“Labour Supply in Care Services”

National Report on Italy

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European Foundation for the Improvement of Living and Working Conditions

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Part 1: Description of the Italian situation

1. Introduction

In this report it will be synthetically described how the high demand for care services in what is today considered the oldest country in the world (United Nations 2003) is currently being met through a mix of formal and informal care work, which is not always easy to identify and quantify unequivocally. This is on the one hand due to the lack of detailed national data on this topic, but on the other hand connected also to the traditionally major role played in Italy - similarly to other Mediterranean countries (European Commission 1998; Schneider and Enste 2000) - by the irregular or “black” labour market, which in this respect implies a relatively high level of “undeclared work” being provided in the care sector, mainly by foreign immigrants (Socci et al 2003).

Briefly, the main characteristics of the Italian labour market with regard to the labour supply in the care services sector, which will be in more details presented in the following paragraphs, can be summarised as follows:

- a growing demand for care services is observed as a consequence of the rapid ageing process of the Italian population;

- the availability of informal care is decreasing, both from both female family members (due to an increasing and longer female participation in the labour market), and from traditional social networks such as relatives, neighbours, friends etc. (due to a reduction and loosening of traditional social ties);

- due to a stronger immigration flow in the last decade, a highly increased supply of private (declared and undeclared) care by means of immigrated foreign personal assistants (in Italian the so called “badanti”) is currently available;

- the supply of indirect public home care - i.e. provided not directly but rather by means of private (profit and non-profit) - organisations and accredited agencies - is slowly increasing, accompanied by with parallel processes:

  - transformation of public bodies from service providers to funders/controllers of care provided by others;
  - transformation of service users into service buyers (due to the increased used of vouchers and care payments);

- a stable or even decreasing supply of residential care is being recorded compared to a decade ago;

- a chronic shortage of nursing workers is observed since several years, with a negative impact on the work load of other care workers, especially in residential settings;

- a current trend to decentralisation and devolution of (health) care tasks to Regions can be observed, with a connected debate on unequal levels of quality of care (“essential levels of care”).

In the following paragraphs, an overview of the size, structure and workforce demographics of the Italian care sector will be provided, in order to try to answer some of the main issues involved: how many care workers are employed in Italy? In which sectors are they concentrated? Who are the users of their services? Is there any evident lack of care workers in Italy? If yes, how is it currently tackled? The presentation of 6 case studies will close the report.
The division of the Italian care sector into different delivery mechanisms

In Italy care work is officially distinguished into two main sectors: health care and social care.

The first kind of care, which is funded and controlled by the Ministry of Health through the National Health System, is mainly provided by means of Hospitals, Long-Term Care Institutions (Rehabilitation, Long-Term Convalescence Settings etc.) and Local Health Agencies. The work provided by these institutions is not included in this report, since the analysis of health care supply goes beyond the purposes of this specific project. However, it has to be kept in mind that this sector has a twofold impact on the supply of social care workers:

- **directly**, i.e. through the employment of care workers: social workers and “technical” care workers (professionals who in Italy are trained to provide basic social care, usually as a support to medical and nursing staff) are employed by hospitals, residential care institutions and home care services run by Local Health Agencies, contributing not only to the provision of care “within” the health care sector, but also to carry out all those actions which are necessary to grant the integration between this sector and the social care sector (which is coordinated by the Municipalities, see below). A tentative estimation of their overall number can start from the consideration that in 2002, of the almost 659.000 employees of the Italian NHS, about 7.000 were represented by social workers, and almost 33.000 by care workers (Ministero della Salute 2003: 5);

- **indirectly**, through the lack of nursing care staff, a shortage which has been estimated in about 40.000 nurses on a total of 326.000 (Massi 2004), and has recently forced the Italian government to allow the re-employment of retired nurses with up to 5 years of retirement (Rampini 2003). Due to this shortage, in a growing number of residential settings and hospitals the lack of nursing staff pushes many patients’ families to privately hire personal assistants to “informally” support the formal care workers, in some cases even on an undeclared - but from care institutions tolerated - basis. Two examples can explain in more detail this situation. The first concerns residential care institutions, where the lack of nurses, especially in the Northern Italian regions, has as a consequence a higher work load for other care professionals (such as those in charge of personal care work) and/or a worse quality of care for the residents, who are characterised by higher and higher levels of disability (Lamura et al 2002). A second example is provided by the phenomenon, which is becoming more and more frequent in hospitals and other health care institutions located in Central and Southern Italy, of “allowing” (if not even “suggesting”) the most heavily dependent residents/patients to be supported (especially during the night shifts in hospital) by personal assistants (usually a foreign immigrant, see also chapter 3 below), who are privately paid by themselves (or by their families), in order to ensure a better assistance, which the lack of formal staff in the institution would not allow to grant properly (Ambito Territoriale 7, 2003: 61).

As far as social care is concerned, it has to be pointed out that while health care is in Italy provided within a National System since 1978, social care has been formally organised as such since the end of 2000 only, i.e. since the law n. 328 fostered the implementation of a more integrated and systematic approach to social services and policies (Parlamento Italiano, 2000). Due to this - and partly also to the fact that the current right-wing government has not supported this law which had been passed by the previous, left-wing one - the supply of social care remains still today in Italy geographically very unbalanced, with Regions (which set up guidelines and spending mechanisms) and Municipalities (which are responsible for the care services delivery) in Northern and Central Italy much more active than in the South (Pavolini 2001).
These geographical inequalities are reflected in the social care delivery mechanisms prevailing in different parts of the country. In the Northern regions and, but to a lesser extent, in Central Italy, public services are relatively widespread, with both residential and home care services available in most big cities and middle sized towns, as well as in some rural areas (Pavolini 2001). However, their availability is usually means-tested, which makes them de facto accessible to a very small percentage of the local population in need. Furthermore, more and more Municipalities are providing these services through more flexible and less expensive external care agencies and/or cooperatives (i.e. private - profit and not for profit - care organisations), whose staff has been growing in the last few years (see next chapter). Until the beginning of the 90s, this system has been growing in a public-private model of relations based on a sort of “mutual accommodation” model (Ranci 1999), consisting in an often implicit agreement between local public authorities and private service providers, with public funding granted without rigorous controls nor selection of the providers, the latter being responsible for the delivery of services without being involved in their plan (Ranci 1999, Pavolini 2001). In the last decade, as a consequence of higher expectations from the users and their families – also in connection with the series of corruption scandals which shook the Italian social and political system in the first half of the 90s – the need for higher service efficiency and quality pushed many Regions and Municipalities towards the introduction of new systems of care delivery, mainly identifiable as follows (Pavolini 2001, Ascoli e Pavolini 2001):

- **residential care**: the Regions grant the authorisations for running residential institutions, and municipalities pay for those residents who are unable to pay themselves the fees;

- **home care**: the “contracting-out” model is introduced, which select the service providers through tenders based on the “economically more convenient proposal”.

In the very last few years, in order to increase the empowerment of users, the flexibility of the private care market as well as the service quality, three further measures have been introduced in the Italian care service sectors (Pavolini 2001: 196-199; Ranci 2001; Da Roit and Gori 2002): the **accreditation** (i.e. in which the public authority, besides funding, identifies minimum services standards to accredit all those providers that responds to these requirements); the **vouchers** (i.e. documents which the public authority grants to the users, enabling the latter to receive the needed services from accredited providers); and the **local care payments**, which are monetary transfers granted by local authorities, in addition to those already provided by the central State.

Although the introduction of such measures has certainly improved the provision of formal care services in Italy, the availability of residential and publicly funded home care services remains in Italy very low, when compared to other Central and Northern European countries (Pesaresi and Gori 2003, Tomassini et al 2004), which is also certainly to be explained with the traditional preference accorded by the Italian welfare state to grant monetary transfers, rather that directly provide services (Lamura et al 2001). This situation on turn contributes to justify why an increasing number of Italian families has resorted over time to the relatively low cost private care provided by foreign immigrants, who in the last decade have represented “the” real structural change in the Italian model of providing social care to dependent persons. As it will be better detailed in the next paragraph on the different types of care workers, the estimated half million of foreign “personal assistants” belong today to the everyday life of many – more or less dependent - older Italians, providing a by now almost irreplaceable support to them and their families (Socci et al 2003; Colombo 2003). Their presence allows many families of upper, but also of middle and sometimes of lower economic level, to care for their mostly elderly members, integrating, but not rarely also substituting the role traditionally played by female relatives, mainly wives and above all daughters (Lamura et al 2001).
This phenomenon does not mean that the relevance of the Italian family carers has vanished: all main national surveys in this sector confirm that they are still the most important actor on the caregiving landscape of the country (see next paragraph for quantitative details). However, the demographic, economic and socio-cultural trends which are observable in Italy - and which are described more thoroughly in chapters 5 and 6 - reveal a major shift of the heaviest care tasks to foreign personal assistants. Other informal carers, such as friends, neighbours and volunteers, although not absent - and, as far as volunteers are concerned, especially in the more urbanised areas of Northern and Central Italy also often present in organised form – provide as a rule a less conspicuous contribution, usually limited to the lightest tasks and not seldom on an irregular basis (Lamura et al 2001; Sabadini 2003).

With regard to the geographical inequalities existing in Italy in terms of care delivery mechanisms, it might be useful to point out that some observers have tried to classify Italian regions into different welfare regimes, identifying four main ones - “munificent”, “efficient”, “under pressure” and “fragile familist” (see Table 1 and Fig. 1) - and confirming that the public expenditure for social care by Regions and Municipalities decreases going southwards, as it does the supply of care services, while the activation of the family complementarily increases (Cantalbiano 2004). According to this classification, the demand for private care services is higher in those regions – belonging to the “efficient” and to the “under pressure” regimes - where the higher impact of the ageing of the population is not compensated by the resources available for public care services.

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<th>Indicators</th>
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<td>Supply of social care services</td>
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Source: Cantalbiano 2004: 7
3. A profile of the different types of care workers

In this paragraph the main characteristics and a first quantification of the different types of care workers currently operating in Italy will be presented, as identified for comparative purposes within the review of key issues proposed by the project coordinator (RHA Newidiem 2003: 6-7).

The traditional formal carers – i.e. waged home carers and care assistants employed by care agencies and mainly funded by public expenditure, who provide care in residential institutions or at the care receivers’ homes – represent in Italy a minority of all existing care workers. Their number can be estimated by summing up the number of care workers in residential institutions to those who provide home care. The first group includes three different kinds of care workers (ISTAT 2002: 18):

- social workers: in 1999 (last available figure) they were 2,634;
- personal care workers: 86,265;
- other care workers: 36,471.

Their total number (125,370) represents almost 60% of the over 213,000 employees working in residential institutions in Italy, who in over two thirds of cases (67.4%) are run by private organisations (ISTAT 2002: 14). It should be however underlined that cases of undeclared work in this field are not unusual, so that the above amount could be increased by 10-20% (Caritas and Migrantes 2003: 332-338).

The number of waged home care workers is much more difficult to estimate, since they are usually employed by Municipalities or cooperatives on a more decentralised and fragmented way, so that their number has to be derived only approximately, starting from the number of home care recipients in Italy, who can be estimated to represent about 2% of the over 65 year old population,
i.e. no more than 200,000 people (calculations based on Terza Età 2003 and Pesaresi and Gori 2003). Even if we “generously” increase this figure by 50%, in order to take into account recipients belonging to younger age groups, we reach an amount of about 300,000 recipients; which for 10 recipients per care workers (assuming that each worker provides an average of 3-4 hours per week per user), makes a total of about 30,000 home carers, of which the majority can be assumed to belong today to the private sector (for-profit as well as cooperatives), with a much less protected position on the labour market than that characterising public employees.

Another category of care workers can be identified in the “mixed-economy” formal carers, who are defined as waged carers working for for-profit organisations or voluntary bodies. This type of carer is likely to be paid less than the “traditional” formal carer, and is also less likely to have trade union representation. In connection to the large proportion of foreign “personal assistants” personally recruited by Italian families (see below), the number of mixed-economy carers is not very high and difficult to be exactly identified, but probably roughly estimable in a few thousands, mainly concentrated in the Northern and Central regions of the whole country.

Almost absent on the Italian landscape are instead “independent” formal carers, meaning by this those workers who are registered with an employment agency for casual and short-notice placements. Although some of these recruiting agencies are starting to operate also in the care sectors (see on this also the case study n° 6 presented in the second part of this report) - having being introduced in the Italian labour market only a few years ago – their role in Italy remains quite marginal in this field. This is partly due also to the fact that they usually charge a commission to the carers that they have registered, while the traditional intermediaries in the care sector between the demand from the families and the supply offered by carers - represented mainly by churches and catholic organisations (of which the most important is “Caritas”) - normally do not charge any commission. Another reason for the little success of formal recruiting agencies in this sector is that most care workers in this sectors are foreign immigrants (see next group: “personal assistants”), who usually refer to “ethnic chains” of recruitment to find a job, i.e. to organisations managed often on an undeclared basis by other fellow countrymen, who not seldom apply an “informal” reward for their “intermediary” service (Caritas and Migrantes 2003: 336).

“Personal Assistant” carers - i.e. waged carers that are personally recruited by the care-receiver or the care-receiver’s family or friends, on a permanent, casual or live-in arrangement – can be considered today the main “pillar” of social care work in Italy. Already in the second half of the 90s, official data collected by the Italian National Statistical Institute (ISTAT) indicated that about 10% of the Italian families with at least one elderly member - i.e. about 750,000 families - were resorting to private supports of different kinds, compared to only 3.5% receiving any kind of public support (Pollastri and Tozzi 1999). If these data testify the relevance of the private sector for the social care, on the supply side Italy recorded in 1999 about 250,000 workers regularly employed in the field of private “domestic services for families and communities” (ISTAT 2001), of which about the half were of foreign nationality, compared to about 20% of 1991 (data from INPS 2002 reported by Da Roit 2002: 45). These data are however extremely underestimated, since ISTAT estimated that in year 2000 about 75% of all workers in the domestic services sector were working on an irregular or undeclared basis, making the total number overcome the million (data from ISTAT 2001 reported by Da Roit 2002: 43). This situation of widespread “black market” affecting this sector has been confirmed by the fact that, in 2002-2003, a big legalisation campaign carried out by the Italian government has allowed to bring into light further 341,000 irregular foreign immigrants for the domestic services sector only (further 360,000 being regularised for other sectors of activity) (Caritas and Migrantes 2003: 297). According to these figures, the current amount of workers in the domestic sector can be estimated to reach around 600,000 units, of which about 80% represented by foreign workers. Even if only half of them are providing care to dependent persons (mainly elderly), this would mean an amount of about 300,000 care workers, which makes this category by
Another group of carers who are quite active in Italy is represented by **voluntary carers**, who provide unpaid support usually through the link of a health or social service organisation. In 1999 (last year of data availability) the number of registered voluntary organisations which provided any kind of care services reached 5,650, representing a total of 345,000 registered volunteers (ISTAT 2000: 6). It is likely however that the real number of volunteers providing care on a regular basis is quite lower than that, since these figures include all registered volunteers, who are not all involved in care activities. On the other hand, it has to be underlined that an undefined number of persons provide voluntary care without being involved in registered organisations - this is for instance the case regarding volunteers operating within local religious and other church related groups at a local parish level – so that it could be reasonably estimated that the number of voluntary carers in Italy lies between 200,000 and 300,000 units.

The most numerous group of informal carers is however by far represented by **family carers**. A recent national survey carried out by INRCA (the Italian National Research Centre on Ageing) on a representative national sample of 2,000 over 50 year old persons has estimated that about 11% of this population group provides care to a dependent elderly, i.e. about 2,350,000 persons (Quattrini et al 2003). Since about 25% of the disabled population (i.e. 700,000*) is less than 65 year old (ISTAT 2001a: 63), and many carers of younger disabled persons are themselves over 50 (as parents or other adult relatives of the dependent cared-for child or adult), from these figures it can be reasonably estimated that about 3,000,000-3,500,000 Italians provide care to a dependent relative. Many of them are involved quite heavily in this care, especially in those areas - mainly concentrated in the “familist” regions of the South and of rural-mountain districts, see previous paragraph - where formal service availability is lower.

The high amount of care provided by family carers is confirmed by another national survey, carried out by ISTAT on 60,000 households, which reports that in 1998 over 11,2 million persons – i.e. 22.5% of the over 14 year old population – provided “unpaid help to not cohabiting persons in the last four weeks” (Sabbadini 2003: 73). This definition of “help” cannot be compared to the one used by the INRCA survey, since on the one hand excludes cohabiting persons from the recipients (i.e. mainly other family members), on the other hand includes any kind of support, i.e. also activities which cannot be strictly considered as “care” in the sense used for this report, such as for instance baby-sitting, financial support etc.; furthermore, it also includes support to persons who are not “dependent”, but simply recipients of any kind of unpaid help. According to this survey, it can be estimated that about 6,3 million persons (i.e. 56% of the total 11,2 millions) provides help to other (non cohabiting) family members.

The same ISTAT survey reports that 23% of all carers (as defined there), i.e. 2,6 million persons, help friends, a further 11% (1,2 million) neighbours and 12% (1,3 million) other categories of persons (mainly on a voluntary basis), making clear that, although residual compared to family carers, the category of **non-kin carers** still plays a not completely secondary role in the Italian landscape.

4. The influence of the State

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*This figure is derived as a sum of the 25,3% of total disabled population (2,615,000 persons) who is younger than 64, i.e. 664,000 persons, and about 36,000 less than 6 year old dependent children, who are excluded from national figures (which include only over 6 year old disabled persons) (ISTAT 2001a).
As already above anticipated, the Italian Welfare State is traditionally characterised by a comparatively low expenditure for social care, which is mainly provided in form of monetary transfers (Gori 2001; Ranci 2001; Saraceno 2003: 13; Sciortino 2003). This, together with the high level of pension spending – Italy being by far the country with the highest level among OECD countries (OECD 2001: 152) – explains why public services play a relatively secondary role in the provision of care within the Italian system, whereas privately paid care, especially in the form of mainly foreign private assistants, is much more relevant in providing support to the families, who remain the core of the whole system. This has been confirmed by a recent study in 5 European countries, according to which in Italy (as in other Mediterranean countries) “private assistance, especially for the elderly, is used to substitute public services”, rather than integrate or complement them, as it happens in the more generous care system of Northern European countries, where also the role of voluntary care is more widespread (Kröger 2003: 11).

Despite this centrality of the family for the whole Italian care system, an explicit public social policy to support families in this task is traditionally lacking in Italy (Saraceno 13-20). Historically, this has been explained with a series of reasons, of which the most important might be identified in the following: the attempt of keep the distance from the fertility and family support policy followed by Mussolini’s fascist regime, which characterised all Italian governments after the Second World War; until the early 90s, the contraposition between the catholic Christian Democratic Party and the Communist Party (which were the strongest in Europe), that through the absence of policies found a compromise useful to prevent the conflict between supporters of the “family” (the former) and supporters of the “individuals” (the latter); and the traditionally high unemployment rate, which has prevented the adoption of social policies which, allowing a better conciliation of working and caring responsibilities, might be considered a luxury or even an attack to the “male-bread-winner pattern” prevailing in the Italian society.

The role of the State in co-determining the peculiar characteristics of the Italian care system is however evident also with respect to how the immigration of foreign care workers has been handled over time (Andall 2000; Colombo 2003). Until 1986, there was no Italian legislation ruling the entry and employment of foreign domestic workers, so that until then this phenomenon was regulated through “little visible” ministerial circulars. This allowed Italian governments to establish a gradually a protectionist segmentation between the better paid domestic work “by the hour” – to be kept reserved for Italian workers - and that involving co-residency – which Italian women didn’t want any longer, and which at the same time discouraged family reunions, similarly to the German “Gastarbeiter” pattern which prevented by all means the transformation of immigrants into “new” citizens. This system of considering foreign domestic workers as a crucial resource for the Italian welfare system kept on working also after the first Italian laws were adopted to limit immigration in 1986 and 1990, allowing for instance in 1991 the entry of 22,000 new workers, but imposing them the “niche” of co-resident care work and the prohibition to change working sector (and partly even employer!) for two years (Colombo 2003: 324). Furthermore, what has made Italy over time a much more desirable destination for migrants than other Western countries is also that laws are not enforced as strictly as elsewhere, since estimations report that over the half of the immigrants today regularly living in Italy has taken advantage of one of the many legalisation campaigns that have periodically followed previous restrictive laws, in many cases after having entered the country with a simple tourist visa, remaining then illegally in the country until the legalisation took place (Parreñas 2001; Carfagna 2002, Colombo 2003: 327; Colombo and Sciortino 2002).

5. The future care needs of the population

Whether the care needs of the Italian population are expected to grow in the next decades or not, is by most observers connected with the trend to an increase in the percentage of older people, which will confirm Italy as the most aged European country also in year 2020, when its over 60
year old population will exceed 30% of the total, compared to 24% in 2000 (Eurostat 2002: 126, 131-133).

This trend, taken alone, would clearly indicate that a remarkable increase in the care needs of the Italian population should be expected for the next future. It has however to be pointed out that, reflecting a common trend affecting most European and other developed countries (Manton et al. 1997, Jacobzone 2000), since a few years a perceptible improvement in the health conditions and dependency level of older Italians is occurring - between 1993 and 2000 the percentage of over 65 year old Italians reporting a chronic disease has dropped from 58% to 53% (Sabbadini 2003: 84) - and is expected to continue in the future (Presidenza del Consiglio dei Ministri 2000: 83). What is still not clear is whether this phenomenon will be so strong to be able to compensate for the demographic ageing of the Italian population, thus delaying or even stopping the possibly deriving overall increase in the need for care (Jacobzone et al 2000).

And how crucial it is the role played in this respect by the improvement in the health conditions of older people can be describe on the basis of the projections recently calculated by the European project SOCCARE (Kröger 2003: 12-13). According to these projections, under the assumption of constant dependency rates, a doubling (+107%) in the number of dependent Italians can be expected between 2000 and 2050; if dependency rates improve, for instance by delaying dependency rate of 6 months in case of one year rise in life expectancy, the number of dependent Italians would grow in the same period by “only” 41%; and if the whole increase in life expectancy would be reflected in a delay in dependency (i.e. one year rise in life expectancy delays dependency also by one year), their number would even decrease by 1%. In the light of these data, it becomes evident how crucial the availability of reliable data on this issue is for making projections, so that it has to be stressed that no reliable official statistics are currently available in Italy to formulate clear projections on this issue.

6. The workforce demand and supply levels

The demand and supply levels of care workers is of course not influenced only by the need of care deriving from demographic and health related changes in terms of population ageing, but represents the result of a complex set of variables, which involve also concurrent supply factors.

A major impact on the demand for care workers in Italy has been determined by the increased female labour force participation. Although still among the lowest in Europe (Tomassini 2004: 31), the female activity rate in the country - that in 1975 was as low as 22% in 1975 (Lamura et al. 2001: 116) – has today reached 37% (but over 43% in the North-Eastern regions), with higher increases in the 35-54 year old age group, in which 58% of women work (ISTAT 2004: 26). This higher female involvement in the labour market is also partly reinforced by the tendential rise of lower retirement age limits, which a current bill, if approved, will further raise, setting them by 2008 at the age of 60, thus determining on average a 3-5 year longer working life (Il Messaggero 2004: 20). Some first effects of a changing in the attitude of older Italian workers towards retirement are however already remarkable today, since two thirds of the 167,000 jobs created in Italy in 2003 are due to the delay in retirement of older workers, rather than to “new” jobs (Cisnetto 2004).

Both above described tendencies contribute directly to a reduction in the potential for family and informal caregiving, which on turn has been recorded in the last few years by several Italian observers. One of the major source of information in this field is the periodic survey carried out by ISTAT on a sample of over 60,000 households, which shows that between 1983 and 1998 the number of Italians receiving unpaid help from non cohabiting persons has been decreasing from 23% to 15% (Sabbadini 2003: 83-90). Since in the same period the number of carers (who provide
this support) has remained unchanged at a level of 22-23%, this means that the same number of carers is providing support to a lower number of recipients. What is interesting in these data is the fact that, among recipients, it is almost exclusively households with at least one older person who record a dramatic drop in received help (from 31% to 16%), while households with children (without elderly) keep on receiving the same amount of help if the mother in it works (about 31%), or just a little bit less if the mother is housewife (from 20% to 15%). This phenomenon seems to be partly resulting from the already mentioned trend to an improvement in the health status of many elderly, which reduces their needs for care compared to the past; partly, however, it seems to be deriving from a cohort effect regarding the 1935-1940 generation of Italian women, who is experiencing a sandwich effect between the help they are asked to provide to their grandchildren (because of their daughters’ higher labour force participation), and the support required by their own very old parents. On the whole, however, it should be kept in mind that, despite its observed trend to a reduction, the traditional availability of Italian families to care directly for their dependent members remains high on a comparative perspective, since over 40% of Italians still think that a dependent parent should move to a child’s house, compared to 30% in the UK or 9% in Sweden (1998 Eurobarometer Data as reported by Tomassini et al 2004).

This trend to a reduction in the amount unpaid support provided to dependent persons – mainly elderly – seems to be parallel to a phenomenon of partial substitution by part of paid forms of care support, as the same survey shows (Sabbadini 2003: 86-87). With regard to this, it has been recorded that the number of older Italians resorting to paid help has increased between 1983 and 1998 from 6% to 16%, reaching its highest amount in the over 80 year old age group (40%, compared to 26% in 1983). This phenomenon has been gradually increasing until the beginning of the third millennium, receiving then a strong acceleration in 2002, when the legalisation campaign launched by the Italian government to regularize the position of illegal immigrants in the Italian labour market has “institutionalised” the niche of care work as “the” working sector for foreign immigrants in Italy (see chapter 3). The relevance of the private care sector in Italy is explained, as already mentioned in chapter 4, also by the central role played in the Italian welfare State by monetary transfers, rather than by direct care services, both at the national and, lately, also at the local level, which tends to transform care recipients more and more into care buyers or purchasers (Lamura 2002).

7. The skills gaps and shortages

The high fragmentation and low level of regulation characterizing the Italian care labour market, are not seldom reflected also by a low qualification and specialisation of care workers, especially when these are foreign immigrants providing support in undeclared forms (Da Roit and Gori 2002: 114; Socci et al 2003; Colombo 2004: 80-81). Due to the high prevalence of this category of care work in Italy, in the following lines we will concentrate mainly on the skills gaps and shortages existing in this crucial sector, trying to identify which strategies could be usefully be implemented to improve them.

Several studies have by now provided insights into the content of the care work provided by foreign immigrants acting as personal assistants of mainly older dependent Italians (Taccani 1994; Gori and Da Roit 2002: 79-80; Gori 2002: 178-180; Socci et al 2003; Toniolo Piva 2004). Among the skills which these and other studies almost universally identify as relevant for the care work, three major sets can be distinguished, which include following aspects: continuity and flexibility; personal characteristics; and technical competencies.

Of the three typologies of skills, continuity and flexibility seem to hold a relevant place in the priority scale of the qualities care workers should possess. As a matter of fact, not few Italian families look from potential personal assistants for a long-term commitment, often also during night
hours, which not seldom coincides with a cohabitation pattern of the care worker with the cared for person (Socci et al 2003: 10). This represents of course a major challenge for many native care workers, who are not available to give up a relevant part of their “socially and family structured” spare time to provide paid care; a situation which makes instead foreign immigrants particularly attractive, since in many cases they arrive in Italy alone, look for convenient living arrangements, thus matching a great part of the request coming from the “demand side”. However, how it will be stressed in more details in the next chapter, the shortcomings of the working conditions deriving from such requests mean for many workers a quite isolated social life, little rest and long working hours, to which their weak contractual position does not always allow them to adequately oppose (Gori 2002: 179).

A second set of skills which is commonly identified by Italian users as essential characteristic of good quality care work comprehend the possess of personal characteristics such as relational abilities, trustfulness, honesty and sense of privacy. These competencies are by many Italians seen to be gender related, justifying in their eyes the preference generally accorded to female care workers, not differently to what occurs in other countries (Colombo 2003). On the other hand, the relevance of these skills for ensuring a “proper” level of care is seen closely related to the content of “affectivity” which the caring task intrinsically includes, thus explaining their essentiality for externalising these tasks outside the traditional locus of the family. Compared to them, technical competencies seem to play a rather secondary role, becoming relevant only in peculiar cases, where particular pathologies, such as for instance the dementia related ones, require from the care worker the ability to handle with special behavioural disturbances or, in case of mobility problems, the application of techniques to mobilize properly the dependent person (Gori and Da Roit 2002: 78-80).

In the light of these main categories of skills, what seem to be the main skills shortages affecting the Italian scenario? One first aspect is certainly represented by the need of ensuring a better specific qualification to the working carers currently employed. This concerns both personal assistants directly hired by the family, as well as care workers employed by private agencies, often providing services on behalf of public authorities, which more and more often are reducing their role to the funding and monitoring of the care services by means of an accreditation system (see chapter 2).

Empirical evidence on this need derives also from recent studies carried out among care workers employed in the two sectors. As far as personal assistants directly hired by Italian families are concerned, a research carried out between 2002 and 2003 by INRCA (Italian National Research Centre on Ageing) on about 220 foreign women providing care to dependent elderly in a Central Italian region shows that 94% of them has no care work qualification at all (Lucchetti et al 2003: 25), although it should be pointed out that well 12% of them has a university degree and a further 38% a high school diploma. When we compare these data with those collected in a parallel study on foreign home care workers employed in social cooperatives (i.e. non profit care agency), which provides care services on behalf of the municipalities’ social care services, it can be found that, by comparatively similar educational level (11% with university degree, 56% with a high school diploma), only a slightly higher percentage (27%) has previously worked in the care sector, and only 52% has had training opportunities in this field (Sartini et al 2003: 15-16).

These surveys, besides confirming how dramatic the need for even very basic information on care topics among these workers is in Italy, allow to unveil also other major gaps which need to be filled in order to improve the overall quality of care supply in this Mediterranean country. One of them is the very poor linguistic skills of many foreign care workers, which - besides limiting their own integration opportunities - represent also an obstacle for a good communication with the cared for person and his/her family (which is in fact by the way lamented by 28% of the interviewed personal assistants): 36% of families’ personal assistants (36%) and 16% of employed home care workers
have none or a just sufficient understanding of the Italian language (but this percentages reach 71% and 52% for the written language!) (Lucchetti et al 2003: 22, 57; Sartini et al 2003: 36).

This situation is reflected by the training needs explicitly expressed by foreign workers themselves, who identify in the first place the wish to improve their knowledge in care work-related topics (31%), the pointed out need for a better preparation in the Italian language (15%), on computer-related topics (13%), safety and worker’s rights (9%), a foreign language (9%), health related topics (7,5%) and topics related to other job opportunities (6%) (Sartini et al 2003: 44).

8. The care sector image and status and career development opportunities

The care sector image is in Italy does not certainly possess a very high profile, as several observers have already underlined and diffusely commented (Colombo A. 2003; Colombo G. 2004; Toniolo Piva 2004; Taccani 2004). This situation is in particular reflecting an overall “bad” image which this sector has in the eyes of the Italian males who, differently from what happens, at least to a higher extent, in other Northern European countries, still generally refuse, especially in the adult and older generations, a stronger involvement in caregiving tasks, thus keeping de facto almost unchanged the traditional division of labour between genders within the family (Andall 2000; Colombo 2003: 321). This societal background situation is well reflected in the gender based division of care work in the labour market, where percentages of 80 to 90% of female workers (depending upon the sectors) are not a rarity (ISTAT 2002: 18; INPS 2002).

In the light of this phenomenon, and of the overall situation described above, which career development opportunities are currently available in Italy in this sector?

One preliminary remark regards the observation that, without an in-depth change in the “intrinsic value” culturally attributed by the Italian society to caregiving functions and care work in general, no significant and relevant improvement in the career opportunities offered by this sector will be possible. The fact that foreign immigrants have been diffusely allowed to find employment in this sector – transforming it today in what could be considered an “ethnic niche”, wouldn’t it be for its huge size, which makes it rather a labour market “segment” by all means – indicates by itself how “low” care work is located in the professions’ “prestige scale” imagined by most Italians, if it is true that “outsiders” are in most societies usually allowed to occupy mainly the worst paid and least desirable jobs, which “established insiders” usually tend to refuse (Elias 1965; Neysmith & Aronson 1997).

With respect to this, it should be pointed out that just the broad diffusion of foreign personal assistants has probably represented an unaware “push factor” for a recent improvement in the career opportunities of two traditional categories care workers, i.e. of nurses and of social workers, whose training curriculum includes since 1999 the opportunity of reaching a university degree, putting them on the same (economic and juridical) footing as any other graduated workers and allowing to take on leading position within complex staff organisational structures (such as for instance municipalities’ social care services, hospitals, residential institutions, community services etc.).

Such a recent development – which represents a form of “lengthening” of the care work “hierarchy” – might be considered on the whole a positive one, since it reflects a sort of levelling of the social and nursing care work with all other kinds of work for which such official university recognition was already available. Its concrete effects on the career opportunities of most care workers are however relatively small, since the training path for becoming a social care worker (as well as a nurse) include a high school diploma, which for basic care work is in Italy not required.
Therefore, the improvements in formal career opportunities which are likely to be expected in the near future for care workers in Italy might consist in very small forward steps within the relatively short care work hierarchy existing under the job positions traditionally placed “under” the coordination of traditional professionals such as social care workers and nurses. Intrinsic improvement of career opportunities might however be possible in terms of improvement of the quality of care work, but this represents more a topic inherent to the bridging of skills gap, as already described in previous paragraph. Some “atypical” career development opportunities might also be found in particular niches of the care sector. One example in this respect can be found in connection with that dimension of care quality concerning the ability to interact properly with the different kinds and typologies of services constituting the care sector (health and social care; residential and home care; public, private, voluntary and family care) (Gori 2002: 179). Although a general training ensuring a basic knowledge of the whole care systems’ knots and paths should be granted to all care workers, it could be identified a possible specialisation of some of them, with connected career opportunities, on the specific task of representing joint elements particularly able to disentangle themselves in this more and more complex system, playing a highly needed mediating role between one sub-sector and the other.

9. Final remarks and introduction of the six case studies

The picture of the Italian situation provided above should have made clear that one of the main problems of the labour supply in the care services sector in Italy is not the quantitative shortage of care workers, but rather their low qualification with respect to the increasingly complex care needs of the ageing Italian population. The peculiar solution found by many Italian families to support their mostly elderly dependent members, i.e. to resort to the support provided by foreign immigrants, mainly on an undeclared basis, makes evident that in the Italian context a supplementary problem of safeguarding the basic rights of such workers exists in more pronounced terms as in other, non-Mediterranean countries.

With regard to this, a set of case studies has been chosen and is presented in the next few pages, which tries to provide an assorted overview of most innovative and at the same time effective measures recently adopted in Italy in the field of care labour supply, a sector which is lacking of major national interventions – with the exception of the recent legalisation campaign aimed at regularising the position of illegal immigrants working as domestic personnel or in the industrial sector – and which is mainly ruled by local and regional regulations.

The first case study illustrates the “SerDom” project, one of the first and long-standing programmes in this sector in Italy, showing how municipalities have been active in promoting cooperation models between families, foreign care workers and service providers, in order to sustain regular care work by foreign immigrants through the financial support, training opportunities and intermediary functions played by local public authorities. It has to be underlined that, in this field, a major role is also played by consortia of private organisation and local public authorities, which offer training opportunities funded through the European Social Fund (ESF).

The voucher system recently implemented by the Lombardy region – the second case study presented here - represents an innovative example aiming at improving the functioning of the care labour market, allowing care recipients to buy services only from accredited providers, who ensure a more rigorous recruitment of care staff. Accompanied by a parallel reorganisation of the whole home care service delivery system run by at a regional level, the voucher system is critically viewed by those who point out the need for higher counselling and monitoring tasks which this system implies, which might however represent an opportunity for new job positions and career developments in this sector.
A surely innovative measure for the Italian history is the launch of a programme by the Veneto Region for the recruitment and training of care workers in the sending countries (case study n°3). Aimed at improving the conciliation of care demand and training/selection needs of care supply, as well as at the prevention of undeclared care work, this project, which is still in its pilot phase, underlines the need for a more integrated approach that, besides the selection and training of foreign care workers, can improve also the acceptability by the final users, i.e. the families who will hire them, both in terms of trust towards such an innovative procedure as well as of acknowledgment of the care workers’ basic rights.

The fourth case study illustrates the improvements in terms of personal care services quality and job opportunities which the application of the Independent Living philosophy can open in Italy, based on the example of a regional programme run by the Friuli Venezia Giulia Region. Through the implementation of a large scale programme, a positive combination of new jobs and care quality improvement has been reached, with a relevant impact on the societal perception of “care work” itself.

The implementation of the RUG III system – the fifth case study – shows how the application of this rigorous assessment system to the residential care sector can improve the planning and monitoring of care staff appropriateness in relation to the care needs of residents, allowing at the same time to national and regional care authorities to estimate the typology and amount of care workers to be provided for residential care, through a systematic accreditation system.

Finally, the “Family Counter” project represents an example of how the match between care work demand and supply can benefit from the partnership between profit and non profit care agencies, acting as intermediates between care workers – to whom they provide also training and continuity - and families – to whom they grant sense of trustfulness, facilitating the selection of suitable care workers and reducing the burden of bureaucratic procedures.

Bibliography


