

Elder care needs & service provision in Italy: current challenges for policy & practice in an international perspective

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1. Introduction

In this paper, we provide an overview of the main features of the Italian long-term care (LTC) system, and illustrate the main challenges affecting it, also in the light of the effects of the recent global recession. To this purpose, we first very briefly outline its main features, to focus then on the formal supply side, and distinguish here between residential and home care services, cash-for-care schemes and the private employment of migrant care workers. After a brief overview of some more recent developments in selected areas, we conclude with a brief discussion of some reform proposals currently under debate.

The reflections proposed here are based on a conceptual framework where, on the one hand, we find the care demand, whose amount and features depend upon factors such as demographic, health-related, socio-economic and technological aspects. As you know, the response to this demand is, on the other hand, traditionally distinguished in two main components, formal and informal. The latter is delivered mainly by the family, while formal care, public or private, is based on two main pillars: in-kind services (in form of residential or home care) and cash-for-care schemes (or care allowances), delivered to address and hopefully match care demand.

Starting with the demand side, it should be briefly reminded that Italy is, after Japan, the country with the largest share of very old population, i.e. of the group where most care demand comes from, as over 6% of its population is aged 80 or over, with a likely perspective to further increase in the next future (European Commission 2015; Japan Statistics Bureau 2014). This high pressure from the demand side is in the first place tackled by the informal care sector, which is actually the real backbone of LTC, and this not only in Italy but even in most developed welfare states (European Commission 2013). The number of informal carers in Europe is indeed estimated to be on average twice as high as that of the formal care workforce (Triantafillou 2011).

However, informal care seems to be facing a series of challenges in Italy, one being represented by the decreasing old-age support ratio, which is in Italy today second again only to Japan in the world (United Nations 2012). This is of course worrying also in terms of formal care staff shortages, as we will see later in this paper. Another challenge comes from the increasing participation in the labour market of Italian women, especially in mature age, who traditionally provide the bulk of informal care: their participation rate has more than doubled in the last decade (with a further jump in the last few years, despite the economic crisis), although it still remains far lower than that of most European countries (Veobecka et al 2013).

These changes do not seem however to have affected the basically “familistic” attitude towards elder care that characterises most Italians. Already before the crisis, a very large majority of Italians thought that it would be a good thing if children in working age would look after their frail older parents (Alber and Köhler 2004), or pay for the care of their own parents, if these are not able to do it themselves (European Commission 2007). These attitudes are very likely to be still there, however, if Italy reports in Europe the highest share of population providing informal care to a dependent relative or friend (Censis 2014).

When we move on to analyse the provision of formal care, we can observe three basic trends that have characterised this sector in Italy on the long run: a strong increase in the number of older recipients of cash-for-care benefits, especially in the last decade; a steady growth of the role played by home care services; and a

marginal position of residential care (Barbabella et al. 2013). If we look at the public LTC expenditure (expressed as share of the GDP), in the last decade we note an overall increase, which has recently only slowed down due to the impact of the economic crisis (Barbabella et al 2013; Ragioneria Generale dello Stato, 2014). This trend, however, has not so much affected the budget for State cash-for-care benefits, but rather that allocated for in-kind services, especially those provided by municipalities. It is also interesting to note that in-kind services (i.e. home and residential care) are in half of cases provided by the private non-profit sector, and only 20% by for-profit organizations, the rest being directly run by public authorities (Rodrigues and Nies 2013).

2. Main trends in the single sectors of LTC provision

2.1. Residential care

If we take a closer look at the single LTC sectors, starting with residential care, we can confirm that also in comparative terms this form of assistance represents in Italy, as anticipated above, a marginal component of care provision. Italy is indeed one of the European countries with the lowest share of older population in institutions, which still today involves no more than 2% of this population group (Rodrigues et al 2013). Over time, as we have seen, there has been a slight tendency to increase; however, in the very last few years this trend has started to drop again, and this certainly has to do with the economic crisis, since less and less households have been able to bear the co-payments for residential care, which usually range, depending upon the Region, between 30 and 50% of the overall costs, which on average reach 110 euros per day. This quick overview on the residential care sector should finally highlight that, much in relation with the already mentioned familistic approach, Italians are, after the Greek, the EU citizens who are traditionally less satisfied about the quality care of their nursing homes (European Commission 2007).

2.2. Home care services

Let us move on to analyse the home care services, which reach nowadays over 5% of older Italians (Barbabella 2013). We have to distinguish in this respect between two different categories of recipients: a larger group of 4,1% benefiting from ADI (*Assistenza Domiciliare Integrata*), i.e. integrated health and social home care services provided by health districts, consisting mainly in nursing, rehabilitation and personal care; and a smaller group of 1,4% receiving municipal home help (mainly household and personal care). As for the first, we have to acknowledge a strong regional variation, since integrated home care goes from a maximum intensity of 75 hours per year in the region of *Molise* to a minimum of 4 in *Friuli-Venezia Giulia*, and from a coverage of over 10% of the older population in the top region, *Emilia-Romagna*, to a close to zero rate in the lowest case, *Val d'Aosta*. Furthermore, a recent tendency to a reduction in the service coverage offered by some regions has been observed, thus interrupting the long-term trend to growth observed in the past (Barbabella, Chiatti and Di Rosa 2013).

As for municipal home help, we observe again a strong regional differentiation, both in terms of coverage and of expenditure. However, in this sector the decrease in the overall number of home help recipients has started already since 2006, i.e. even before the economic crisis hit the country. It should be noted, though, that the number of hours of home help received per capita have been slightly increasing in the same period, indicating that this service has become more selective and focused on most severe cases only.

Municipal home help belongs to social spending, and here we can see in comparative terms how Italy belongs to the unenviable group of countries which has experienced both a dramatic drop in GDP (down by over 8% since 2008, back to the levels recorded in the year 2000) and remarkable budget cuts in terms of public social spending (OECD 2012). This has exacerbated the problems reported by Italian LTC service users already before the crisis, who more frequently than their European counterparts complain about high bureaucracy, lack of information and too long waiting lists (Lamura et al 2015).

2.3. Cash-for-care schemes

The situation described above is strictly related to what has been happening in the other two areas of LTC provision, that of cash-for-care schemes and the related private employment of migrant home care workers. As

for the first one, it should be underlined that this form of support concerns a huge share of Italy's older population, since well 12,5% of the over 65 year old Italians receive the State care allowance (*indennità di accompagnamento*) (Barbabella et al. 2013); and this is true also in comparative terms, since cash benefits have been estimated to reach 38% of the whole Italian dependent population (European Commission 2015).

However, it is not only a matter of coverage. Cash benefits are relevant in Italy also in terms of amount, as Italy's State care allowances can reach, depending upon the type of disability, an amount varying between 500 and 750 Euros per month. On top of this amount, many local authorities pay additional means-tested allowances, up to 300-400 Euros per month, so that, in the end, an Italian older citizen can almost double his or her average income.

A crucial challenge characterising this pillar of Italian LTC provision is that, despite its federal role, the State care allowance is not based on common eligibility assessment criteria. This means that even for such an apparently country-wide homogeneous benefit the coverage is geographically quite unequal, ranging from almost 20% to 8% of the regional older population (Barbabella et al 2013), with a clear tendency to grow in the past, which has however stopped since 2009, also in terms of expenditure, due to stricter controls introduced to reduce abuses.

The importance of this measure is shown also by the budget allocated to it, which with 49% represents, by far, the largest component of public LTC expenditure for older people. Now, a crucial aspect in this regard is that its unrestricted use implies a strong incentive to the private employment of migrant care workers, a component which can be considered, in combination with the just illustrated cash-for-care schemes, the real pillar of Italian LTC.

2.4. The employment of migrant care workers by private households

The phenomenon we are talking about should be, conceptually, part of the formal care provision. However, the fact that in the peculiar Italian system (as in many other countries of the Mediterranean area and beyond) these migrant care workers are primarily hired, often on an undeclared basis, by private households, makes many observers speak of "informal" care workers. This is, however, a misleading formulation, since it confuses the remunerated care activity provided by these workers with that, unpaid, granted by family members. In our opinion, this represents simply a case of illegal employment, as far as it is not based on regular contractual obligations.

In any case, the connection with the cash-for-care system is quite clear: when State and local care allowances sum up, the probability of privately hiring a migrant care worker skyrockets. This makes the presence of such workers in Italian households with dependent older persons much more frequent than anywhere else, in Europe and beyond, already since a longer time, thus making it by now a structural component of Italy's LTC provision (Lamura et al 2008). This trend started to gain strength already in the 90s, with the number of foreign domestic workers, mainly women from Eastern Europe and South America, rising from one sixth to four fifths of the total, and pushing up their overall number (grown by over four times in two decades), with a peak in 2015 (Barbabella 2013; INPS 2015). The real news in this regard is indeed the fact that, due to the economic crisis, the number of Italians working as home helpers has started to increase again in the last few years, as the crisis has made this low paid job attractive to many of them experiencing unemployment and financial constraints.

What has been the role of official policy with regard to this phenomenon? The national level has tried to formalise this "low-cost approach" or "care-revolution from the bottom" - as some observers have defined it, to underline that it has started and been developing without any major explicit policy from the government - by means of a series of "acknowledging" and supportive measures (Pasquinelli and Rusmini 2013). Among them, the most significant have been repeated backwards legalizations, immigration quotas reserved to care migrants, and fiscal incentives to reduce undeclared labor. To fight exploitation, the minimum wage level for domestic work was raised by 30% in 2007, thus ensuring higher protection but making at the same time regular employment more difficult and irregular work more widespread. At a regional and local level, training and accreditation programs have been introduced to improve quality of care and fight undeclared work.

Most migrant care workers are employed on a live-in basis, in order to ensure an around the clock, 6 day per week supervision, a comparatively low cost solution, since they are often employed as undeclared workers, this happening, as you can see here, in a very large number of cases (Lamura et al 2008; ACLI Lombardia 2014). For many tasks, migrant workers have become the main providers, even compared to family members

(Barbabella et al 2015), so that many observers no longer talk of a family-based model, but rather of a migrant-in-the-family elder care model (van Hooren 2010).

A clear sign of how pervasive this phenomenon is represented by the fact that almost half of Italy's recipients of formal home care service at the same *time* privately employ also a migrant care worker (Barbabrlla et al 2015). This has of course had an in-depth impact on the formal home care services, too. Compared to households with no migrant care workers, those employing them on a part-time basis have seen a shift of the tasks performed by home care services from heavier tasks (such as personal care, housework and meal preparation/administration) to lighter tasks (such as medicine administration, company and transportation) (Di Rosa et al. 2012). And this shift becomes quite dramatic, creating a real "crowding-out" effect, in the case of live-in migrant care work, when home care services remain relevant only for personal care and transportation.

The motivations reported by Italian households for employing migrant care workers sound as a list of the priorities currently unmet by the Italian formal LTC system (Spano 2006): care continuity, ageing in place, reconciliation of carers' paid work and family responsibilities, and an acceptable level of care quality. In the light of these circumstances, it is no wonder that a longitudinal study indicated migrant care work as the only single support able to reduce, at a statistically significant level, the burden suffered by family carers of older Italians (Chiatti et al. 2013).

Once we move to look at the perspective of migrant care workers, however, we should acknowledge that their activity in Italian households is far from being ideal (Lamura et al. 2008). They often work a huge number of hours per day, reflecting the frequent live-in, around the clock engagement. This is certainly a risky situation for exploitation, as they are frequently employed as undeclared staff, under circumstances which make not few of them experience emotional and physical burden, with very little spare time and freedom, many of them reporting that they can hardly go out of the home in which they work).

Another perspective not to be forgotten is that concerning the care drain occurring in migrants' own source countries. Here, their left behind children are often economically better off but socially deprived and taken care-for by frail grandmothers, and not few migrant women returning back home after long years of isolated, unhealthy life as care workers abroad report mental diseases such as paranoia (Tolstokorova 2008). Furthermore, it should not be underestimated that huge amounts of money could be saved by destination countries like Italy, since training costs have been borne often by the migrant's countries of origin.

3. Recent developments in selected areas

To gain a more comprehensive, updated picture of the Italian context, some interesting, innovative attempts undertaken to improve LTC provision in a more structural way should be briefly mentioned (for more details on these developments refer to Barbabella et al 2017).

3.1. National and regional strategies focused on specific LTC needs

Recently, two major national plans have been adopted in Italy in LTC-related fields. The first is the "National Plan for Dementia" (*Piano Nazionale Demenze*), launched in October 2014 by Ministry of Health, as a result of a close cooperation between the Ministry itself, the Regions and the national patient/carer associations (Ministry of Health 2015). This plan offered for the first time in Italy the opportunity to address the challenges of dementia via a comprehensive and cross-sectoral strategy defined at national level. More recently, a "National Plan for Chronic Diseases" (*Piano Nazionale Cronicità*) has been adopted by the Ministry of Health (2016), with the aim of harmonizing the interventions at regional and local level in the area of chronic disease management. This plan has been approved by all Regions and represents now the main strategic reference for all interventions and policies aimed at improving quality of life of the individuals affected by chronic diseases and their families.

These national strategies are important in countries like Italy, where policy responsibilities are split among different administrative levels, so that country-wide strategic recommendations and interventions have to be addressed at regional level and tailored according to the specific characteristics of the local contexts. This is the reason why recently many regions, responding to their specific needs, have approved Regional Dementia Plans for the implementation of the national strategy. In the field of chronic care, interesting regional models are represented by the CReG (*Chronic Related Group*) system experience in Lombardy (Bussola Sanità 2016) and the Expanded Chronic Care Model in Tuscany. The first is designed as a health care reimbursement system,

according to which GPs are reimbursed a fixed sum to provide comprehensive care plans for older people, in integration with other care providers in the area, to improve continuity of care for people with complex needs, which cannot be satisfied by a single professional. A further refinement of this approach is currently under preparation, in which patients in most critical conditions would be no longer followed by GPs, but by care managers. Similarly, the aim of Tuscany's Expanded Chronic Care Model aims at overcoming the traditional approach focused on pathology only, and tries to deliver a more comprehensive care which takes into account also health, social, economic and cultural conditions.

3.2. The promotion of corporate welfare programmes supporting work-care reconciliation needs of family carers

Italy's Stability Law for 2016 has introduced a series of novelties concerning the promotion of welfare measures at company level, aimed at strengthening the supply of services to support employees with care responsibilities, including informal elder care provision. These novelties focus, among other things, on different areas fiscal incentives for companies/employees who decide to grant/receive performance related benefits in form of welfare services. This is likely to have an expansive impact on the market of services for frail (older) people and their carers, as a result of the combined effect of different factors (Maino 2016): 1) the company has a fiscal incentive to provide performance-related bonuses in form of services, rather than as an addition to the salary; 2) the employee has a fiscal incentive to receive the bonus in services; 4) services for carers of frail (older) people are included for the first time as a possible component of company welfare schemes; 5) these services can be provided also by means of vouchers, in order to simplify adoption also by small and medium enterprises.

The Stability Law for 2017 pushes towards a further strengthening of welfare measures at company level (Lodi Rizzini 2016)), by a threefold strategy: enlarging the audience of potential recipients (by raising the employees' income upper limit for eligibility); increasing the potential benefit for employees; and incentivizing the involvement of employees in the companies' organization.

The number of working carer benefiting from support services provided thanks to welfare measures at company level was still low at the end of 2015, when only 3% of companies providing measures to facilitate the work-life reconciliation was addressing carers of dependent (older) adults (Mallone 2015). However, things are rapidly changing, as shown by the fact that, in the last months of 2016, the first networks of company-based welfare services addressing employees with caring responsibilities towards dependent adult family members were established, and during 2017 the first recipients will start receiving these services (De Carli 2016).

3.3. Organisational innovation

Two major developments took place in recent times at organisational level: the update of the list of nation-wide minimum standards for care delivery; and the push for a more effective social care delivery via aggregation of municipalities. As for the first, at the beginning of 2017 the list of new "essential levels of care" (*livelli essenziali di assistenza*, LEA) have been formally approved (President of the Council of Ministers 2017), after a long consultation process with Regions and other institutional actors and stakeholders involved. The new LEA updated the list of healthcare services which all Regions are obliged to guarantee to citizens. They include a re-organisation of some aspects of LTC, especially concerning: a better integration of health and social services through an individual care plan taking into account both health and social needs (art. 21); an improvement of community care services guaranteed (art. 3-20); a better economic protection in case of institutionalisation for people with high-intensity health needs (fees entirely paid by the State) (art. 29); a re-structure of home care into four levels of intensity, with different characteristics and types of professionals (e.g., medical doctors, nurses, healthcare workers, social workers) involved (art. 22).

In the field of social care, whose responsibility is in charge to municipalities, the main policy innovation in last years was the progressive stimulus by the central government to foster the union of municipalities for the management and provision of social services. Policy makers established that small-size municipalities should work together for organising social services, when single municipalities do not reach a minimum number of inhabitants (Banchero, 2015). Such a measure increased the agreements between municipalities with more centralised services, with expected financial savings and resource optimisation.

3.4. Integration and coordination of LTC-services creating social innovation

A recent study, the EU-funded MoPAct project (www.mopact.group.shef.ac.uk), has highlighted that many Italian stakeholders, experts and policy makers identify in services integration and coordination a crucial issue to improve Italy's LTC system (Casanova et al., 2016). Not surprisingly, many Italian local initiatives of social innovation are currently addressing this challenge, following three main approaches (Leichsenring et al., 2016):

- a) Integration and coordination of policy areas, in particular social support and health policies: this approach promotes integrated planning and permanent monitoring and evaluation of public policies and measures, thus aiming to achieve a more integrated governance and sustainability of LTC provision;
- b) Integration and coordination of stakeholders to create mixed networks: this approach aims at promoting the joint collaboration – often at local level – of public institutions and private enterprises (particularly non-profit organizations) to design and provide services;
- c) Integration as multidisciplinary staff: this approach finds its most common expression in the implementation of case management and multidisciplinary team care, adapting the design of care policies to the diversity of health and social care profiles, and following a prevention-based, long-term perspective.

The findings of the MoPAct project, based on the in-depth analysis of case studies of social support and LTC initiatives across Europe, show that in Italy innovation in LTC takes place if the integration and coordination strategy is applied on a multi-level basis through a *bottom up* process, starting from the local level to reach the national level, and moving from the professional coordination to policy integration.

4. Closing remarks

Despite the most recent attempts to introduce reforms in the LTC sector illustrated in the previous paragraph, Italy's policies in this field have not been characterised by a strong dynamism in the last decade, mainly due to the impact of the economic crisis, so that some observers speak of a sort of *substantial institutional inertia* at national level in this respect (Pavolini, Ranci and Lamura 2017). Actually, in times of financial constraints the majority of the measures adopted at both national and regional level have implied an overall decrease in the supply of LTC services to the older population. As for the area of privately employed migrant care workers (Pasquinelli and Rusmini 2013), in some regions so-called “one-stop shops” or single access counters have been introduced to facilitate users in accessing services delivered by different providers (health, social, state and local). A critical factor which is preventing many regions from implementing this solution, however, is represented by the lack of integration between different authorities with partly overlapping competencies in the LTC field.

Although different proposals have been made to promote coordination of care provision at different levels, a major drawback in this regard has been so far the lack of a strong federal government to push and monitor the whole process. As a consequence, regional inequalities in care provision remain strong, and proposals to overcome them through a more systematic connection between the national cash-for-care system and local care services have been opposed in many cases by regional authorities themselves.

At a national level, the State care allowance system has been recently put under stricter controls on eligibility; while this has stopped the increase in spending, it has however also pushed up the number of people going to court because they feel to be undeservedly controlled.

As for migrant care work, many attempts have been undertaken at local level to reduce undeclared work by granting allowances only in association with formal work contracts. The low uptake of such initiatives shows that Italian families' desire to feel unrestricted in this respect is very strong, also because the level of local benefits is usually lower, compared to the State allowance. The latter initiatives aimed actually also at improving the quality of migrant care, an objective pursued also through local training, tutoring and competence certification programmes, which have however had geographically very unequal outcomes.

Finally, steps have been undertaken to improve the match between care demand and supply, by activating registers and counters offering users the possibility to receive information, to be assessed or monitored in their own support needs, and to match home helpers and households with dependent older persons. While evidence shows that these initiatives work at best when local employment centres are directly involved, we can conclude by saying that the effectiveness of most measures remains limited, as they come mainly from local authorities and do not receive much support from the State. Without a stronger, more systematic cooperation between these

two governance levels it is unlikely we will see any remarkable improvements, which are badly needed, especially to connect care payments, care services and care workers into one single integrated approach.

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