the care relationships. In this sense, the relationship with the services becomes problematic[36].

The informal caregiver can be invested with an ambivalent meaning. She/he reveals a lack of services, and may be assimilated to the family system; if it is so, that brings the family to withdraw into itself. At the same time, the informal caregiver allows families overcome isolation and find resources to focus on their future. There is a "need" of someone "extraneous", and families are looking for new communication codes in order to transform this presence in a new way of dealing with ageing issues while "safeguarding" their traditional role in society.

This implies a challenge for the welfare system: changing the representation of care as a function related to concrete, objectified and individual problems (physical assistance, basic needs) on which to intervene by reducing deficits, to an integrative competence to deal with relational and coexistence problems, caring the family bonds without separating the survival needs from their emotional and relational component.

Current policies are still mainly oriented towards a replacement approach to care functions. The national plans seem to approach the aging and non-self-sufficiency issues as something to manage within the healthcare and social assistance domain, considering the elderly condition separated by that of caregivers, without a particular attention to intergenerational aging, and still a focus on the diagnosis process as a criterion to access to the services.

[35] Here we will refer to the family definition presented by Vogliotti and Vattai (2015, p.12) as a symbolic relational structure between sexes and generations that allows individuals to represent themselves and face the outside, the new, the stranger and unfamiliar. It transmits the values of the society and at the same time produce resources to rework them in the light of the new contexts that the different generations deal with.

[36] It results in emergencies where problems and objectives of the intervention are "taken for granted": the survival of the individual.

On the other hand, focusing on the specificities of the condition of chronicity and dementia, for the first time the coexistence conditions in which elderly people live, have become a specific target of the services, with a growing attention to the caregiver's commitment.

Further resources dimensions may come from the changes in care mandate highlighted by the critical relationship between welfare devices and families. The demand for informal caregivers with a confused role within the system of obligations and values of the traditional family seems to preserve the sense of failure that the inactivity and illness of the elderly can lead.

This might take the form of an attempt to recover a commitment position of family and elderly, which is different from the auxiliary, delegation and dependence usually expected within the healthcare and social paradigm. Commitment that is oriented instead, to request support in identifying new codes to deal with diversified problems, and in building networks of reliable relationships by which to explore resources and productive perspectives, avoiding isolation without a future (Paniccia et al. 2014; Vecchiato 2018).

Several issues could be usefully explored.

An interesting prospect could be the investment in organizational competences, not only on the clinical side, but also in caring the coexistence relationships that organize the daily life of elderly and caregivers, starting from the problems that motivate the resort to public intervention in homecare pathways or in intermediate, employment, socialization and recreational services.

Moreover, a new scenario in the caregivers' and elderly policies integration could be promoted: an intervention approach that integrates an "active care paradigm" with the "active aging paradigm"(UNECE 2017).

In this direction, it could be crucial to identify the non-self-sufficiency problems questioning the idea that providing services means applying general principles without an exploration of the different meanings and social and cultural contexts in which the services are implemented. Problems and questions are indeed even less related to the specific nature of the living conditions considered individually, but concern the dynamics of the relationships within which the individual paths take shape.

Following this criterion, with Bramanti and Carrà (2011) it would be possible identify different kinds of taking charge, moving the focus from the diagnosis of the individual condition, to the relational dimension of coexistence transitions that family through. The minimum level could contrast the elderly isolation with a general emphasis on primary relationships to ensure survival within a nursing/care goal. An intermediate level could hold the caregiver as a resource in the co-design of

specific interventions also replacing his function; a third level could consider the dynamics of relationship that cross the entire family system in coping with aging.

In this case, the focus of intervention could encourage the development of a reflexivity about what the relationship with the ageing entails within different contexts and generations. Here, the different transitions that aging involves could become a resource to identify the development lines for a customer-oriented definition of a common plan of life.

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