**Migrant care workers in Italian households: recent trends and future perspectives**

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**Abstract**

Italy is characterized by a very high and increasing demand for elder care, but also by a low level of in-kind public service provision in this sector. The informal and family care for dependent older people represents the largest share of long-term care provision in Italy, with public policies and interventions largely supporting it. The ‘cash-for-care’ approach - which represents one of the main features characterising the Italian welfare system, consisting in direct payments to older people and their family members - drove Italian families to use more and more such monetary transfers to privately employ home care workers. The latter have indeed become today the “third pillar” of long term care policies in several industrialised countries, especially in Italy, where most of them are foreign-born migrants living with the cared-for person. The widespread employment of migrant care workers has certainly relieved many families from most burdensome care tasks, with competing (“crowding-in” and “crowding-out”) effects between the use of private care and public formal services, according to a clear pattern of care tasks allocation: family and private carers are responsible for assisting the older person with basic tasks of daily living, while the residual competences of public formal sector relate to specialised health care services. This phenomenon has been so pervasive, that it has radically changed Italy’s traditional approach to elder care and, within this context, several challenges are raised in terms of care quality, possible undeclared work, exploitation and abusive situations, as well as care drain risks.

**Keywords:** Migrant Care Workers, Elder Care, Family Caregiving, Care Services, Italy

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# Introduction

The Italian society is amongst those which are most extensively affected by the phenomenon of population ageing, due to its longstanding very low birth rates (1.32 children on average per woman in 2018) and increasing life expectancy (85.2 years of life expectancy at birth for women and 80.8 for men) (ISTAT, 2019). This is true in the long-term, although in 2015 it was registered a slight decrease of the life expectancy compared to 2014 – the third time in the last forty years (previously occurred only in 1974-1975 and 1982-1983). This fact might be due to a shift of a number of deaths in older age across the 2014-2015 solar years. In fact from 2016 life expectancy continues to grow. Furthermore, Italy is facing the challenge of addressing the complex care needs of older individuals for a long period of time since among the countries of the European Union (EU), it is just above the EU average of healthy life years (in 2014: 62.3 vs. 61.8 for women; 62.5 vs. 61.4 for men) (Eurostat, 2016). On the whole, currently over 22.5% of the Italian population is over 65 years (13.6 million people), with circa 2.5 million (equivalent to about 19% of older adults) estimated to have functional limitations and to be in need for care (Barbabella et al., 2017).

Generally, long-term care (LTC) policies are a set of social policies with the objective of contributing to the wellbeing of people with care needs and limiting the risk of inappropriate care. However, in Italy, home care policies for dependent older people do not constitute a coherent component of welfare, but depend on institutional actors, financial resources and different processes (pertaining respectively to the Regions and to the Local Health Authorities for the health component, and to the Municipalities and Local Social Areas for the social-welfare component), in many cases with integration problems.

The most significant criticalities of the home care sector in Italy can be summarized as follows (Barbabella et al., 2013; Barbabella et al., 2017; Gori, 2017; Jessoula et al., 2018):

1. **predominance of monetary transfers:** the Italian LTC system is based above all on the provision of a monthly allowance of 516 euros for those with total disability and a continuous need for assistance to carry out daily activities or for the walking. The allowance is assigned to approximately 13.5% of the elderly (65 or older) in Italy (Jessoula et al., 2018). Home care reach an elderly audience of 5.8% provided by the National Health System (NHS) (OECD, 2019) and 1.6% provided by local social services (ISTAT, 2019a). The possibility of spending it without accounting or formal constraints represents a strong incentive for using it to pay private care work. In 2013, circa 12% of the older population was receiving allowances, i.e. a slightly lower share than in previous years, due to a re-centralization of need-assessment procedures (with the integration of evaluators from the National Institute for Social Protection, INPS) and monitoring measures to combat misuse at local level (previously, entitlement was assessed by a committee of the local health authority which had higher discretionary power). Its amount and the large number of recipients make it the most substantial public resource Italian families can count on to provide LTC, as shown also by the fact that, while in 2011-2013 both community and residential care expenditure did not increase, spending for allowance increased of half billion Euros, up to a total of over 10 billion per year (Barbabella et al., 2015). It should be furthermore be noted that, in addition to the State attendance allowance, many municipalities and regions offer themselves local cash-for-care schemes, which in some cases are additional to the national benefits;

2. **low average intensity:** the available home care statistics show a low average intensity, less than 20 hours per user per year, which presumably fails to cover all the health needs of the clients (Barbabella et al., 2017);

3. **poor integration between health and social care services:** despite the priority and the importance officially attributed to the integration between health services and socio-welfare at home, the connection between these is unfortunately often non-existent or marginal. ISTAT data (2019) indicate that only 0.6% of the elderly benefit of both home care services integrated at the same time;

4. **territorial disparities:** the coverage and the intensity of services vary widely from region to region and also on the basis of local programs of Local Health Authorities, Municipalities and Territorial Social Areas (Barbabella et al., 2017). In particular, for socio-welfare services the eligibility and co-financing criteria are established locally with a large variance;

5**. ‘double track’ of public and private care services:** a significant proportion of dependent older people must resort to the use of private assistance staff and care workers in order to compensate for the lack of public care services. The lack of standardized convention paths for private services and mandatory training for care workers create a second parallel track of services (in addition to or replacement to the public), contributing to the overall inefficiency of the system;

6. **limited financial resources for direct assistance:** most of the public resources are concentrated on the allowance, financed in 2016 with over 10 billion euros and not linked at all to the actual assistance costs. Considering that in the same year the Municipalities spent 2.7 billion for socio-welfare services and the NHS 5.9 billion for the overall offer of home, semi-residential and residential health services, it is possible to understand the total disparity in allocation of resources among these items (Barbabella et al., 2017).

The impact of demographic trends on the Italian LTC system is not only exacerbated by a traditional lack in the coverage and intensity of formal LTC services, but more recently also by the deepest economic recession since the Second World War. Historically, Italy’s LTC provision has been relying on the in-kind and financial contribution of families (Ferrera, 1996). However, in the next future it will be harder and harder for households to be able to deliver the amount of care needed by their older members, as the ratio between adult (45-64 years) and older people (75+ years) is expected to grow (from 0.91 in 2017 to 0.99 in 2050, our elaborations on ISTAT data), and the number of family caregivers needed to maintain current care levels to double (Colombo et al., 2011).

Another indicator that estimates the “effort” of Italian family caregivers, of all employed people who in 2014 benefited from the work permits granted by law 104/1992 (i.e. the law regarding the rights of persons with disabilities and their families), 78.4% were represented by family caregivers (INPS, 2019)

The combined impact of a relatively weak role of formal in-kind LTC provision (both in terms of coverage and intensity), a widespread use of substantial attendance allowances, and the presence of a still strong family network allowing most older people to “age in place”, has stimulated an increasing reliance on home-based, privately hired care workers (Lamura et al., 2010). The number of these workers, in most cases represented by women, has been estimated to reach 908,983 in 2016 units across the country (Fondazione Leone Moressa elaboration on INPS and ISTAT data, 2017), of whom about 90% have a migrant background, two thirds are without a regular contract and often have not received any professional training in care or nursing (Pasquinelli and Rusmini, 2013). This estimate is based on a process, refined over the years, combining official and informal data sources and consists of a calculation using social welfare (INPS) data relating to domestic workers, the data on foreign citizens (ISTAT) and those on irregular migrants (Institute for the Study of Multiethnic, ISMU), as well as the evidence provided by other stakeholders (Caritas, trade unions, voluntary organizations, social cooperatives, services involved in guiding and supporting the labor insertion).

The legal and employment position of migrant care workers (MCWs) plays, in this respect, a crucial role in shaping their own living and working perspectives, and indirectly affecting some of the main features of the whole LTC sector (Pasquinelli, 2013; Pasquinelli and Rusmini, 2013). A particularly weak position characterizes the MCWs who have no or expired residence permit – since they have no possibility of training and professional development nor access to public services – as well as those who, while having a legal residence permit, work however without a regular contract, thus making their social, employment and pension status rather precarious. To some extent, this is fed by the search of short term benefits by both sides: by the families, who try to pay less and are free from legal constraints; and by MCWs themselves, who renounce to a set of guarantees and safeguards for a higher salary, as this does not include (actually mandatory) social and fiscal contributions (Mesini et al., 2006).

To complete the overall picture, it should be finally mentioned that, despite the recent economic crisis, the out-of-pocket costs borne by Italian households to meet their own care needs have been recently growing. Available data on the consumption in the health care sector (ISTAT, 2018) seem indeed to suggest that the private expenditure born by older people’s households for health services (including expenses for goods and services for personal care, personal effects, social services, insurance and financial services) has reached today about 7% of total expenses (which is a higher value than the one reported on average by the general  population: 4.8%). Not surprisingly, the purchase of private LTC insurance policies to cover the risk of a (temporary or permanent) disability condition is also growing, although 90% of older Italians still do not have any kind of insurance (with less than 6% reporting a health insurance, 2.5% a life insurance and 1.6% both of them) (ISTAT, 2015).

The aim of this article is to explain the role played by migrant care work within the Italian LTC system.

# Methods

In order to provide an up-to-date framework of the LTC interventions for frail older people in Italy, secondary data analyses were carried out, based on existing institutional sources. The aim of this article, therefore, has been not only to contribute to overcome the fragmentation traditionally characterising these specific data in Italy, but also to provide a clear and concise set of core figures on the complex phenomenon of migrant work in LTC for dependent older people. In the following sections, the most recent data available for each source are analyzed and used to build a comprehensive and in-depth picture of the main aspects of this phenomenon.

For this reason, alongside ISTAT surveys or other official sources, other surveys and research conducted in the sector have been taken into consideration, in order to propose reliable estimates of the phenomenon, despite the inevitable methodological limitations. The main interventions and sources considered were collected in Box 1 and include:

1. family caregivers: informal care provided by people who care for an elderly family member free of charge;

2. (migrant) care workers: assistance provided by workers directly hired by the elderly or his family;

3. other out-of-pocket private assistance: health and social-assistance services provided by private (non- or for-profit) organizations, as well as supplementary services (supplementary funds etc.) and insurance (on health, life etc.) purchased directly by the elderly or by the family on the market.

**Box 1.** Data sources by kind of LTC service for dependent older people

|  |  |  |
| --- | --- | --- |
| **Kind of assistance** | **Available instituitional source** | **Latest available year** |
| Family Caregiver  | Rapporto annuale. La situazione del Paese nel 2018 [*Annual report. The Country condition in 2018*] (ISTAT, 2018a) | 2018 |
| Bes 2017. Il benessere equo e sostenibile in Italia [*Fair and sustainable well-being in Italy*] (ISTAT, 2017) | 2017 |
| Aspetti della vita quotidiana [*Aspects of daily life*] (ISTAT, 2015) | 2013 |
| (Migrant) Care Workers  | Osservatorio sul lavoro domestico [*Observatory on domestic work*] (INPS, 2017) | 2017 |
| Out-of-pocket assistance | La spesa per consumi delle famiglie. Anno 2017 [*Spending on household consumption. Year 2017*] (ISTAT, 2018) | 2017 |
| European Health Survey (Eurostat, 2018) | 2018 |

# Results

Using the data from the European Health Interview Survey, it is possible to analyze the specific needs of the population group aged 65 and over, for which there are characteristics related to the type of aid they need and the level of satisfaction they achieve. 20.7% of the elderly need help or require help to carry out the daily activities of personal care, 57.6% of these report not having sufficient aid for their needs. Among those over 80, given the greater need for help (44.7% say they need help for daily activities), we observe the lower share of unmet need (54.5%). For daily household activities, ​​37.6% of the elderly need help or help from a person, but the share is 73.0% among women over eighty. Almost half of people 65 and older complain about the lack of help. The help network is activated more to meet the needs related to the management of housework activities than for personal care. The direct involvement of the family in household chores is more frequent than in the care of an older person to help him dress, eat, wash, etc.: for these latter activities, delegation to third parties is more frequent, whatever the real motivation or combination of physical prowess or specific skills). Moreover, older people living alone, who are often even those at a later age, express greater need for help both for personal care (31.7% compared to 20.7% for the elderly in general) and for domestic activities (52.7% compared to 37.6% of the elderly in general).

Where the aid received is considered insufficient there is a greater use of private pay services. The services purchased by the family are consistent with the expressed needs: if the need for help is on domestic activities, 12.5% of families make use of a domestic worker, while if the expressed need is on the care activity at person 5.9% of families are employed by a care worker (Figure 1). Families with elderly who receive sufficient help in care activities make greater use of carers (22.9%) and domestic help (18.8%), and a similar trend is observed in families with elderly who receive sufficient aid for daily domestic activities (11.7% and 19.4% respectively).

 **Figure 1:**Families with at least one person aged over 65 years in need of help for care activities or houseworks, 2015 (% of total households)

*Source*: our elaboration based on ISTAT data (European Health Interview Survey)

Data referring to regularly employed care workers, while unable to capture the condition of those working under undeclared circumstances, still allow to highlight some peculiar characteristics of this phenomenon (Figure 2). The main MCWs’ region of origin is Eastern Europe, in particular Romania (a country representing alone circa a quarter of the total migrant labor force employed in LTC), while all other major nationalities are outside the EU (including the Philippines and South America). It is also worth noting that the number of MCWs has steadily increased over the past ten years, and it is likely to continue growing in the next future. It is also interesting to note that the economic crisis only partly stopped this trend, especially until 2012, while from 2009 on the number of Italian care workers also started to increase, pointing out that this activity became profitable and attractive again for the autochthonous population, too.

 **Figure 2:**Trend of care workers according to the areas of origin (2005-2017)

*Source*: our elaborations on INPS data (2005-2017)

# Discussion

The negative, significant role of the economic crisis was also highlighted by a country-wide survey (Paolisso, 2013), conducted on a sample of 1,500 over-75 years old people, showing that, in order to pay for a care worker, three-quarters of respondents reduced the quality and quantity of food and almost half them had to ask for children’s help. Often these sacrifices were not sufficient, as 55% of respondents had to resize the help provided by the care worker and 25% had to completely give it up. The reduction or renounce of employing a care worker increased at the same time the risk of a deterioration in the health and quality of life of older people, increasing also their hospital re-admissions, while shifting back the care burden (partly or totally) on family caregivers’ shoulders.

As for their main areas of activity, MCWs are employed primarily to carry out housework, preparation and administration of meals, companionship and personal care, while less often carry out tasks concerning the management of finances, the organization of care and transportation. Cohabiting in the same household of the care recipient is a condition that deepens the MCWs’ involvement in all activities, except those which the family wants to continue to keep control on (such as finance management, organization of care and transportation) (IRS-Soleterre, 2015).

When the family employs a live-in MCW, the role of home care services decreases substantially for most tasks, up to a complete replacement. The only two activities that continue to be delegated to a considerable extent to formal home care services are personal care and transportation, for which MCWs do not always have the necessary means and/or skills. Overall, the living-in option represents the situation that more likely can produce a “crowding out” (or replacement) effect on home care services by MCWs (Di Rosa et al., 2012).

In terms of *policy,* there have been no innovative interventions by the central government in recent years to regulate the employment of private care workers. In general, since about a decade tax incentives are being granted to care recipients and their families when they employ care workers with a regular contract (laws 342/2000 and 296/2006). This reflects a more general strategy, aiming at promoting the regularisation of those MCWs who are employed without a regular contract or a residence permit (especially if they come from a non-EU country), by enabling both them and their employers to legalise their position without penalising consequences.

In order to understand how MCWs could become such a crucial pillar of the “Italian way” of providing LTC, it is useful to analyse more in-depth the relationships which are established between the care recipient, the family caregivers and the MCWs.

While family caregivers’ burden - defined as “the physical, psychological or emotional, social, and financial problems that can be experienced by family members caring for impaired older adults” (George and Gwyther, 1986) - has been largely studied, much less empirical evidence is available on how the presence of MCWs is impacting on it. In particular, it is interesting to analyze whether and how family caregiver’s burden changes in relation to the shifting of tasks from the caregiving dyad (informal caregiver – care recipient) to the caregiving triad (informal caregiver – care recipient – migrant care worker), and what are the effects on each actor involved. Recent evidences from the Italian context has demonstrated that employing a MCW to care for an older dependent person can result in a decrease of the burden affecting the family caregiver (Chiatti et al., 2013a; Ludecke et al., 2018). This is true even if the family caregiver remains a crucial actor constantly negotiating the caring tasks with the MCW, as the latter would relieve the family from most of the everyday care responsibilities, instrumental but partly also emotional ones, assuming possibly also a central role within the caregiving triad. This is consistent with studies carried out in other countries, demonstrating that MCWs are the key actor defining the overall satisfaction level in the caregiving triad (Ayalon and Roziner, 2016). In this care context, care recipients can benefit from a dedicated and good quality of care, which promotes the increase of his/her quality of life and, accordingly, the reduction of both mortality and institutionalisation (Fusco et al., 2015).

However, the handover of care responsibilities to a MCW does not always lead to positive outcomes only. The possibility of an inverse dyad reciprocity has been indeed recognised between the family caregiver and the MCW. Within this delicate care setting, a lower level of burden reported by family caregiver can correspond to a higher level of burden experienced by the MCW (Ayalon, 2015; Della Puppa, 2012). In other words, in addition to the care responsibilities, also the burden of care would be passed to the MCW, with substantial consequences on the caregiving triad and its members. As for the MCW, some contextual and individual characteristics, such as the lack of a proper qualifications, the degree of dependency of the care recipient, the emotional connotation of the daily tasks, the unpredictability of the care situation and needs, the demands for high levels of interactive work, as well as the difficulties in communicating with both family members and older person, can further expose or even exacerbate the MCW’s burden of care, impacting negatively on care and interfering with a good care relationship (Bauer and Österle, 2013; Di Rosa et al., 2016). Moreover, the MCW’s burden seems to be even more relevant than family caregiver’s one, which is conversely a predicting factor of elder mistreatment, as well as elder abuse, within the caregiving dyad (Melchiorre et al, 2017).

In summary, it becomes thus evident that MCWs play a crucial role within the caregiving triad, being responsible of addressing most of the care recipient’s needs, ensuring an overall balance within the triad, co-determining the overall quality of care, as well as contributing to the care recipient’s quality of life.

As illustrated in the previous sections, Italy’s LTC system relies heavily both on the traditional care provided by older people’s family caregivers and, increasingly, on the more recent contribution granted by MCWs, who are privately hired by Italian households to support them in the daily care tasks. Given the invisibility characterizing care, especially when delivered within private homes, the role played by this relatively new actor went first unnoticed. Only at a later stage, when the presence of MCWs became massive – showing its feature of a real “care revolution from the bottom” – this role was first acknowledge and then even supported. This occurred by means of a series of direct and indirect policy measures, including the implementation of local cash-for-care schemes (in addition to the already existing State attendance allowance), fiscal facilitations, training and accreditation programs.

It can be finally concluded that the strategic role MCWs have reached within the Italian LTC context is certainly related to the several positive opportunities made possible by their presence in terms of a more tailored home care, a reduced institutionalisation at an apparently reasonable price for all involved parties, including a re-focussing of formal home care services on most severe cases (Lamura et al. 2010). However, several challenges are raised at the same time in terms of care quality, possible undeclared work, exploitation and abusive situations, as well as in terms of care drain risks. With regards to the latter, it should not be underestimated that, especially in some Eastern European countries (Ukraine and Moldova in primis), many children are growing up without their mothers, working as MCWs abroad, becoming the so-called “orphans of migration” or “left-behind” children (Fellmeth et al, 2018). The paradoxical neglecting of natural children for seeking work in the care sector abroad has heavy psychological consequences for both migrant women and children, who much too often end up suffering from the “Italian syndrome”, a particular form of depression caused by multiple migration related shocks, such as separation, neglect and sense of guilt (IRS-Soleterre, 2015). For this reasons, the most appropriate approach to analyze a complex phenomenon such as migrant care work would necessarily include the consideration of pros and contras at micro (i.e. individual), meso (family/organizational) and macro (societal) levels in both source and destination countries (Lamura et al., 2013), instead of looking at it – as it is often the case in most Western European countries like Italy – only as a means to solve the care needs of our ageing societies.

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