Chapter 11
Long-Term Care Italian Policies: A Case of Inertial Institutional Change

Giuliana Costa

11.1 Introduction

Even though the Italian social protection system has undergone some reforms over the last 2 decades (Ascoli 2011; Ranci and Migliavacca 2011), long-term care (LTC) issues have been systematically neglected over the same period. Welfare reforms in the 1990s focused mainly on the redesign of pensions schemes—including a shift to a contributory system—and partially on health policies, where instruments reflecting a "New Public Management" approach (i.e., adopting market-based principles; Ferlie et al. 2005; Jessoula and Alti 2010) were introduced. It is only since the beginning of the new millennium that LTC has entered the public reform agenda, when several national reform proposals were first mooted. However, the only public action specifically directed to address care needs over the last 10 years was the creation of a very modest and temporary "National Fund for Dependency" in 2007. Since then, two other measures have also indirectly offered some assistance to those with caring needs: the establishment of a national contract for homecare workers (including personal assistants) and the "regularization" (i.e., legalization) of migrants who wished to work as personal care assistants in 2009, as will be explained later on.

Sociodemographic trends clearly indicate that a new set of risks related to dependency and care needs has emerged in Italy. Indeed, the number of individuals and families affected by dependency is increasing. Nevertheless, LTC policies have not undergone explicit institutional change through legislation at the national level. The ongoing decentralization of social policies in Italy, even if potentially innovative in terms of responsiveness to growing social demands, has not been able to keep apace with growing LTC needs, which remain partially unmet.

This chapter sets out to describe and discuss the main features of the Italian "care regime" (Ranci and Pavolini 2008) and the LTC policy arena, clarifying what the opportunities and constraints for national and subnational LTC reforms have been. The central argument of the chapter is that a substantial inertia (in the context of huge societal transformations) characterizes this policy arena (Ranci and Pavolini 2011)

G. Costa (✉)
Politecnico di Milano, Via Bonardi 3, 20133 Milan, Italy
e-mail: giuliana.costa@polimi.it

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and, as a result, the LTC field has undergone only an "incremental institutional change" (Streeck and Thelen 2005). This interpretation of LTC policies trends is based on two interlaced phenomena. First, the core support tool for LTC needs in Italy consists of a cash transfer, which was introduced 30 years ago. It was originally devoted to adults with disabilities, but it is now almost completely used by severely dependent older people without any recalibration of its design. Second, Italian families are responding to the care needs of older relatives via a huge private care market that has developed without any substantial public-specific regulatory intervention to qualify, formalize, or finance it. The lack of any steering actions during the emergence and consolidation of the private care market, together with the absence of any additional public support for those with LTC needs, can be interpreted as an ongoing, partial, and gradual institutional change process. As a result, the Italian LTC system has evolved from a "familialistic" model to one where those with caring needs are obliged to simply "cope" through a mix of public and private resources within an overall "marketization of care" trend (Bettio et al. 2006).

11.2 The Italian Care Regime: Overloaded Families, Private Solutions, Public Absence, and Caregiving Gaps

Along with other southern Europe countries, Italy's care regime has been defined as "familialistic" since comparative studies have pointed out the strong role of family in the organization, provision, and financing of personal care (Bettio and Plantenga 2004; Naldini and Saraceno 2008; Ranci and Pavolini 2008, 2010). As a large body of research has shown (Eurofamcare 2006, Fujisawa and Colombo 2009; Österle 2001), care in Europe remains a "family matter": most care work is provided by family members and families have, even when public or private services are available, a pivotal role in care arrangements. What is peculiar to Italy and other Mediterranean countries is the assumption that families "are always there" and that they will provide all kind of resources, including care (Saraceno 2002).[1] Moreover, an "implicit familialism" (Saraceno 2010) is in place because the welfare system assigns significant caring responsibilities to families: the State intervenes only in limited, urgent cases. The scarcity of public services thus feeds back into the traditional Italian "care responsibility culture" (Titmuss 1973), whereby it becomes very difficult for family members to opt out of caring (Costa 2007a; Lewis 1993).[2]

If we analyze the caring arrangements of Italian families that have at least one older person, the extent to which care is a family issue becomes clear. Throughout all age groups (65+) and for a range of caring needs (from not dependent to severely dependent), most help and services-in-kind are provided by family members (*Istituto*

[1] As shown by Groppi (2010), this assumption is historically constructed: the "ideology of blood" is the outcome of a continuous negotiation between family and collective responsibilities with the intervention of the State or tribunals throughout the Modern Era.

[2] See how the responsibilities towards relatives stated in the Civil Italian Code are heavier as compared to other countries (Millar and Warman 1996).

Table 11.1 Percentage of Italian families with older people per type of help received (2009). (Adapted from ISTAT 2010)

Kind of family	Families that receive help	Informal	Private	Public	Mixed help	Families that do not receive any kind of help
With 65+	29.2	16.2	14.0	7.9	7.5	70.8
With 65+[a]	49.6	29.6	22.9	22.0	20.1	50.4
With 65+[b]	31.1	17.6	14.6	6.0	6.4	68.9
With 80+	45.0	26.0	23.6	13.2	14.8	55.0
With 80+[a]	61.5	37.1	31.9	27.6	28.0	38.5
With 80+[b]	43.9	25.4	22.2	9.2	11.2	56.1

[a]Severely dependent
[b]Dependent

Table 11.2 Caring arrangements of severely dependent older people receiving the IdA living at home and number of hours per week of care (2008). (Adapted from DaRoit 2008)

Caring arrangements	Percentage of severely dependent older people living at home	Number of hours/week of care received
Only informal care provided by family caregiver	39.8	90.7
Only public care services	0.8	13.9
Only private services	3.3	66.0
Informal care + public care services	11.3	92.9
Informal care + private services	29.6	119.5
Public care services + private services	1.8	103.3
Informal care + private service + public services	13.4	121.3
Total	100.0	102.4

Nazionale di Statistica [ISTAT] 2010; see Table 11.1). Along with this preeminence of family care, it is important to point out that a large part of the dependent older population, almost 40 % of families with an individual aged 80+, do not receive any kind of formal or informal help. The amount of help drops for those younger than 80 or with less severe autonomy limitations.

If we focus on highly dependent individuals aged 65+ who receive the LTC allowance "*indennità di accompagnamento*" (described in further detail in the next section), Survey data show that only 5.9 % of beneficiaries cannot rely on informal family care: the vast majority are assisted exclusively by a family caregiver or by a combination of informal care and public or private services (Da Roit 2008). In particular, see Table 11.2:

- Around 40 % of beneficiaries are only helped by family care givers for a total amount of 91 hours per week (an average of 13 hours per day!).
- Another 30 % are able to mix family care with private provision (mostly migrant care workers); this mix assures the highest number of care hours per week (119.5).
- Only 13.4 % of beneficiaries are able to rely on informal, private, and public resources.
- In general, public LTC services reach only a limited number of highly dependent individuals in receipt of an allowance (27.3 %), whereas almost half of the households utilize private paid care (47.9 %).

Some scholars have argued that the emergence of the private care market, made up of mainly foreign migrants, changed the nature of the Italian model of care with a "'transition from a 'family' to a 'migrant in the family' model" (Bettio et al. 2006, p. 272). In fact, the gap between the expanding demand of care services, the modest public LTC service provision and the reduced capacity of families to care on a long-term basis (as will be clarified further on) has largely been filled by low-cost care work provided by migrants. Carers are mainly women from less developed countries:[3] An old Italian word—"*badante*"—has been revived specifically to name those who "care/mind for" someone on a long-term basis. The growth of this private market is due to many different factors: the availability of a large immigrant female labor force, the scarcity of and difficult access to public personal care services, the traditional preference for caring at home, the increase of the female employment rate in the country, and finally, the availability of an adequate income by a significant proportion of the current generation of Italian pensioners (Da Roit 2007; Spanò 2006). Hiring a personal assistant is less expensive than other caregiving solutions and is also more flexible than availing of more formal services, be they private or public. Often, migrant workers in this field offer care 24 hours a day and are able to monitor the daily lives of frail older people at home. Employing a "*badante*" has turned out as a common, relatively reliable and "ready-to-go" arrangement, even for nonaffluent households. In general, migrant care workers are employed through the "gray" market without proper employment contracts being signed: therefore households can pay as little as € 700–1,200 per month for a "*badante*" (Pasquinelli and Rusmini 2010). Supply has also increased the demand in Italy (Colombo 2005). As shown in Table 11.1, more than 14 % of families with an older relative (aged 65+) employ a personal assistant and the percentage continues to grow within the older population. According to recent estimates, Italian families are spending around € 9.5 billion a year to pay for personal assistants (Pasquinelli and Mesini 2010).

However, if we consider the overall burden of care towards older people, it is clear that even with the entrance of "*badanti*" into the sector, a significant proportion of care is still provided by family members. Empirical evidence shows that personal assistants do not completely replace families in their caring activities. Instead, they are complementing them (Eurofamcare 2006; ISTAT 2010). Families provide the bulk of personal care and domestic help as well as health and psychological assistance. They also have a crucial organizational role in monitoring financial aspects and in coordinating different kinds of care resources. As already stated, the centrality of families (and private assistants) in care arrangements can be at least partly attributed to the low level of public provision of services and by weak entitlements related to caring needs (see next section). In Italy, care policies do not rely on actual, clear eligible rights. To be cared for is an "incomplete right" (Knijn and Kremer 1997; Leira 1993) because obtaining personal help is not legally enforceable.

[3] Typically, migrant care workers come from a relatively limited number of countries and geographical areas, which have changed over the last 15 years due to different migratory waves. Most of those nowadays working in Italy come from eastern Europe (mostly Ukrainians, Moldavians, and Rumanians). They are largely middle-aged women, often highly educated and ready to live at the home of the cared person in order to save money.

11.3 The Shaded Perimeter of the Long-Term Care Policy Arena

Like many western countries, LTC policies are not defined as a specific arena in the Italian welfare system (OECD 2011); instead, they are spread among different, uncoordinated policy fields and national, regional, and local agencies. Available data reflect this fragmentation and dispersion (Chiatti et al. 2011) and in turn make it quite difficult to obtain a clear, overarching picture of LTC interventions. Furthermore, LTC needs are not defined by any national law, which set out common criteria. Instead, each regional government has defined care needs in different ways and in different contexts, sometimes within regional laws, sometimes simply through administrative norms (Pavolini 2004). Differentiation in what is considered "dependency" in old age also exists at the local level. Only "severe handicap," "civil invalidity," and "being in need of the *indennità di accompagnamento*" are conditions defined by national laws, though dependency is assessed locally (by the "*Aziende Sanitarie Locali*" (ASL) the Italian local health services).

The Italian welfare system is strongly dualistic and is financially imbalanced in favor of cash transfers. Indeed, social assistance represents approximately 80 % of total public spending on social welfare. Cash transfers are normally regulated at the national level, while the few in-kind services are locally designed and provided. Dependence as a condition of LTC support is supported by the public system mainly through social care policies and partly by health policies, two arenas that in most regions are not integrated; as already underlined in the previous paragraph, home health services are organized by local health agencies, whereas social services are delivered by the municipalities. Homecare and residential services started to be developed by some municipalities in the 1970s outside of any national law or regulation. In the following decade, after the foundation of the National Health Service (NHS; law 833/1978), these services were strengthened in some areas of the country with different levels of integration between medical and social provision. The *National Plan for the Elderly* was delivered in 1992 but it was never fully financed, leaving the evolution of LTC services at the discretion of the regional governments and the local municipalities, which were responsible for the provision of those services. Thus, providing for those with disabilities and/or dependence has never been a specific national policy objective.

LTC services with a high health component are tax-funded (under the National Health Service). Only residential homes, which are organized and/or delivered by the ASLs and managed by the regional governments, are partly copaid by users. These homes offer not only residential facilities with different levels of medical services, but also day care centers. All service users also have access to the assistance provided by general medical practioners. Residential services are offered largely to the oldest, most dependent older people, or to adults with the most severe disabilities, who are generally coming to the end of their lives: a reason why they are considered nowadays as a "last option" to be used when all other arrangements are exhausted (Da Roit 2007). On the contrary, home health services cannot be fully considered LTC

Table 11.3 Coverage by the Italian LTC system (2008–2011)

Percentage of more than 65 receiving	Italy	Center-northern Italy	Southern Italy
Attendance allowance (IA; 2011)[d]	11.6	10.4	14.7
Social home care (2008)[b]	1.6	1.5	1.8
Nursing home care (2009)[a]	3.7	4.3	2.2
Residential and day care (2009)[c]	2.5	3.0	1.2

The figures of social home care (run by local authorities) and nursing home care (run by the NHS) cannot be simply added together because they partially refer to the same beneficiaries
Own elaboration from:
[a]*Ministero della Salute* 2011
[b]ISTAT 2011
[c]ISTAT 2012
[d]INPS 2012

supports because they are organized to provide medical, nursing, and physiotherapy interventions solely on a temporary basis for just few hours per week. The ASLs are responsible for assessing the degree of care needs of those who live in their area through a multidisciplinary team, to set a "personal care plan" for them. Normally, the evaluation processes are built on validated international multidimensional schemes.

Public support for LTC is funded through taxes and is managed directly both by the municipalities and by the central State. The municipalities offer mainly services in kind and, in the last 10 years, modest cash allowances. Social services in kind for LTC provide only a very modest level of coverage (see Table 11.3) and they are also locally fragmented. They consist of home care services, residential services, and day care centers. Homecare and residential care are normally means-tested because users contribute; day care centers are mostly accessed on a free basis. Each territory offers a very different care model in terms of the numbers of home visits, the qualifications of the staff, the number and kinds of services provided, and integration with other services. Eligibility criteria (including economic ones) are not homogeneous and are defined at the municipality level, in some cases following regional regulations. Municipal cash transfers are provided to maintain frail older people at home and are normally an alternative to services in kind. They consist of allowances devoted to family caregivers or to pay for private assistants on a strictly means-tested basis. Their amount varies from € 200 to 500 per month (Pasquinelli and Rusmini 2009) but their coverage rates are still very low, less that 1 % of the target population.

The main and most widespread support for LTC is the "*indennità di accompagnamento*," a disability benefit regulated by the central State, managed and paid directly to the recipients from the National Institute for Social Security (INPS). It is an allowance devoted to those who are assessed as completely dependent on a long-term basis by local health medical commissions, independent of their age and economic status. It is the only universal measure in the Italian welfare system especially designed for those who are severely dependent (in this case dependency means being completely unable to perform the basic activities of daily living without help). It consists of a flat rate allowance of € 480 per year (2010) and it is not graduated in

relation to different care needs. It can be used freely and there is no public control over its use. The medical commissions, which are the gatekeepers to access this measure, do not take into account any possible mismatch between the available resources (other economic means, family help, networks) and needs. Indeed, empirical research shows that it is frequently used to pay for some form of care, in most cases to integrate the cost of private assistants (DaRoit 2008).

Table 11.3 synthesizes the main figures related to the functioning of the Italian LTC system. The coverage level of the *Indennità di Accompagnamento* among the older population was equal to 11.6 % in 2011.[4]

It can be estimated that around 4.5–5 % of the older population in Italy benefits from public home care programs (1.6 % of home care provided by local authorities and 3.7 % by the NHS) and 2.5 % have access to residential care. Data for other European countries are different and often higher (see Chap. 2). Yet, if we differentiate between the coverage of LTC services in the center–north of Italy and in the south, we can see that the availability of services in the center–north is closer to central Europe (3 % coverage in residential care and around 5.5 % in home care), whereas the situation is dramatically lower in the south (1.2 % coverage in residential care and around 3.5 % in home care). The territorial divide in LTC availability is quite a specific and worrisome feature of the Italian system: also in LTC, as in other welfare services, we can describe the situation as consisting of "two different welfare regimes" (Pavolini 2011).

Other Italian LTC policies are even less well developed. There are no specific fiscal benefits for LTC expenses: a modest amount of contributions paid to regularly hired personal assistants can be rebated (around € 1,500 per year) and only 19 % of expenses devoted to buy vehicles and technological devices for disabled people can be deducted from the total amount of gross payable taxes. On the contrary, health costs are generally favored as they can be fully deducted from taxable income. No figurative contribution schemes are in place for those who leave their employment to care for someone on a permanent basis. The only benefit provided for working caregivers is 3 days' parental leave per month, offered to close family members who care for someone who has been defined as severely disabled according to the criteria reported in a national law (104/1992), assessed by ASL medical commissions.

According to available data in 2008, public spending on LTC represents 1.18 % of total GDP, around € 18 billion: 0.49 % of GDP is made up of NHS LTC spending; 0.56 % for the provision of the IdA; and 0.13 % for social care spending by the municipalities (Chiatti et al. 2010). Public spending on LTC grew by a modest 0.13 % from 2004 to 2008. Private spending on LTC (what families pay for personal assistants) has been estimated at around 0.59 % of GDP, equivalent to half of the total public spending on LTC (Pasquinelli and Rusmini 2009).

[4] Author's own calculation, based on the data provided on the INPS website.

Box 11.1 The Italian LTC panorama: actors, services and provisions, and funding

LTC actors	LTC services and provisions	Funding LTC
Ministries and national agencies regions	Health home services (ADI)	NHS (general taxation) regions
ASL	Social home services (SAD)	Municipalities (general taxation and local taxation), INPS (general taxation), users private resources
Municipalities	Residential services and day care centers (with different degrees of medicalization)	
Families	Cash transfers	
Third-sector organizations, for-profit organizations	Mediation services, tax credits	

11.4 Drivers for LTC Reforms

The ageing of the population, the shrinking care capacity of households and the rising social costs of LTC in old age represent potential driving forces for institutional changes in the Italian LTC system. Italy has one of the oldest populations in the world and, along with Germany, its ageing rate is the highest in Europe. The proportion of the 65+ population is, according to ISTAT (2009), 20.1 %, a value that grew by 37 % in the last 20 years and almost doubled in less than 50 years. In the early 1990s, there were 8.7 million older people living in Italy, which had risen to 11.9 million by 2008; a net increase of 3.2 million individuals (see Table 11.4). The ageing of Italy can be better understood by analyzing the evolution of those aged 74 and over: they represented around 3.9 % of the population in 1971 but 9.6 % at the end of last decade. Even if the "compression of morbidity" scenario (Baltes and Smith 2003) partially holds true for the Italian case (the older disability rate decreased from 21.7 % in 1994 to 18.8 % in 2005, see Table 11.4), the absolute number of dependents has grown and the qualitative composition of dependency has changed: the severe dependency rate (defined as being confined at home) is increasing. So, even if disability rates are decreasing for the whole population, the number of dependent individuals is growing and dependency, when present, is getting more severe.

These figures should be considered jointly with those related to demographic dynamics and structural changes in the female participation in the labor market. Analyzing the life course of three generations of Italian women at the age of 40 (see Table 11.5), it is clear that couples are having fewer children, usually at a later age, and more generations coexist for many years (ISTAT 2011).

More than 60 % of 40 year-old women are now in employment; this figure has doubled in 30 years. Nowadays, 51.9 % of the so-called "caring pool," represented by women aged 40–59, is in the labor force, compared with 39.5 % in the early 1990s. As household division of labor between men and women has not changed significantly over the same time period, care work by families, and particularly by women, can

Table 11.4 Ageing and dependency in Italy. (Adapted from Ranci and Pavolini 2011 from ISTAT [different sources])

	The 1990s	The 2000s	Variation over time	
	(1993/1994)	(2005/2008)	Absolute	Relative (%)
Number of older people (millions)	8.7	11.9	3.2	+36.7
Number of older people more than 74 (millions)	3.7	5.7	2.0	+54.0
Number of dependent older people (millions)[a]	1.8	2.0	0.175	+9.4
Number of dependent older people with severe limitations (millions)	0.7	1.0	+0.3	+35.6
Number of dependent older people with less severe limitations (millions)	1.1	1.1	−0.0	0
Disability rate among older people (standardized): general	21.7	18.8	−2.9	−13.4
Disability rate among older people (standardized): severe limitations	8.8	9.3	0.5	+5.7
Disability rate among older people (standardized): less severe limitations	13.3	10.3	−3.0	−22.6

[a]These numbers do not include older people living in residential settings

Table 11.5 Projected indicators for three generations of women at 40 years old. (Adapted from ISTAT 2011)

Year of birth	Average number of children	Average age at first child	Percentage of women who do not give birth	Average number of years coexistence with an older parent	Percentage of 40-year-old women in the labor market
1940	2.0	25	13	12	30
1960	1.7	27	13	18	50
1970	1.4	30	20	22	62

thus no longer be taken for granted. More Italian adult women are employed and are staying longer in the labor market because of the worsening of eligibility criteria for pension schemes and their late entrance in paid activities: this situation lowers their will and capacity to provide personal care, at least on a full-time basis. Even if families are "still there," their caring capacity has clearly decreased in quantity (Eurofamcare 2006): from 1998 to 2009 the total number of hours dedicated to adult personal care adults decreased from 759,000 to 730,000 (ISTAT 2010).

The last crucial aspect related to the growing demand for a wider reform in the LTC Italian system is the increasing economic impact of LTC needs. This kind of need has been identified as the second cause of household impoverishment after unemployment (Centre for Economic and International Studies [CEIS] 2009), not only because of out-of-pocket spending (to buy private services or to copay for public-regulated ones) but also due to costly family rearrangements. As a matter of fact, LTC

needs are facilitated less and less by health services, which are focused increasingly on acute conditions. The introduction of hospital reimbursement mechanisms, which has accelerated the discharge of patients, is a good example of the process that sees the embedding of LTC more and more into the social arena, delegating caring responsibilities to families and municipalities. Last but not least, it has been estimated that 2 % of the older population remains excluded from the IdA (Ranci et al. 2008), because, even if they are frail, they do not fit eligibility criteria, which are designed to facilitate physical impairment rather than cognitive or mental disorders.

11.5 Institutional Reform Attempts and Substantial Inertia: The National and Regional Levels

Many LTC reform proposals have been advanced since the "*Commissione Onofri*" was set up by the left-wing government to reformulate the Italian social protection system in 1997. This commission suggested redesigning invalidity pensions and benefits for dependent people with the creation of a ring-fenced "National Fund for Dependent People." This proposal was never put into practice and LTC issues were sidelined by government priorities until the beginning of this millennium when an important Act (328/2000) reframed the whole assistance system in Italy. Between 2001 to 2006, LTC issues received more attention from the Center–Right government with many technical and political (even bipartisan) proposals to innovate and fund the system (Gori 2008). Most of them focused on the following policy priorities: providing universal coverage for LTC costs (even with the introduction of homogeneous copayment formulas throughout the country), ensuring more coordination between health and LTC policy arenas, widening the take up rate of services, and developing more home care arrangements (in line with other countries in Europe; see OECD 2011). Some proposals were devoted only to those aged 65+, others to dependent people in general. Some of them intended to modify and to incorporate the available economic resources into a single fund on assignment to the IdA. However, none of the proposals were implemented mainly because of the absence of consensus on how to finance new schemes and because of veto players who resisted reforming the IdA, as will be clarified later.

Meanwhile, incentives for the development of national programs and ring-fenced resources decreased. In Italy, as in a large number of European countries, devolution, rescaling, and subsidiarization processes of public policies have been enforced in the last 2 decades (Kazepov 2008). The decentralization has not been supported either by the transfer of consistent national resources or by an increase in fiscal autonomy by regional governments. The redesign of the institutional architecture of competences towards welfare policies started with the above mentioned Act 328/2000. This law assigned precise duties to all levels of government (regional, provincial, and the municipalities), set specific instruments for social planning and created the National Fund for Social policies (FNPS) to finance basic services, which should have been offered all over the country, acknowledging the strong territorial differences in terms

of social infrastructures. A few months after the enforcement of the law (in 2001), a Constitutional reform delegated most of the responsibilities for social care to the regional governments and moved towards a more federalist structure of the Italian State. Regional governments now hold exclusive jurisdiction over social assistance policies, leaving to the central State the responsibility of fixing the "basic levels of provisions concerning the civil and social rights that must be ensured all over the national territory" (Art, 117, comma m, Title V of the Italian Constitution). Previously, regions already had large planning capacities in several matters but were strongly checked by (and dependent on) the central government through a system of fund transfers linked to specific aims (Arlotti 2009; Brosio 2003). The Constitutional reform attributed new tasks to the regional level. Such attribution of competencies has, nonetheless, been adequately supported neither by tax levy[5] nor by the fixing of the mentioned basic levels of provision, meant not only to protect the universal rights of citizenship but to ensure, at least up to such minimum levels, the funding of social policies by the central government. The resources of FNPS supposed to ensure the funding of social services are therefore transferred to the Regions without any central control over their final destination.[6] One of the consequences of the devolution enforced by the Constitutional amendment is that each region uses the assigned resources in accordance with its own standards and programs, eventually adding different amounts of their own resources and allocating them to the municipalities.

Such a standoff has to some extent been filled by regional initiatives. However, such initiatives have not been consistent and, in the decade following the constitutional reform, many regions—especially in the southern part of the country—have not been able to clearly define their own social care policies. This inertia towards LTC social policies can be attributed to many reasons. The first is that most available resources come from the municipalities (70 % on average; ISTAT 2009) while the funding from regional and national governments (like those of the FNPS) is more modest. Limited regional resources imply a low capacity to condition local rules. Another reason is related to very strong territorial differences, mainly between northern and southern Italy, both in terms of economic development and LTC services coverage rate (see Table 11.3; Costa 2009).

In 2007, the left coalition Government led by Prodi tried to introduce a reform for LTC, but the legislature was prematurely concluded and only a very modest National Fund for Dependency was created with the allocation of € 500 million (later increased to € 800) for a 3-year period (2007–2009). Thanks to an agreement signed by the regions, the Fund was confirmed for 2010 with an allocated budget of € 400 million but it has been completely cancelled for 2011 and onwards, in the context of a massive reduction of funding for all social policies (not only LTC ones)

[5] This is particularly crucial for social assistance policies because most of the regional resources are used to finance their health services. In any case, it is important to know that from 2001 onwards, the central State had systematically limited the mentioned Region's fiscal autonomy.

[6] The only exceptions are the funds related to the National Fund for Dependency (see later) and the Plan for preschool services, both implemented with the general annual budget law of the State of 2007.

due to austerity measures. Some regions decided to develop their own social policies in favor of dependent people, creating their own Funds in order to enlarge the coverage rate of territorial services, diversify the offer of services, or redesign the body of regulations (Cembrani et al. 2010). However, quite often the amount of resources in these regional funds was not able to overcome the shortcomings of the local LTC system.

11.6 Factors Leading to Institutional Reforms: The (Relative) Success of the "Indennità di Accompagnamento" and of Migrant Personal Assistants in Italy

We will now discuss the main elements and processes that have played an important role in creating the inertia surrounding LTC policies in Italy (Ranci and Pavolini 2011). They are basically related to the role played in the whole system by the IdA and the consolidation of a private and unregulated care market, as we have already shown. Paradoxically, the existence of the IdA can be considered as a factor leading to the inertia in the creation of wider institutional reforms of LTC in Italy. This cash transfer was launched in 1980 to compensate for the loss of economic income among those who were unable to work. After 8 years, it was extended to those aged 65+. Since then, an exponential growth in its coverage rate and a progressive ageing of its beneficiaries has developed. By means of demographic and epidemiologic changes, the IdA has completely changed its scope and use over the last 20 years, though there has been no revision of its eligibility rules, targeting, or the amounts granted. As shown in Fig. 11.1, the increase in the take up rate grew exponentially at the beginning of the 1990s, almost completely due to the entrance of older beneficiaries.

As shown in Fig. 11.2, the coverage rate of IdA rate among older people was 11.6 % in 2011, after rising rapidly in recent years (it was 6 % in 2000). In the same period, homecare and residential care did not increase by as much. The huge growth of IdA can be explained first of all by demographic ageing and, more specifically, the growth of the population aged 75+. In fact, the actual distribution of beneficiaries by age reveals that the IdA is mainly distributed to the very old: more than 50 % of the recipients are aged 80+. Other factors can explain the "success" of the IdA: a growing welfare consumerism, the lack of other public supports for LTC, the absence of universal income supports in the Italian welfare system, the availability of migrant women to perform caregiving tasks, and the separation of the IdA gatekeepers (regional governments, through their ASLs) and financers (the National State, through the INPS; Gori 2010).[7]

Despite being a universal measure provided to those who are assessed as dependent on the basis of (in theory) nationally defined criteria, there are markedly

[7] From 2011 onwards, the INPS imposed the presence of their own doctors in the Commissions to assess the needs of applicants in order to control the whole process from IdA applications to their payment.

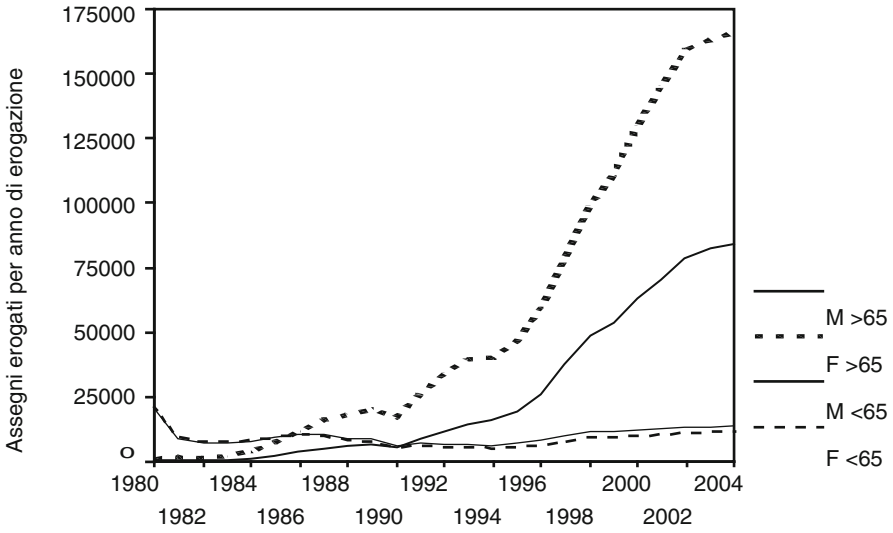

Fig. 11.1 Evolution of new yearly provisions per gender and age at the beginning of provision. (Adapted from INPS data, Ranci et al. 2008)

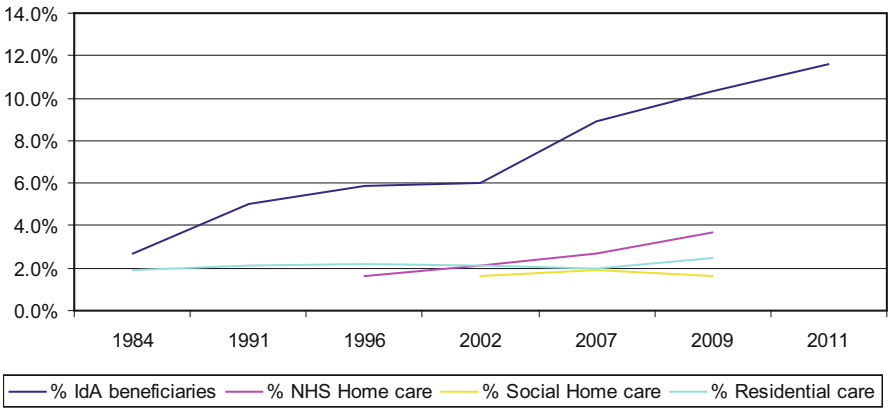

Fig. 11.2 In-kind services and cash programs for frail older people in Italy 1984–2011. (Adapted from Ranci and Pavolini 2011)

different take up rates of the IdA in different regions, which are not explained by differences in dependence rates (Table 11.3 already showed some of these features comparing northern and southern Italy). Calabria (15.6 %), Campania (15.0 %), Sardinia (13.9 %), and Umbria (18.2 %) are among the regions with relatively high take up rates. Between 2006 and 2010, the older population grew as a whole by 4.3 %, while older IdA percipients increased by 32.8 % (25.1 % among those aged 65–79 and 36.4 % among those aged 80+). It appears that some regions are using the IdA

more than others, as epidemiologic data cannot explain this level of heterogeneity. The last government, in power from 2008 to 2011, was relatively convinced that this heterogeneity in the territorial diffusion of the IdA was related to opportunistic patronage behaviors[8]: on different occasions during parliamentary hearings, the Minister for Labor and Social Affairs illustrated the strategy of the government in order to limit abuses in access to IdA through stricter control measures (including introducing sanctions for doctors working in the needs' evaluation commissions). Recent actions went in that direction with a massive campaign of controls performed by INPS during 2010–2011 on beneficiaries all over the country in order to cast some light on what seemed to be an uncontrolled device.

Italy spends more than € 12 billion on IdA (mostly for older people). Recent estimates indicate that economic resources assigned to the IdA can assure levels of coverage that are not far from those dedicated to LTC in other European countries (Ranci et al. 2008). Such an amount of resources cannot be ignored in reform hypotheses. In a context of budget restrictions, high fiscal pressures and "permanent austerity" (Pierson 2001), it is hard to finance a wider reform for LTC without including these huge (and growing) resources. At the same time, it is not easy to "touch" (a word frequently used in the current Italian debate) the IdA. Empirical research shows that most recipients spend the "*Indennità*" on some kind of care support (Da Roit 2008) and that the freedom of use they enjoy is highly appreciated. In a context of scarcity of public provision for LTC needs and of fragmentation and discretion in its management, the IdA constitutes the only certain and available public support for "ageing in place" (OECD 2003). For this reason, organizations for older people and those with disabilities formed longstanding advocacy coalitions (Sabatier and Jenkins-Smith 1993, Sabatier and Weible 2007) that have blocked any attempt to review and integrate this measure within other schemes, even continuing its pressing action for increasing public investments in LTC.[9] Finally, pensioners' trade unions and umbrella organizations for people with disabilities (*Federazione Italiana Superamento Handicap*, FISH *and Federazione Associazioni Nazionali Disabili*, FAND) lobbied in the same direction throughout the decade, united by the same objective. Adults with disabilities obtained much more than severely dependent older people in terms of services in kind (with growing coverage and diversification) but organizations for dependent people as a whole prevented the violation of what is considered as an inalienable right. As confirmed by some policy makers, observers, and activists,[10] "nobody wants to risk the certain for the uncertain even if the limits of the IdA are evident to everybody." As a matter of fact, the IdA is a flat rate amount, it can represent a good economic compensation for those who have less severe caring needs but it is insufficient for those who are completely dependent. Furthermore, no form

[8] Italy has a quite long story of patronage practices in the use of public benefits (see Paci and Ascoli 1984).

[9] As stated by Kingston and Caballero (2009), "existing institutions can affect the configuration of interest groups and their bargaining power, and groups with a vested interest in the status quo may attempt to block subsequent institutional change" (p. 173).

[10] Interviewed for this research.

of case management is organized around it: those who cannot rely on family helps are left alone to organize care responses by themselves. In this sense, the societal resistance to change the IdA regulation and functions can be seen as a constraint for reforms.

As illustrated before, Italian households are nowadays—and have been in the last 10 years—massively helped by immigrant women in assisting dependent individuals at home, mostly older people. These "private to private" arrangements have been called a "hidden welfare" (Gori 2002) because "it has worked" for many years without any public effort in terms of regulation. The relative success of this solution has not been addressed either by explicit or by specific LTC or family policies. At the same time, migration policies were not specifically designed for care workers, despite their growing numerical importance. The issue of the "*badanti*" has entered the Italian public debate very slowly, when they were already quite widespread and in a historical moment when the accelerated ageing of the population and the social risks involved came to the fore in the public agenda (mainly related to the pension system sustainability).

At the beginning of the 2000s, the Italian government was obliged to acknowledge the important social role played by the migrant care workers, thanks also to the lobbying made by an active advocacy coalition, consisting of a number of Catholic organizations as well as NGOs with a left-wing political orientation (Van Hooren 2008). But this acknowledgment deployed its effects only via migration policies through the introduction of preferential regular entrance conditions for care workers. No other support was introduced at the national level. To fully understand the implications of this reorientation in terms of gradual institutional change, it is important to briefly describe how immigration policies have been used in Italy. They are traditionally based along two different approaches. The first and more important one is immigration "amnesties" that have the aim of regularizing the legal position of illegal migrants already present in the country. Such amnesties occurred in 1986, 1990, 1995, 1998, 2002, and 2009. The second one is the definition of migrants incoming fluxes, defined year by year.[11] In the Bossi-Fini law of 2002, passed by a right-wing government, special and favorable conditions were set for the first time to regularize care workers, accepting the regularization of those who could prove to be at work in an Italian family. Fluxes for those who apply to enter in the country regularly as home or care workers have been widened as well. The acknowledgment of the importance of private assistants in coping with care needs (abundantly supported by media between 2002 and 2009) pushed the right-wing Berlusconi government to launch a special amnesty law in 2009 only for migrants who worked as carers. On this occasion, care issues were put on the agenda calling for public responsibilities once again (and more than in 2002) through a vivid debate on immigration policies. About 500,000 demands of regularization/legalization were expected but only 295,000 were presented and only 114,000 by carers and the families who hired them

[11] According to the present legislation, these regular fluxes are defined at national level by a decree every year (but based on a 3-year timeframe), with the help of local institutions and according to market needs.

(Pasquinelli and Gori 2009; Pasquinelli and Rusmini 2010). The context in which this special amnesty law occurred was the approval of a strongly contested security law to criminalize families and enterprises hiring undocumented immigrants. It has been estimated (Pasquinelli and Gori 2009; Pasquinelli and Rusmini 2010) that after the 2009 amnesty law, there were around 750,000 migrant care workers employed in Italian families, 46 % documented and with a formal contract, 28 % documented but without a formal employment contract, and 26 % undocumented and without any formal contract, which means that almost a half of the market is illegal.

Even though it has been argued that 2002 was a turning point year in policies towards "migrants who care" (Van Hooren 2008), the immigration policy pursued by the Italian government, based on ex post calls to regularize rather than a clear ex ante plan has helped the perpetuation of an irregular and cheap labor market because undocumented migrants cannot be hired with regular contracts (Bettio et al. 2006; Costa and Pavolini 2007). This policy to some extent fuels irregularities in the market. As a matter of fact, employed workers and employing families wait for amnesties to eventually regularize their position, because the present legislation encourages a sort of "abuse by necessity" (Ambrosini 2007). This is due to the fact that regular channels to include immigrants are quite ineffective in the care market, where face-to-face relationships are crucial. Because of Italian immigration laws, it is not possible to legalize the presence of an undocumented person if she or he is already in the country, employed or not. She or he must return to his/her country and await a call from his/her employer in order to stay in Italy and apply for a permanent residence and a work permit. Such a possibility has to be fitted into the formal immigration fluxes that are far from being sufficient to meet all the received applications. The only way to have a regular residence permit is therefore rather complicated and it is far from likely to ensure success.[12]

No efforts have been invested in connecting the IdA with this private market even if it is known that public money from the IdA feeds elusive and irregular practices. The only investment in the regulation of the specific market of care was the introduction of a *National Work Contract for Homecare Workers*, applicable also to care workers who are involved in other LTC activities, designed to fix minimum salaries and basic contributions, protection, and work conditions. However, this attempt to legalize such workers has had only limited success because, on one hand, there are still limitations related to regularly hiring an undocumented carer and, on the other, there are few incentives to formalize their employment: controls are quite modest and tax rebates on household services and personal care are very modest and not generous enough to compensate for higher costs emerging from the correct application of contracts, especially for carers working on a cohabitation basis.

The national inertia has been in some way filled by some regional and local administrations, which developed local policies trying to support care workers and family's needs (Costa 2007b). The most evident aims of these policies are the qualification

[12] In the Conference State/Regions, there are nowadays some proposals to separate fluxes for personal assistants from those devoted to other sectors applicants. This can be considered as another attempt to support what is considered to be a fundamental component of the Italian welfare system.

of care work and the improving of contractual relationships. To do so, they created special "public agencies" where families can find the right "migrant carer "; they created registers of "migrant carers" with certified personal and professional standards; they developed training courses devoted to those who wanted to be a personal carer; they tried to integrate personal assistants work with the support provided by formal services; and they provided means-tested allowances for those who hired personal assistants with a regular contract, paying part of or all their contributions costs[13] (Costa 2007b; Pasquinelli and Rusmini 2010). These local attempts to regulate and qualify the private market are very innovative and interesting but they are poorly funded and affect only a very small number of migrant carers and households.

In conclusion, it can be stated that public choices towards the regulation of this market over the last 10 years have been affected both by: (a) the rising demand of (cheap) care by Italian households and (b) the public sector that partially avoided the rising pressure for LTC services. The absence of explicit steering actions towards the emergence of a private and nonregulated care market can, to a certain extent, be interpreted as an intentional effect. In this sense, the success of the private market can be considered until now as an inertial factor in respect of a more compelling (for public finances) reform in LTC. But many observers argue that the "private way" for LTC needs is not sustainable for the future: in the next 20 years Italy will experience a shortage of people available to be home carers as this kind of activity will not be attractive enough for future migrant generations (Costa 2004; Mesini 2008); pensioners will get relatively lower benefits due to pension reforms and, last but not least, it should be remembered that the demand for personal carers is very elastic in relation to revenues (Ranci et al. 2008), which implies that inequalities in their use will be more manifest and perhaps no longer avoidable at a political and collective level.

11.7 Missing Reforms, Inertia, Future Trends, and Institutional Change in LTC

Huge social reorganization has occurred around LTC needs and dependency in Italy in the last 15 years. However, this occurred in the context of institutional inertia; thus, the LTC service provision system is nowadays almost the same as 2 decades ago. Trends in the different coverage rates show that the only public support that has accompanied the demographic and care needs evolution is the IdA. Moreover, the Italian care regime has been profoundly redesigned by the emergence of a private care market and the use of migrant care workers. The model of care experienced a transition from being "family-based" to a more mixed one, with migrants often living in the family home (Bettio and Simonazzi 2006).

[13] The Regions that have activated special cash allowances to support the regularization and qualification of personal assistants are Abruzzo, Emilia-Romagna, Friuli-Venezia Giulia, Veneto, Sardinia, and Valle D'Aosta. Their amount, duration, and economic eligibility criteria are very different.

Using the institutional change literature, the evolution of LTC policies at a national level in the Italian case can be interpreted as a case of partial and probably not foreseen "gradual transformation" (Streeck and Thelen 2005). This is because, institutions, to remain as they are, require active maintenance. They need to be reset and refocused and even in certain contexts more fundamentally recalibrated and renegotiated in response to changes in the political and economic environment in which they are embedded (Streeck and Thelen 2005). The disjuncture between social programs and changing profiles of social risk can result from natural trends or from political cultivation. How then can we interpret the Italian case? To what extent can the lack of strong and effective steering action towards LTC issues be intended as unintentional or rather as the result of rational action? Whatever the answer to these questions, it is evident that the existence of the IdA and the availability of (cheap) migrant female labor have led to the avoidance of further public investment into LTC.

Since LTC issues entered the public agenda, many projects have been drawn up to radically or partially reform the actual public system to support dependent people. Some of them planned to link the IdA (the bulk of resources devoted to dependence) to the services system, including the caring activities provided by migrant workers. Political instability as well as budget constraints and the action of advocacy coalitions have undermined any attempt to change the IdA regulation and at the same time have worked out an original (but problematic) solution to the need to use migrant workers to guarantee caring activities on a long-term or on an extensive basis. In the Italian case, it can be stated that some sort of universalism in cash programs (the IdA) has therefore paradoxically prevented any radical change in LTC policy. The societal rationale of not losing or even weakening eligible rights has made it very difficult to enlarge and differentiate public support for LTC needs in older age and has also led both public and private actors to focus on private solutions to the unmet care needs.

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