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SOCIO-ECONOMIC LITERATURE REVIEW REPORT ON CARE REGIME AT COUNTRY LEVEL

ITALY

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Long Term Care policy and care work – Italy

1. Introduction

According to Eurostat (2023), with an average age of above 48 years, Italy has the fastest population ageing among EU countries followed by Portugal; outside Europe it is second only to Japan (UN 2022).
Population ageing is a long-term trend that reached his peak in 2020, when both the birth rate and the mortality rate were respectively the lowest and the highest ever recorded in the country (Istat 2021). The average number of children and death per 1000 inhabitants are respectively 6 and 12 (Istat 2023).
According to interpretation by the National Institute of Statistics (Istat 2021), the fear of contracting Covid-19 and national restriction policies both had negative psychological consequences on reproductive choices, and in 2020 there were 6000 births less than expected. Therefore, it is likely to conclude that, even if have not significantly accelerated the population ageing, the pandemic certainly did not interrupt long-trend demographic process. Indeed, in 2021 the dramatic increase in number of deaths caused by the pandemic outbreak was already diminishing (Istat 2021). In this context, contrary to popular belief, the migratory flows are still far from being able to counterbalance the loss of population (Istat 2023).
The individuals aged 65 or more is the 24.3% of the total population (14. 358. 000), while the so-called great elderly people (over 85 years old) are more than 4 million individuals. Interestingly, the median life expectancy is significantly higher among woman (84.7) than men (80.1) (Istat 2023).
However, while Italy has a high life expectancy rate, the healthy life expectation rate is still lower compared to other Eu countries (Domina 2023: 39; Istat 2021). In 2022, according to Istat (2023), almost half of the people over 75 years old reported multiple chronic conditions and almost one-third of those individuals is not autonomous (8,5% in EU).
In the past, families had to cope with elderly people that needed help with everyday tasks or a short-term intense assistance for a brief end-of life period. Nowadays, there is a growing number of older adults with complicated health condition which last for decades and that require assistance of increasing intensity. The increase in the participation of woman in the labour market and the disappear of extended families have contributed to create the contemporary care deficit (Bettio, Simonazzi, and Villa 2006).
Alongside the other Mediterranean countries, the Italian long-term care (LTC) system is sustained by informal care. The "familistic" care regime leaves most of the care arrangement to the families, that have relied on migrant workers to care for their oldest members (Bettio, Simonazzi, and Villa 2006).
The Italian care system relies on live-in migrant care workers from Eastern Europe, Northen Africa, and Southeast Asia– popularly called *badanti*[1]. However, more recently political

[1] *Badare* – is often used as a derogatory term even if some care workers – and employers too – do not necessary attach it a negative meaning (Diodati 2022). In contemporary discourse about the professionalization of care

authorities have fostered the creation of a formal care market and the number of not-for profit and for-profit companies that provide home-care services have grown especially from the first decade of the 2000s (Farris, Marchetti 2017: 121-122; Bihan; Da Roit, and Sopadzhiyan 2019). Nevertheless, with few economic resources allocated by the state and without the necessary regulatory intervention at the national level it is difficult to predict to what extent the institutional fostering of the formalization of the care market can meet the goals claimed by the political authorities.
The next sections will describe LTC polices and home care in Italy, focusing on: 1. Funding: the national Cash for Care measure (IDA), the Fondo Nazionale non Autosufficienza and the regional vouchers available for the dependant adults and family caregivers, including the few in-kind services publicly provided; 2. Regulatory instruments 3. Migration policy concerning home care workers and regularization trends; 4. Outcomes.

2. Funding: Cash for Care schemes and in-kind services

According to the calculation of Domina (2023: 20), Italian families spend almost 8 billion for regular domestic workers (housekeeper and care workers) and 7 billion for irregular ones. Domina estimates budget savings to the public pursue of more than 14 billion (0.5 % of Gdp). This is the amount that the State would spend if all the older adults were institutionalized.
Citizens can benefit from two main public subsidies: the national cash benefit scheme, IDA (Indennità di accompagnamento- attendance allowance), and multiple regional vouchers, which can have different amount as well as scopes and eligibility criteria.
As for the in-kind services, the nursing care, Adi (Assistenza Domiciliare Integrata), is provided by the NHS, while municipalities through the social services are responsible of a social care program, the SAD (Servizio di Assistenza Domiciliare).
According to Pesaresi (2023), the overall public expenditure for LTC was the 1.7% of GDP, of which approximately three-quarters was for people aged 65 or older: it corresponds to 32.4 billion of euro, of which 24.4 destinated to totally disabled older adults (Pesaresi 2023). Therefore, Italian public expenditure in Ltc is in average with the other European Countries (1.7% of GDP) (Pesaresi 2023).
Since the 1990s, LTC polices has been mainly consisted in cash transfers to citizens (Pavolini, Ranci 2008; Pavolini 2022). As Pavolini (2022) recently reminded, Italy is one of the very few EU countries that invest more than half of the total LTC national spending in cash-for care schemes (Cfc) for the purchase of private care.
According to Domina (2023: 166) – the National Domestic Work Employers Association – out of 33 billion: half (50.3%) is allocated to public subsidies given to beneficiaries without specific restrictions; 33.5% is allocated to subsidised residential care; only 16.2% concerns in-kind provision of home care.
However, except for IDA, the provision of subsidies is far from covering a significant part of the population. A recent survey conducted by a trading union of the employers to its

work, home care workers are generally called "family assistants" (*assistenti famigliari*) (Diodati 2022), even If, as we will see in paragraph 2.3, some regional care vouchers still use the word *badanti*.

members found that half of the respondents did not benefit from any form of public subsidy or in-kind service provided by the State or the regions (Censis-Assindatcolf 2022: 16).

Tab. 1 – Survey conducted by the National Trading Union of Employers of domestic workers on the beneficiaries of state and regional welfare programs for LTC [author's translation].

Support received	%
Geriatric programs and home visit	3.9
Adi	8.2
IDA	42.1
Other national subsidies	4.3
Regional or municipal subsidies	3.6
None of the mentioned options	51.2

Source: Censis-Assindatcolf 2022

2.1. "IDA"

In 1980, the government established IDA (Indennità d'accompagnamento) as the main welfare program for dependant older adults. In 1988 it was extended to all ages. Since then, it has remained substantially unchanged despite some attempts to reform its structure and scope. IDA is a public subside disbursed to eligible individuals with a complete and permanent disability. It is supplied by the National Social Security Institute (Inps). The amount has fluctuated around 400-500 euro per year. According to the Inps, in 2023 it reached 527 euros per month (which rises to 947 in the case of total blindness) (quoted in Ranci et al. 2024). In 2018, 70% of beneficiaries were people over 65 years old; 11,5% out of the population over 65 receive the IDA (Ranci et al. 2024). According to the assessment of the LTC Observatory of Cergas-Bocconi (Berloto, Perobelli 2019: 41), IDA corresponds to around one third of the total LTC settings for the people over 75 years old, despite important differences among the regions.

Different experts (Ranci et al. 2024; Berloto, Perobelli 2019; Gori 2012) have criticized the measure over time. Indeed, it is no means-tested and its amount does not vary according to the health condition of the beneficiary, and it corresponds to an isolate measure that is not linked to any in-kind service provided: individuals and their family still are totally in charge of the organization of care work (Ranci et al. 2024).

According to Ranci et al. (2024), even if it is a fundamental sustain for many poorer individuals and families, the measure has proven to be inadequate to address the care needs of older adults with the most serious health conditions, such as people suffering from late dementia, who require help for daily life activities and night supervision. Interestingly, contrary to the initial expectations in the 1980s, the public expenditure in cash benefits has gradually increased while the provision of in-kind services has fallen down (Gori 2012). Indeed, the number of IDA beneficiaries multiplied in the last 30 years. As Gori observed (2012: 261), in the first decade after 2000, "while the number of IDA users has increased by 75% (5.4–9.5%) [from 1980], the number of home-care users has grown only by 29% (3.8–4.9%)". Therefore, IDA has gradually absorbed almost half of the public expenditure in LTC, becoming the major national welfare program for dependant older adults even if it has

proved to be very expensive, unequally disbursed, and with a limited amount compared to care demand – as we will discuss in the next paragraphs.

2.2. "Fondo Nazionale Non Autosu fficienza"

Before discussing the vouchers that regional authorities disburse to citizens, we will briefly mention the *Fondo non autosufficienza,* a fund financed by the State and the regions for fostering local welfare program for individuals with sever disability or totally disabled citizens – *non autosufficienti*. The Fund was instituted in the 90s as a program that should have granted a basic level of assistance to all disabled citizens regardless of regional residency (Pelliccia; Guarna 2021). It was part of a general plan of sustaining home care and at the same time contrasting the territorial inequalities driven by the decentralization of the welfare state. However, in the following decades, the criteria used for the financing and allocation of the resources have limited the possibility of developing long-term welfare programs able to reach a significant part of the population. Indeed, the state expenditure depends on the annual law on finance, and the amount of co-financing is left to the discretion of the local authorities (Pelliccia; Guarna 2021). In 2018, the Fund constitutes only 1.6% of the overall public expenditure for LTC and it barely cover 15% of the social expenses for older and disabled adults (Pelliccia, Guarna 2021: 160). Rather than sustaining the provision of in-kind services for home care, regions used the Fund mainly to disburse cash benefits within the general LTC policy in the country, as we will see in the next paragraph.

2.3. Regional cash-for care programs and the care vouchers

Over the last thirty years regional authorities have disbursed subsidies to dependant older adults and families funded through *Fondo nazionale per la non autosufficienza*, regional programs created *ad hoc*, and the European Social Funds (ESF) (Pelliccia, Guarna 2021: 176). These cash benefits aim to promote ageing in places and, according to many scholars (Pasquinelli, Rusmini 2021; Gori 2012; Gori, Gubert 2021), they initially succeeded in allow Italian regions to cope with population ageing. Nevertheless, the cost of these programs has dramatically increased, and decentralization policy have raised the pressures on regions and municipalities for the provision of medical care and social services. Since the 1990s, national polices have fostered the decentralization of welfare services, increasing the financial autonomy of regions and municipalities. Local authorities have therefore gained independence in healthcare and social policy regulation. However, this shift has also increased the financial pressures on regions and municipality which must deal with the care demand of an aged population (Ferrario 2005; De Maria 2014). Alongside with economic crisis and austerity measures, this process resulted in widening regional disparities between richer Northern territories and the poorer Southern ones (Del Pino, Pavolini 2015).
In the last ten years, the sustainability of regional cash benefits seems particularly at risk; in many situations, regional authorities disburse subsidies to citizens which last for a short period of time (Pasquinelli Rusmini 2021)
It is difficult to estimate the coverage and effectiveness of regional vouchers because only few regions publish the data. According to the data available, only half out of the Italian regions provide vouchers restricted to the regular employment of home-care workers

(Pasquinelli, Rusmini 2021:105). Pasquinelli and Rusmini (2021) investigated the effectiveness of regional vouchers, concluding that only a small number of citizens benefit from them. Taking Emilia-Romagna as the most exemplificative case, which is the first region to have introduced this measure as well as one of the few transparent in the publication of data, the two authors (Pasquinelli, Rusmini 2021: 105) conclude that, as for care vouchers, beneficiaries in 2018 were only 2.646 against 6.400 beneficiaries of any regional voucher not subordinated to the purchase of home care, and against the 95.891 elderly people receiving IDA. Furthermore, in the overall period ranging from 2009 to 2018 the number of care vouchers beneficiaries fell from 4.846 to 2646 (Pasquinelli, Rusmini 2021: 105).

Tab. 2 – Regional cash bene fits for older adults who receive the support of home -care workers

Region	Eligibility and priority in access (Isee-Equivalent Economic situation Indicator)	Amount (per month)	Registration to regional lists of home-care workers
Basilicata *Assegno di cura di tipo B*	Isee 10.635 euros Priority in access: means-tested	300 euros	No
Emilia-Romagna *Supplemento all'Assegno di cura*	Isee 20.000 euros	160 euros (plus regional care voucher)	Commitment to training
Friuli-Venezia Giulia *Contributo per l'aiuto familiare*	Isee 30.000 euros	From 230 to 910 euro depending on health conditions, income, and care worker's working hours weekly hours	No
Lazio *Sostegno economico per l'assunzione di un assistente alla persona*	Subordinated to regional districts	Subordinated to regional districts	Yes
Liguria *Bonus badanti*	Isee 35.000 euro Priority in access: means tested	150 euro for those who already benefit from the regional program for *non autosufficienza;* 500	Yes

		euro for those who don't benefit from the regional program for *non autosufficienza*	
Lombardia *Bonus Assistenti Familiari*	Isee 25.000 euro	Max. 125 euro	Yes
Toscana *Buono servizio per l'assistenza familiare*	Isee 32.000 euro	From 400 to 700 euro, depending on economic condition	No

Source: Pasquinelli, Rusmini 2021: 105 [author's translation from italian]

2.4. LTC insurances

Private options to pay for LTC are not widespread in the country, The LTC insurances available mainly offer annuities and reimbursement rather than health and social care. They constitute only a small part of the total expenditure (Notarnicola 2019). However, according to Notarnicola from Cergas–Bocconi (2019: 61), the annual growth rate (above 10%) indicates that LTC insurances may play a significant role in the future care market.

2.5. In-kind services: ADI and SAD

As for the in-kind services, ADI (Assistenza Domiciliare Integrata) consists in free weekly hours of nursing care financed by the NHS and provided through the local healthcare units (Aziende Sanitarie Locali) – which are managed by the regions. It was introduced in 1990s and since then it has been the sole medical care service publicly provided to dependant adults living at home. To receive Adi, citizens must obtain the certificate of being total or partial disabled, and the intensity and duration of the service depend on the disability assessment even if its covering rate varies among regions. Contemporary estimates suggest that ADI reach only one third out of the individuals who need everyday care, even if the number of beneficiaries have doubled since the beginning (Ranci et al. 2024; Noli 2021). ADI provides an average of 18 hours per year to each older person; it is offered mainly for two-three months as a follow up care service after hospital discharges (Pelliccia 2022). As stated by Pelliccia (2022), "it means that totally disabled older persons who need to be assisted at home for years are excluded from this care service".
SAD is the social assistance disbursed by municipalities. It was born in the 70s to help older adults who did not require intense assistance. However, in the following decades the service has been too weak to respond to the increase in the number of seniors who lack of personal autonomy; families started to look for migrant care workers who became almost the sole providers of everyday care (Noli 2021: 35). Citizens must apply for SAD to the social services – managed by the municipalities, which oversee the assessment of the service, consisting in some help offered for activities as cooking and housework. Beneficiaries must share the costs and prices vary in accordance with their income and the rules set by the different

institutions. In 2017, only the 1% out of the individuals aged 65 and more benefited from SAD (Ranci et al. 2024: 4).
The small coverage and the split between medical and social care are the mains shortcoming of the in-kind provision of care in the country.

3. Regulatory instruments for home care

The funding channels outlined above are regulated through access criteria that are not very restrictive and uneven across the territory.
As for IDA, no formal restrictions are posed to beneficiaries in the usage of the subsidy. For this reason, trade unions of domestic workers, such as Domina (2023), state that IDA has fostered the irregular employment of home care workers.
For Gori (2012: 261), the increase in the number of beneficiaries can be explained by the fact that regions are not economically responsible for the provision of IDA, and therefore are incentivized to accept applications. To be eligible, citizens must be declared to be 100% disable and dependent by a health commission from the NHS, which is nominated by the regional authorities. However, "eligibility criteria are not homogeneous, and each Region has a specific dependency classification system taking into account mainly activities of daily living (ADL) limitations and to a lower extent instrumental activities of daily living (IADL) limitations" (Corbage, Montoliu-Montes, and Wagner 2020: 1132-1133)[2]. For example, in the Autonomous Province of Bolzano it represents the 10,72% out of the total public LTC settings, while in Calabria reaches the 51,27% (Belrloto, Perobelli 2019: 41). According to Cergas-Bocconi (Berloto, Perobelli: 2019: 41), Northern and Central-Northern Regions presents a more articulated offer of public medical and sociomedical services for dependant adults than Southern Regions, where LTC mainly consists in the informal care "driven by IDA" and provided by relatives and care workers.
Also with regard to the Fondo Nazionale non autosufficienza, according to Pelliccia and Guarna (2021), the allocation of resources to beneficiaries is not strictly subordinated to an evaluation based on patients' health and the costs for healthcare services. For these reasons, there is a high variability among regions in the eligibility criteria (the health conditions) and in the resources allocated to beneficiaries.
The regional subsidies include some care vouchers – differently named as *assegni di cura, buoni badanti, contributo per assistenti familiari* – subordinated to the regular employment of a home care workers with a regular permit of stay (Pelliccia, Guarna 2021: 176), that can be combined with IDA. Care vouchers can be disbursed alongside training program for home care workers, guidance desks for family caregivers, respite care services, and mediation services among families and care workers. In this form, care vouchers are ideologically driven by regional authorities' or health experts' discourses on "community

[2] According to the clinical assessment of disability, "the activities of daily living (ADLs) is a term used to collectively describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility [...] The Instrumental Activities of Daily Living (IADLs) include more complex activities related to the ability to live independently in the community. This would include activities such as managing finances and medications, food preparation, housekeeping, and laundry" (Edemekong et al. 2023).

caregiving": caregiving provided by the community itself but under the lead and supervision of healthcare and social services (Diodati 2022b).
However, the number of beneficiaries, the amount of benefit, and the criteria used for weighting the economic conditions of applicants often varies not only among regions but also at a sub-regional level. In some localities, where selection of beneficiaries is implemented by giving priority to those with the lowest income, it may happen that successful applicants may be excluded because the funds are exhausted: families are thus rather uncertain about the duration of the subsidy. In other regions, the small amount of the voucher is another critical point of these programs. These negative factors do not really stimulate citizens to opt for the regular employment of home-care workers through public (regional registers of qualified workers) or private channels (private or social agencies). Therefore, in many regions, as Emilia-Romagna, care voucher can be considered an important incentive for the purchase of regular home-care services, and a significant support to beneficiaries but with a limited coverage. In other realities, these programs are a small subsidy that cannot make any significative economic difference without a significative investment in tax relief for the employment of care workers (Pasquinelli, Rusmini 2021).
In March 2023, the national government introduced the "National System for Totally Disabled Older Citizens" ("Sistema Nazionale Anziani non Autosufficienti"), a national program to monitor and develop integrated interventions for this category of citizens. The bill planned two main reforms for home care (Ranci et al. 2024). The first intervention was the implementation of an integrated public socio-medical service for home care (ADISS) coordinated by local health authorities – NHS - and social services – municipalities, which should have replaced the medical service provided by NHS (ADI) and the social care provided by social services (SAD). The hours and the intensity of this integrated home-care services should have been based on the care needs of the beneficiaries. The second action – which was probably the most significative intervention - was the introduction of a universalistic cash benefit for totally disabled citizens ("Prestazione universale per non autosufficienti") to replace IDA (attendance allowance) (Ranci et al. 2024). This cash benefit should have been structured as a graduated cash transfer based on the health condition of the citizens, which allowed the beneficiaries to choose between receiving an economic contribution and the help of a care worker (in this case, the amount is higher).
However, as Pesaresi recently observed (2024), in the first months of 2024 the government introduced implementing decrees which substantially changed the reform. The implementation of an integrated network of public home care services was postponed to a subsequent negotiation between municipalities and national government (Pesaresi 2024). The decrees did not mention anymore the possibility of increasing the hours and the intensity of public home care services (Pesaresi 2024). The introduction of a universalistic cash benefit for totally disabled citizens was substituted by an experimental measure for the 2025, which should involve less than 30 000 of 1.5 million beneficiaries of IDA, and which should provide an average of 850 euro per month (instead of the 500 euros of IDA) without specific graduation made according to the health conditions of the beneficiaries (Pesaresi 2024).

4. Migrant care work: an ambiguous trend of regularization

The Italian care system relies on live-in migrant care workers from Eastern Europe, Northen Africa, and Southeast Asia. Italy is part of the so-called phenomena of global care chains (Parreñas 2021), in which migrant individuals (especially woman) from poorer countries compensate a "care deficit" in the country of arrival, caused by the population ageing and the increase in the participation of woman in the labour market. This process generates a subsequential care deficit in the country of provenience, filled by migrant workers from even poorer country. Bettio, Simonazzi, and Villa (2006) coined the term "migrant-in-the-family model" to describe how migrants from global care chains – most of them are woman – have allowed Italian families to carry on traditional obligations of caring for elderly people at home. Scholars sustain that Italian migrant policy has indirectly promoted the employment of undocumented care workers to provide population with a cheap and flexible workforce, which is also open to blackmail (Ambrosini 2013; Bettio, Simonazzi, and Villa 2006; Simonazzi 2009).

As highlighted by several scholars (Sciortino 2004; Bettio et al., 2006), Italy's migration regime, foreseeing a nexus between employment contract and residence permit, appears particularly restrictive in legal channels to enter for working reasons while being quite tolerant towards undocumented migrants (Da Roit, Weicht 2013; van Hooren 2012). This concretely produces a flexible and cheap labour force to be hired in low-qualified and low-paid jobs as domestic work. The recourse to undocumented migrants is the easier solution households find within the framework of Italy's DIY welfare (Borelli, 2020). Domestic work has been systematically excluded from the national quota system on legal labour migration[3], and migrant domestic workers usually come to Italy with a tourist visa staying here as undocumented immigrants for more than the three months envisaged by this specific kind of visa -which, anyway, does not allow for working. Domestic workers have thus been forced to regularize themselves via extraordinary amnesties which may occur even after 10 years from each other, being under the complete blackmail of their employers while waiting for the regularization[4].

The care regime has negatively affected all the parties involved: an increasingly older and dependant mass of individuals has struggled to find qualified care for their complex health condition; families have been overwhelmed by bureaucratic obstacles, care expenses, and the exhausting search for an adequate caregiver; unstable, poorly paid, and precarious working conditions resulted in many cases of anxiety, depression, and burn-out among live-in migrant care workers (Simonazzi 2009; Bettio, Simonazzi, and Villa 2009; Da Roit, Sabatinelli 2010; De Giuli 2010; Redini, Vianello, Zaccagnini 2020).

While care vouchers and regional registers of qualified workers pushes for regular employment, the current national legislation on migration and domestic work prevent

[3] Namely, the Government planning of the foreign workforce entitled to legally enter Italy for working in specific sectors characterized by labour shortage.

[4] The latest extraordinary amnesty has been released in 2020 duringCovid-19 pandemic to regularize domestic and care workers and agricultural workers. In 2012 and in 2009 there were other two extraordinary amnesties specifically conceived for migrant domestic workers, while in 2002 and in 2006 two extraordinary amnesties were issued for all migrant workers.

regularization trends from becoming structural. Many workers opt for irregular or partly irregular employment to preserve an already low salary from taxation. Despite the side effects in terms of social security contributions, labour rights, and safeguards for employers, it seems that for many people formalization is not a viable option.
Foreign workers make up 70% of the total workforce; the number raise 80–90% in the live-in sector, depending on the region (Pasquinelli; Pozzoli 2021). The application for regularization is complex and implies a long bureaucratic process. All the costs are covered by the employers, who are also legally responsible of the validity of every document and certificate submitted (Stuppini 2013). Hiring a documented workers without visa is a criminal offense also punished with significant sanctions (up to 5000 euros) (Assindatcolf 2022). The application for regularization presumes that care workers are still outside of Italy, and that families should hire them without having even met them (Stuppini 2013). Some employers prefer to rely on private companies or recruitment agencies but with a significant increase in the costs. The tax benefits and the tax relief for the regular employment are far from covering all the costs of hiring a full-time live-in worker (almost 17.000 euros per year) (Pasquinelli, Pozzoli 2021; Assindatcolf 2022). Furthermore, as already discussed, IDA and regional care vouchers have proved to be ineffective in producing long-term regularization trends.

5. Outcomes: the formalization of the care market and the public qualification programs

As we have seen, long term care in Italy is mainly entrusted to families. Some estimates suggested that in 2010 only 3% of the older adults lived in residential facilities (Triantafillou et al. 2010: 14). Public care homes are almost confined to the older adults with the most severe health conditions, they have huge waiting lists in all the country, and have a reduced staff compared to other residential services (Gori 2012; Guaita 2021). Indeed, Italy has one of the lowest number of beds in long-term care facilities in Europe (Guaita 2021).
This limited public service intervention is often delivered through social cooperatives that participate in public tenders. Due to the nature of the needs of the users targeted by these interventions, the cooperatives only have specialists in the health sector (Operatori Socio Assistenziali, OSA and Operatori Socio Sanitari – OSS). This implies that the home care services offered by the cooperatives refer exclusively to these services. *"We do not do intermediation, also because it is forbidden. Our mission is to offer work to our workers, and we do this through services. Our mission is not services, which are only a way to offer jobs. We do not offer carer services in the facilities where we operate, so even if we wanted to, we cannot make them available to individuals. There are discussions about introducing unskilled carers also in the facilities, for example, to help with meals. If this were to happen, then we could think about opening up the services of these workers to private individuals as well, but for the moment it is not possible"* (CAIDAI)
Even if the number of regular employments has risen in the last twenty years, especially for live-in care workers, undeclared workers still make up half of the total workforce (Domina 2023; Pasquinelli, Rusmini 2021). According to recent estimates, domestic care work is

responsible for 37.8% of the overall undocumented workers in Italy, which is a significant percentage of the irregularity rate (Assindatcolf 2022).
There are almost 1 million undocumented care workers and 894.000 regularly employed (Domina 2023). Italian workers generally consider the "24h care" as more suitable for migrant care workers, represented as woman with low expectations, whose husband and children live far away, and who desperately need to work (Diodati 2022). This popular belief is contradicted by young care workers who nowadays tend to avoid the live-in regime of care work (Domina 2023). While the percentage of male workers is increasing, still 86% of the total workforce are woman.
The regular employed increased due to lockdown policy and the Covid-related amnesty for undocumented migrants. During the pandemic, only workers with a regular employment contract were allowed to travel. According to Domina (2023), this measure and the Covid-related amnesty led many employers to regularize their care workers. Nevertheless, as underlined by Pasquinelli and Rusmini (2021: 8), "in the absence of significant national intervention there is a danger that we will assist to a strong coming back of the underground economy". This situation indeed occurred for the last amnesties. The regular employment rate reached the peak in 2009 with the amnesty specifically made for domestic care workers (Domina 2023: 118). However, in the following years this rate gradually decrease in the absence of structural measure for the regularization of care work (Pasquinelli, Rusmini 2013, 2021; Stuppini 2013). Indeed, many workers choose domestic care work as a fictive entry in the regular job market (Stuppini 2013; Domina 2023) because the costs for regularization was in fact lower in this sector (Domina 2023: 120). Furthermore, it is necessary to mention that families often declare a lower number of hours than those worked: according to Assindatcolf (2022: 11), it happens in almost 40% of cases. Even workers tend to prefer this option to benefit from tax-free income. Otherwise, the taxation would reduce an already low wage, especially for part-time employed care workers (Assindatcolf 2022).
Moreover, the wages are still low compared to the social significance of care work: only 10 % of care workers earn more than 12 000 euros per year and almost 50 % do not reach 6000 euros (Domina 2023: 114). Despite this, many families and individual struggle to cover the costs of care work.
These data can be explained by reconstructing the characteristics of the care services supply system in Italy. The Italian provision of care services has traditionally relied on a welfare mix-model, in which catholic charitable organization and other not-for profit actors have played a significant role. Since the 1990s, political authorities have promoted de-centralization policy of welfare provision through an ideology of community service and 'free giving' (Muehlebach 2012). According to some studies, these changes are part of a general policy trend in which political authorities aim to overcome the informal market to contrast the illegal employment (Farris, Marchetti 2017; Bihan; Da Roit, and Sopadzhiyan 2019). This governance of home care relies on the formalization – or, as some authors suggests, "bureaucratization" and "corporatization" (Farris, Marchetti 2017) – of the domestic and "familiar" private care through the market. Agencies and companies that provide home-care services or intermediate care services have grown in recent years. Authorities, owners, but

also some unionists claim that turning out to organizations and companies is a valid option for many reasons (Assindatcolf 2022; Censis–Assindatcolf; Diodati 2022b; Marchetti, Scrinzi 2014). First, ideally, customers receive support for all the administrative and legal issues of employment as well as a workers mediation service. Secondly, still according to this idealistic model, customers receive higher quality care because workers are selected for their emphatic attitude and trained by specific programmes for home care (Diodati 2022b). Even workers are encouraged to call on agencies rather than informal channels because agencies thanks to mediation services should protect them from exploitation and guarantees them better working conditions (Diodati 2022b; Marchetti, Scrinzi 2014). However, quantitative and qualitative studies (Censis–Assindatcolf 2022; Diodati 2022b; Marchetti, Scrinzi 2014) have cut back the ambition that not–for profit actors and for–profit actors are significantly ameliorating the conditions of families, workers, and dependant adult (Censis–Assindatcolf 2022; Diodati 2022b; Marchetti, Scrinzi 2014). First, fiscal regulations and migration policy still pushes many families and workers to opt for partly illegal or illegal options that drive them away from care agencies. It is also important not to overestimate the phenomena. A survey conducted by Assindatcolf (Censis–Assindatcolf 2022: 7) suggest that few families decide to turn out to recruitment agencies or other formalized channels, probably because these options are very expensive, and the available subsidies are far from covering the cost.

Tab. 3 – Selection channels used by families

Selection channels used by families for hiring domestic workers, care workers, and babysitters (%)	Domestic workers	Care workers	Babysitter
Word of mouth (family and friends)	76.4	70.8	61.6
Churches	2.0	5.1	3.4
Online platforms with free ads, newspaper	4.2	5.5	24.0
Recruitment agencies	4.7	16.1	14.4
Recommended by an already hired care worker or hired by someone of my acquaintances	19.2	16.7	6.8

Source: Censis–Assindatcolf (2022: 5) [author's translation]

Furthermore, qualitative research suggest (Diodati 2022b; see also Vietti 2019) that the formalization of the care market is still far from substituting a consolidated informal model based on word of mouth, family relations, friends, transnational network, personal reputation, and private negotiations within the household. As Amorosi states (2023: 473), Labour Market Intermediaries – which mediate the relationship between employers and employees: "Are not automatically drivers of domestic work's formalization […]". Moreover, employment and working conditions are not the same in all those agencies: "Top–level agencies respecting contractual provisions and ensuring good working conditions are still a minority" (Amorosi 2023: 473).

The digital platforms currently on the market do not hire workers directly. Some act as a showcase for adverts by carers or clients, without being registered as agencies and without intermediating the process. Others offer intermediation and to an extent declare that they are registered as authorised agencies, while in some cases they do not indicate this on the site.

As for the workers, they encounter several limitations in turning out to care agencies. Contrary to what rhetoric states, even in social agencies the recruitment of the workers may be based on ethnic and gender characteristics considered as the most suitable for caring work. The racialization of the workers may also include proper economic exploitation based on the reproduction of popular stereotypes about "docile" and subjugated migrants (Ascione 2012). Mediation can easily be resolved in favour to families and employers, while workers are generally in a weaker position (Ascione 2012; Diodati 2022). Furthermore, as Marchetti and Scrinzi (2014: 5) observed: in comparison to entering private employment with families, obtaining a job as a care worker in a cooperative is quite difficult for migrants, as this requires them to a professional qualification such as the OSS or ASA diplomas, and a good level of linguistic skills in Italian[5].

Illegal migrants or migrants who have recently arrived in Italy are excluded from this option. In the absence of a national regulation, training programmes offered by care agencies are generally only made up of abstract lessons on empathy and self-sacrifice with few practical guides on assistance tasks. They can also reproduce ageistic consideration of older adults and even proper racist and sexist consideration of care work (Diodati 2022b; Ascione 2012; Marchetti, Scrinzi 2014). Alongside care agencies, several regions have created registers of qualified workers, a system in which care vouchers are part of a broader program that includes support for families in finding a worker and in managing the employment relationship (see p. 2.3) (Pasquinelli, Rusmini 2021: 107-108). For example, Emilia-Romagna has relied on this model which implies an institutional governance of home care in which the supervision of social services and local healthcare services is stronger than in other regions (Diodati 2022, 2022b). Social services can suggest workers from the list, support the families with administrative tasks, and mediate the relationship among employers and employees (Diodati 2022). In some territories, local healthcare workers can be part of public training programs for families and workers (Diodati 2022). To be enlists in the registers, workers generally need to possess diploma, to do not be found of criminal convictions or pending criminal charges and, for foreigners, to have visa stay and possess an adequate knowledge of Italian (Pasquinelli, Rusmini 2021: 107-108). Workers also need to possess experience as home care workers; otherwise, they need to attend a training program which can also be part of the register (Diodati 2022b). The two major shortcomings of these programs are related to the financing mode and the lack of structural interventions. The programs are often funded by temporary financing, which limit the possibility of developing

[5] Oss (Operatore socio-Assistenziale) and Asa (Ausiliario Socio-Assistenziale) are two groups of providers that can work in hospitals and residential facilities. The training program for Oss is the only one regulated at a national level while regions and municipalities are responsible for training courses for ASA and home care workers (Pasquineli, Rusmini 2011). Unlike home care workers, OSS are fully recognized part of the NHS. They are included in the ADI (see the first paragraph) and are legally authorized to perform some nursing interventions, such as some medications (Pasquineli, Rusmini 2013).

long-term plans (Pasquinelli, Rusmini 2021: 109). Furthermore, the absence of homogeneous standard at national level for home-care workers – as it is for OSS and ASS – is a significant obstacle to the possibility of structuring training programs (Diodati 2022b; Pasquinelli, Rusmini 2013, 2021). Moreover, families and workers have still very often mutual convenience for undeclared work.

To conclude, this evidence calls on for the absence of a stronger role play by the State in the formalization of the care market, which implies the involvement of the healthcare and social services. The entrance of companies, NGOS in the care market alongside original regional welfare programs may fight against irregular employment, which, without doubt, seriously limits the possibility of ameliorating the conditions of workers, families, and dependent adults. However, without the national regulation, as we saw in the last paragraphs, the increasing marketization of private care tend to increase social inequalities, produce benefits only for a small part of the population, and generate limited regularization trends.

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