ESPN Thematic Report on work-life balance measures for persons of working age with dependent relatives

Italy

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Jessoula M., Pavolini E. and Strati F.
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Contact: Emanuela TASSA

E-mail: Emanuela.TASSA@ec.europa.eu

European Commission
B-1049 Brussels

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European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Summary / Highlights

In Italy the supply of long-term care (LTC) has traditionally been characterised by a highly selective public services system set against the considerable capacity of family (especially women) and kinship networks to internalise caring functions.

Since the late 1990s this configuration of care arrangements has been put under pressure by the ageing of the population and the increase in the female participation in the labour market.

The Italian LTC system is organized around two institutional pillars, based on different criteria for eligibility: cash allowances and services.

The *Indennità di accompagnamento* (attendance allowance - IA) is a nationwide universal measure, accessible to all citizens certified as totally dependent, independent of age. Its monthly amount is a flat sum equal to EUR 508. The IA can be considered as an allowance for the informal carer.

Home and residential care services are provided by municipalities for social care and by regions for health care – nursing is the most important form of carer's in-kind support. Local authorities have also started to develop respite support services and counselling services for families, especially to help them in the regulation of the private market of (migrant) care workers.

In addition to these two main pillars, carer's leave also plays an important role. The Italian care leave system is relatively generous and developed. It offers a combination of both short term leave for urgent cases and longer leave provisions. In particular the carer is mainly entitled to two different types of care leave: 3 working days of paid leave per month for short term leave; up to 2 years of paid leave for longer leave provisions in order to care for a seriously disabled child or relative.

Coverage and take-up rates through carer's leave and carer's cash benefits are relatively high, as are the economic resources dedicated to these programmes by the Italian State.

However, the provision of home and residential care services is limited to a very small number of people, if compared with most of the other Central-Northern European countries and other types of carer's in-kind services (respite, counselling, etc.) are scant compared to the requirement.

Overall the system based on leave and allowances, rather than services, seems to allow a certain level of reconciliation, but it also has important limitations.

In particular, the scant availability of services creates a greater strain on reconciliation compared with many other European countries and one of the main strategies for reconciling care and work for many households has been to use the cash allowances to access a peculiar type of private market, the (migrant) care workers.

Given these characteristics and the fact that in Italy the weaknesses of the system are not closely related to care leave and carer's cash benefits, but, above all, to the provision of carer's benefits in-kind and LTC services, three directions of change are necessary.

First, respite care and counselling services should be further developed and, in general, a more robust system of home and residential care put in place.

Second, reforms in this policy field should aim at changing the way resources are spent rather than adding new ones.

Third, the main cash allowance programme, the IA, needs new and more effective regulation.

1 Description of main features of Work-Life Balance measures for working-age people with dependent relatives

1.1 Overall description of long-term care regime

In Italy the supply of long-term care (LTC) has traditionally been characterised by a highly selective public services system set against the considerable capacity of family and kinship networks to internalise caring functions. For a long time these two elements have constituted the principal traits of what has been termed the Italian "familistic model" (Naldini M. and Saraceno C., 2008).

For many decades the poor provision of long-term care services did not constitute an urgent public policy problem as the strength of family-based intergenerational ties made it possible to absorb a large part of the emerging demands for care.

It is only since the late 1990s that the traditional familistic configuration of care arrangements has been put under pressure by the emergence of two new trends: the ageing of the population and a relatively sizeable increase in the female participation in the labour market.

Therefore it is not just the ageing of the population, but also the increasing difficulty of conciliating working and caring, in a context of unchanged family organisation, that has weakened the traditional intergenerational solidarity on which the Italian LTC system was historically grounded.

The national public welfare system has reacted to this crisis with institutional inertia. As opposed to the reforms in this field in most other European countries, in the last two decades Italy has not introduced any major reform in the LTC (Ranci C. and Pavolini E., 2012).

However, some policy changes have taken place in the regulation of traditional tools of LTC provision. Some of these policy changes have had an important impact in terms of outcomes, as will be shown below.

The Italian LTC public system is organised around two institutional pillars, based on heterogeneous criteria for eligibility: cash allowances and services.

The *Indennità di accompagnamento* (attendance allowance - IA) is the main universal national cash programme.

Service provision is based on regional and local welfare programmes, which include the provision of residential and home care, offered either by the National Health Care System (NHS) or the social services departments of Local Authorities. In addition to these two main pillars, carer's leave has been playing an increasingly important role (Section 1.2).

In 2014 around EUR 20 billion (equal to 1.28 per cent of the GDP) was spent by the Italian State on LTC provision, specifically addressing the needs of the elderly (Pavolini E., Ranci C. and Lamura G., 2016). Half of this expenditure was cash allowances (more precisely the IA) and the other half was delivered through services (mostly home and residential care).

Looking at what happened during the crisis years (Table 1), LTC public expenditure for services decreased slightly in real terms between 2005 and 2014, especially if we look at older people, the largest group of beneficiaries by far (for example elderly people represent around 78% of IA beneficiaries in 2014).

Table 1: LTC public expenditure for elderly people (65+) by type of provision (2014) in Italy

	Expenditure by source (%)		Variation of expenditure in real terms over time (%)		
Type	2005	2014	2005-14	2005-08	2008-14
Services (NHS and Local authorities)	53.9%	49.8%	+0.4%	+10.0%	-8.7%
Cash Allowances (CA)	46.1%	50.2%	+19.2%	+15.7%	+3.1%
Total	100.0 %	100.0 %	+9.2%	+12.6%	-3.0%

Source: Pavolini E., Ranci C. and Lamura G., 2016; Barbabella F., Chiatti C. and Di Rosa M., 2015

Strong growth (+10% between 2005 and 2008) took place before the crisis, but thereafter cuts were clearly implemented (-8.7% between 2008 and 2014). The cash allowance programme (IA) increased by 19% between 2005 and 2014. The IA growth was particularly robust before the crisis (+15.7%), but continued at a slower pace even after the onset of the crisis and the austerity plans (+3.1%). Therefore, compared with the years before the crisis, the LTC system seems even more cash-based than in the past.

1.2 Description of carers' leaves

The Italian care leave system is relatively generous and developed. It offers a combination of both short term leave for urgent cases and longer leave provisions. In particular Law No 104/1992 and Law No 388/2000 (and all the legislative changes made subsequently to these two Laws) define how and when workers with care responsibilities can have access to care leave. This care leave is fully compensated and receives pension coverage (pension contributions are paid during the care leave – *contributi figurativi*).

Care leave is granted only to workers who have to care for severely disabled relatives. Law No 183/2010 introduced the principle of "sole carer", which means that in a household no more than one worker can attend the needs of a severely disabled person. The carer is entitled to two different types of care leave:

- *3 working days of paid leave per month for short term leave.* Parents and close relatives of the person with the disability can access this, even when not living together with the person in need. The three working days can be taken in half days or on a piecemeal hourly basis, in order to tend to a relative in case of an emergency or to accompany them to medical appointments.
- *Up to 2 years of paid leave for longer leave provisions in order to care for a seriously disabled child or relative.* The leave was paid at 100% of earnings up to an annual ceiling of EUR 47,351 in 2014 (the annual ceiling is adapted over time according to inflation). Parents, close relatives and individuals with severe disabilities can access this type of leave. However, there is an important limitation to access to this type of paid leave: the family carer has to live in the same building as the person with serious disability. This disposition substantially limits the access to the paid leave only to co-resident working relatives caring for frail older people. The reason is that the regulation was initially designed for working parents with seriously disabled children. Only in more recent years with the transformation in social and health needs has it become important for family carers with frail older people.

Only public and private employees are entitled to these types of care leave. The self-employed and those employed in domestic and household services are excluded.

Although Laws No 104/1992 and 388/2000 define the two main care leave schemes in Italy so far, another important legislative initiative is being discussed in the Italian Parliament.

A bill is being discussed in the present legislature on "The recognition and support of care activities"[1]. It focuses in particular on family caregivers. The proposal intends to systematise and recognise the activities of caregivers in a more explicit and formal way than in the present legislation. Caregivers are defined as "individuals who take care in a continuously, voluntary and free way of a person for whom she/he feels affection who is not able to perform daily tasks by herself/himself". The family caregiver should be helped by a "support network" made up of social workers, nurses, general practitioners and voluntary organizations. The support should be based not only on services and care allowances but also on psychological and "relational" help (including self-help). The bill also favours early retirement for caregivers, especially for those who have difficulty in conciliating work and care.

The bill is important for the recognition and the support it wants to offer to care activities. However, it does not introduce any increase in economic resources for promoting family caregiving as is evident in the last article of the bill, the 8th, which explicitly states that no provisions have been made for additional costs to the State budget. The tight budget limits introduced in Italy with austerity measures since 2009-2010 help to explain the absence of specific economic resources.

1.3 Description of carers' cash benefits

IA is a nationwide universal measure, accessible to all citizens, independent of age (including children), certified as totally dependent. Its monthly amount is a flat rate equal to EUR 508.

What has remained unclear is whether IA should be considered as an allowance for the dependent person or for the carer. A judiciary sentence given by the "Court of Cassation" (*Corte di Cassazione*), the highest judicial authority in the Italian system, has clearly stated that: "the IA is a peculiar type of provision whose main aim is mainly to support the family of a person with severe disabilities in order to encourage her/his family members to take care of her/him and, therefore, to avoid access to residential care, helping also to reduce public LTC expenditure" (Sentence n° 1268, 21st January 2005). Therefore the IA can be considered as a carer cash benefit, although the legislation is not sufficiently transparent. Once the cash transfer is received, the beneficiary can decide how to use it. It can be used to pay for a professional carer but this choice is the beneficiary's personal decision, not changing the nature of the cash transfer from the State to the individual: where it is used to pay a professional carer, the beneficiary becomes the employer and the professional carer receives a wage. The amount of the IA (EUR 508) is not usually sufficient to pay an entire salary, in which case the beneficiary and their household have to use their own private resources.

The right to this allowance is guaranteed for those who are unable to walk and perform everyday tasks thus requiring continuous care. The programme is managed by the National Institute for Social Security (INPS), without any substantial coordination with local authorities' own care provision.

Although this measure was introduced in the 1980s primarily to help disabled youth, adults and their families, in the last 25 years there has been an unforeseen exponential growth of its use by the dependent elderly.

IA cash benefits are provided once health care authorities have certified the intensity of the disability of the beneficiaries concerned, but without any further request for those

[1] Proposta di Legge n° 3414, Chamber of Deputies: Disposizioni per il riconoscimento e il sostegno dell'attività di cura e di assistenza – 15th November 2015.

beneficiaries to be accountable. This means that frail elderly people and their households can use the monthly allowance without the need to justify to public authorities how it is used.

Neither the access nor the amount of social transfers related to the IA scheme is means-tested. The IA is provided only on the basis of disability intensity.

While IA guarantees a coverage level that is comparable to the benefits provided by national programmes in France (it is even higher than APA – the French "personalised allowance for autonomy") and in Germany, it is however less generous towards the most severely dependent as the amount offered is not related to the degree of dependency. In the two Continental countries, on the other hand, there is a diversification of provision according to the beneficiaries' level of dependency (3 levels in Germany, 6 in France). Secondly, IA consists solely of monetary transfers, while the scheme adopted in Germany allows a choice between money transfers, services and a combination of cash and care while APA is a voucher which the beneficiary can only spend by purchasing services in kind. Furthermore, IA does not involve any form of ex ante definition (or ex post control) on how the cash granted is actually used. Once the right of a citizen and her/his household to the benefit is recognised, it is given without any restriction placed on its use. IA can consequently be used to purchase services on the private market without restrictions and may indirectly encourage the growth of a care grey market.

In addition to the IA there are regional schemes offering cash and carer's allowances. However these schemes are not particularly widespread: only some regions have introduced them and only 0.5% of the population of 65+ years received them in 2012 (ISTAT, 2015).

1.4 Description of carers' benefits in kind

Home and residential care services, provided by municipalities (for social care) and regions (for health care – nursing) are the most important forms of carer's in-kind support. There are two main types of home care provision: support for daily living tasks (cooking, cleaning, etc.) and nursing activities. Residential care is mostly provided through nursing homes. In recent years there has been a broader diffusion of day centres.

The provision of residential and domiciliary services is very fragmented, as a result of the considerable division of responsibilities among local and health authorities. A good part of health services (hospitals and health home care) is offered almost free of charge, but it is strictly limited to medical and nursing services. Nursing home provision has co-payments, whereas social services are provided by local authorities on the basis of highly selective and extremely varied criteria of access.

Local authorities have started to develop respite support services and counselling services for families, especially to help them in the regulation of the private market of (migrant) care workers. In relation to the latter, there are many examples at the local and regional levels of counselling offices which are often managed jointly by the third sector and public authorities. They try to intercept the migrant care worker market and offer, on the one hand, help to households who need and want to hire a (migrant) worker. They provide them with information and cash allowances in order to foster the adoption of a regular labour contract. On the other, they help the workers themselves, providing them with information, training and support.

Although these types of services (respite support services and counselling services) are becoming more common, there are no statistical data available able to provide a precise idea of how widespread they are and how they function in general.

2 Analysis of the effectiveness of work-life balance measures for working-age people with dependent relatives

2.1 Assessment of individual measures

2.1.1 Coverage and take-up rates

Carers' leave

The National Institute for Social Security (INPS) provided information on the extent of carer's leave among private sector employees in Italy in 2014 (INPS, 2015). 293,770 cases of short term leave (3 working days of paid leave per month) and 38,865 cases of longer leave provisions (up to 2 years of paid leave) were financed. Looking at the characteristics of the beneficiaries, it is clear that practically all of them have open ended working contracts and that there are only a few workers with fixed-term contracts.

The data from the Department of Public Administration (*Dipartimento della Funzione Pubblica*) shows that around 10% of public sector employees had access in 2014 to the short term leave schemes (including also workers with severe disabilities) for a total amount of 6.2 million working days[2].

The amount of resources dedicated to this type of provision is significant. Battaglia (2014) estimated an overall public expenditure of around EUR 1.6 billion for carer leave by workers in the public and private sector in 2011.

Carers' cash benefits

IA beneficiaries grew strongly over time in terms of coverage: 6% of elderly people and relative households received it in 2002 and around 13.5% in 2014[3] (see below: in the same timespan home care increased from around 3-4% to 5% and residential care remained substantially stable).

There are at least two reasons behind this increase in coverage. Firstly, the change in the nature of dependency needs (with a relative shift from less to more severe forms of disability) had a significant impact on the growth of those eligible to access the programme. Secondly, the limited presence of services put more pressure on families to ask for this type of cash provision.

Carers' benefits in kind

The provision of home and residential care services is limited to a very small number of people if compared with most of the other Central-Northern European countries (Ranci C. and Pavolini E., 2012). In 2013 around 5% of the elderly population benefited from public home care programmes and around 2% were in residential nursing care (Barbabella F., Chiatti C. and Di Rosa M., 2015). This data can be contrasted with that from other European countries: around 7-8% receive home care in Germany and France; around 5-6% receive residential care in Germany, France and the UK (Ranci C. and Pavolini E., 2012).

The fact that residential care coverage is relatively low also creates more pressure on public home care provision as it means that in Italy many (severe) cases, that elsewhere would be treated through different forms of residential care (last stages of Alzheimer or other forms of dementia, etc.), are left at home. In addition respite care is not widespread in the country either. This means that the majority of the elderly in need of care at home have often severe disabilities.

[2] http://www.funzionepubblica.gov.it

[3] Data were retrieved at the INPS website (www.inps.it), statistical database (*banche dati statistiche*).

With regards to home care there is not only an issue of coverage but also of intensity. In 2013 health home care covered 4.3% of the population of 65+ years, but at the same time it provided a *yearly* average of 21 hours of care (Ministry of Health, 2015)[4].

Moreover there is a strong differentiation in coverage rates between Northern and Southern Italy, with the former showing rates often twice as high as the latter (Pavolini E., 2015).

2.2 Assessment of overall package of measures and interactions between measures

In order to make an overall assessment of the impact of these measures on the participation of informal carers in the labour market and on their well-being as well as on that of the people with disabilities, it is necessary to make a distinction between direct and indirect effects.

2.2.1 Direct effects

The direct effects regard informal carers. The system based on leave and allowances, rather than services, seems to allow for a certain level of reconciliation, but it also has important limitations.

There are several elements which help reconciliation: firstly the opportunity to have access to a relatively generous short term leave scheme (3 working days per month, available also on a piecemeal base); secondly the possibility of longer leave, albeit with limitations for carers with elderly parents, accessible only if they are co-resident with the frail older person; thirdly the IA allowance.

Leave schemes can be obtained only by public and private sector employees: Italy is characterised by a high percentage of self-employed workers (they represent around a quarter of total employment among those aged between 50 and 64 years).

Moreover the amount of IA is relatively low (around EUR 500 per month), given the average high disability level of beneficiaries, nor does it provide the dependent elderly or the carer with an adequate support. Nevertheless it does paradoxically limit the risk of entrapment for the caregivers. The monetary incentive to leave work is often simply too weak to have an effective impact on the labour strategies of caregivers.

However, the scant diffusion of services creates a greater strain on reconciliation than in many other European countries. Naldini, Pavolini and Solera (2016) show that among working women in their 40s and 50s, with caring responsibilities toward their parents, around 14% of them have reduced or given-up labour-market participation in Italy due to reasons related to coping with informal elderly care for their parents.

This percentage is around 5% in Scandinavia and around 8% in Western European Continental countries (e.g. France, Belgium, Germany, etc.). It must be added that the majority of these working women shift from full-time to part-time (in around 58% of the cases) instead of giving up work completely. In this sense the opportunity to shift to part-time seems fairly prevalent.

Nevertheless 6% of women in Italy gave up work entirely in 2008 in order to take on care duties: the same figure is 1.5% in Scandinavia and 3% in Western European Continental countries.

These results can be partially explained by the intensity of care provided on average by Italian working women. The European Quality of Life Survey for 2012 shows that around 15% of working women in Italy declare they are involved in caring for their elderly or

[4] Data were retrieved at the Health Ministry website:
http://www.salute.gov.it/portale/ministro/p4_9_0_1.jsp?lingua=italiano&categoria=Assistenza_sanitaria&menu=ministeroSalute&id=144.

disabled relatives at least several days a week, whereas the same data at the EU-27 level is 11% (EQLS, 2012).

More specifically, looking at working women aged 35-49 and 50-64, this percentage rises respectively to 16% (around 11% in the EU-27) and to 22% (around 14% in the EU-27).

The fact that Italian family caregivers have more difficulty in conciliating work and family life is also confirmed by Table 2. The table reports the author's own elaboration from EU-LFS 2005 and 2010 microdata on the ad hoc modules on reconciliation between work and family life. It reports the percentage of women employees with caring responsibilities toward relatives/friends aged 15 or over in need of care, who are able to access flexible working times (see the definition at the bottom of table 2). The Italian percentage increased from 46.2% in 2005 to 57.5% in 2010, but it remains lower by around 12% than the average in Western Europe (EU15), where it was 69.2% in 2010.

Table 2: Access to flexible working times for female employees with caring responsibilities toward relatives/friends aged 15 or over in need of care (% among female employees with caring responsibilities toward relatives/friends aged 15 or over in need of care) (2005, 2010)

	2005	2010
Italy	46.2%	57.5%
EU-15	66.3%	69.2%

Definition of flexible working times: the employee can have access either to part-time or can vary start/end of working day for family reasons (at least one hour) or can organize working time in order to take whole days off for family reasons (without using holidays)

The table focuses only on caring responsibilities toward relatives and friends aged 15 or over because it would have been difficult to differentiate between children under 15 with general care needs related to their age and children under 15 with also disability care needs

Source: own elaboration from EU-LFS 2005 and 2010 microdata on the ad hoc modules on reconciliation between work and family life

2.2.2 Indirect effects

In order to understand how families cope with caring responsibilities in Italy, it is fundamental to also take into consideration another type of strategy adopted by households. Given the growing difficulty of directly providing care and the weakness of public provision, a substantial proportion of households with frail elderly turned, in the last two decades, to a peculiar type of private market: care workers that are often migrants.

The phenomenon grew fast because even though care work is increasingly provided by ethnic minorities in many European countries (Williams F., 2013), it is particularly widespread in Italy. In 2013 there was an estimated presence of 830,000 paid care workers, 90% of them migrants, mostly working on an individual basis in frail elderly people's homes and very often without any specific formal training in LTC activities (Pasquinelli S. and Rusmini R., 2013).

The recourse to individual care assistants is highly competitive in terms not only of costs but also of flexibility of working hours and services. Families do not seem to place excessive importance on the workers' professional qualities (Costa G., 2012), while they mostly value the discretionary use they can make of these assistants and the absence of specific contract rules.

The practical absence of administrative controls contributes to the high amount of irregular work in this field. The rate of irregular jobs in the "domestic services" sector is estimated by ISTAT at 64% (ISTAT, 2015a).

The phenomenon taking place in Italy does not really seem to be a marketisation of care, but more an adaptation and extension of the informal family-based model to critically

changing conditions in family arrangements and the presence of public policies that indirectly continue to foster a familistic model through cash measures.

Italy faces a transition towards an 'Italian way' of privatisation of care, which is based on: a) a high incidence of paid carers who live together with the frail elderly, bringing elements to the work relationship that are not typical of employment contracts (co-residence); b) a very high level of irregular employment contracts; c) strong complementarities between the use of private paid carers and the informal care supplied by relatives of the person with severe disability.

2.3 Policy recommendations

In Italy the weaknesses of the LTC system and of the measures taken to reconcile the work-life balance for people of working age with dependent relatives are not very closely linked to care leave and carer's cash benefits, but, above all, to the provision of carer's benefits in kind and LTC services.

Respite care services should be further developed. In general, a more robust system of home care and residential care is required in order to match the needs of the frailest and to support their relatives.

This is particularly the case where there is limited informal care support or when home treatment for someone with a complicated health status is simply not feasible.

Reforms in this policy field should aim at redistributing resources rather than adding new ones: the main debate over LTC in the last few years has concentrated on the possible introduction of income criteria (means-testing) in relation to the access to the main cash allowance programme, the IA. Such a choice seems to be necessary and it could allow the redistribution to lower income beneficiaries of part of the resources now spent on higher income beneficiaries or it could strengthen home and residential services.

Moreover, there are two additional important shortcomings of the main cash programme, the IA. Firstly, the absence of any accountability requirements for beneficiaries giving rise to the proliferation of an irregular care market; and secondly that benefits are provided on a flat rate basis. This means that there is no differentiation on the basis of the severity of the disability as is the case in most other EU countries such as Germany – which has a three-tier system - or, for example, France, England and Spain. What is required is the development of a system where the generosity of provision is differentiated according to the level of disability.

Counselling services to support families, as well as more training activities and support for private migrant carers, should also be strengthened, given the diffusion in Italy of this type of care market.

In relation to care leave, the two main shortcomings are the absence of coverage for self-employed workers, who represent around a quarter of all employed, and the limited access for working children and relatives of frail elderly to long term leave (given the rule of co-residency at least in the same building written into the norms governing access to this benefit).

To sum up, the Italian LTC system has invested a significant amount of resources in fostering reconciliation between family life and work but has obtained less positive results than many other European countries.

A) The role of uncontrolled cash allowances (e.g. families spending the allowance in the grey market of migrant care workers), B) the relatively limited diffusion and coverage of professional (residential, home and respite) services, C) the diffusion of migrant care work (often irregular), D) the absence of any "selective universalism" to partially restrict cash allowance access to those in need both in terms of dependency but also economic resources, are elements that reduce the cost-effectiveness of the whole system, and make reconciliation more difficult for family caregivers.

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