Caring for non-self-sufficient older people in Italy: from a familistic system to the immigrant live-in careworker model

Cuidar de idosos não autossuficientes na Itália: de um sistema familístico ao modelo de trabalhador corresidente imigrante

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ABSTRACT
The aim of the article is to describe the specificities of the aging phenomenon in Italy and the social policies for non/self-sufficient elderly people, highlighting both the change from a model that relied heavily on a family system to a model based on co-resident immigrant workers to care for the elderly, and the contradictions of this new model. While in Italy the percentage of older people and very older is the highest in Europe, social policies for them involve a limited offer of home and residential services and widespread allowances. At the same time, in Italy, the rise of the aging population has been intertwined with the transformation of family structures, the increase of female employment, the lower capacity of families to take care of their non-self-sufficient relatives, and the improvement of older people's economic conditions. Due to these changes, a new care model has been established

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in the past two decades, based on the employment of live-in caregivers, usually immigrant women, so-called '*badanti*', who are hired and paid by the caretakers and their family. This model has led both caregivers and caretakers to experience a double dependency and a double solitude, which question its sustainability and the familistic nature of the system. This paper presents both demographic and economic data from institutional sources, and the regulatory framework on social policies, and, finally, the data that emerge from various research on immigration.

Keywords: Older people; social policies; familialism, immigrant women; informal care models.

RESUMO

O objetivo do artigo é descrever as especificidades do fenómeno do envelhecimento em Itália e as políticas sociais para pessoas idosas dependentes, destacando a mudança de um sistema em que o apoio a pessoas idosas era prestado essencialmente por familiares, para um modelo em que o apoio é assegurado por pessoas imigrantes, que em muitos casos passam a residir no domicílio destes idosos, e as contradições que este novo modelo encerra. Apesar de em Itália a percentagem de pessoas idosas ser a mais elevada da Europa, é possível constatar que as políticas sociais de apoio à população idosa são limitadas, quer no que diz respeito a serviços de apoio domiciliário quer na atribuição de subsídios. Simultaneamente, em Itália, o aumento da população idosa tem estado interligado com vários fatores, nomeadamente a mudança nas estruturas familiares, uma maior integração da mulher no mercado de trabalho, a menor capacidade das famílias para cuidar dos seus familiares dependentes e a melhoria das condições económicas das pessoas idosas. Devido a estas mudanças, nas últimas duas décadas foi estabelecido um novo modelo de cuidados assente na contratação de cuidadores em permanência no domicílio, geralmente mulheres imigrantes, as chamadas "badanti" que são contratadas pelos cuidadores informais e seus familiares. Este modelo levou tanto os cuidadores como as pessoas idosas a vivenciar uma dupla dependência e uma dupla solidão, que põe em causa a sustentabilidade desta solução e a natureza familiar do sistema. O documento apresenta dados demográficos e económicos de fontes institucionais, o enquadramento jurídico das políticas sociais, e por último, dados de vários estudos sobre a população imigrante.

Palavras-chave: Pessoas idosas; políticas sociais; familialismo, mulheres imigrantes; modelos de cuidados informais.

1. Introduction

In the last few decades, all Western countries have faced a constant increase of their aging population, yet this increment has not been homogenous.

In Europe, in January 2019 the average ratio of the population aged 65 and over was 20.3% (Eurostat, 2020), but the percentage was 14-15% in Ireland and Luxembourg, 18-20% in Austria, France, Great Britain, the Netherlands, Spain and Sweden, and over 21% in Germany, Greece, Portugal and Italy, which is the 'oldest' country with 22.8%.

On top of these contrasting figures, the differences among European countries are even more significant in terms of the strategies used to tackle the aging phenomenon and the increased need for care. Central and Northern European countries have mainly developed home and residential services, while countries in Southern Europe have first delegated the responsibility of non-self-sufficient people to their respective families and then adopted a model based on the employment of immigrants, the so-called 'badanti' (Esping Andersen, 1990; Saraceno, 2008).

The aim of this essay is to analyze the Italian situation, with regard to the demographic and health aspects related to aging, as specifically discussed in the second paragraph, and with regard to public policies related to the older population, as described in the third paragraph. In the fourth paragraph, the rise of the 'badanti' model is discussed to highlight how this model is connected to the increase of non-self-sufficient very older people, a higher female employment rate, better economic conditions of older people, but also to the limited development of home and residential policies combined with the availability of immigrant workers (especially women) as live-in caregivers.

In the last paragraph, we highlight both the positive aspects and the challenges of the 'badanti' model. Among the positive aspects, we emphasize the economic gain for the workers and their home countries profiting from their remittances, and the social gain for the assisted older people and their countries that are not yet required to develop appropriate policies for non-self-sufficient citizens. At the same time, there are economic challenges for the older people and their families and social challenges for these immigrant workers who give up a normal family life and for their home countries that are deprived of family caregivers.

In a comparative perspective, the conclusions point out how this model is contradictory and hardly sustainable in the long run. In addition, the 'badanti' model also questions the traditional distinction between countries with a strong welfare state and familistic countries, defining a 'third' way for both immigration and emigration countries. In the former, the family becomes the 'director' of the care system. In the latter, emigrant people improve the economic conditions of their family while dismissing the care commitment towards them.

In both countries, this model affects responsibilities and family roles and has very little in common with the traditional familistic model.

For our analysis, we refer to the regulatory framework and public policies concerning the older population in the last decades, socio-demographic data collected by ISTAT (National Institute of Statistics), data on pensions and household income of older people, and research studies on both older people and 'badanti'.

2. Aging, poly-pathologies and dependency

In 2019 in Italy, the ratio of citizens aged 65 or older was 22.8% (17.6% in 2001 and 13.2% in 1981), the ratio of those aged 85 or older was 3.6% (2.1% in 2001 and 0.8% in 1981), and the forecasts for 2050 are up to 34% and 7% respectively (ISTAT, 2020). This means that in a 40-year time frame, the relative share of the older population doubled, and the share of the very older population increased fourfold (Mazzola et al., 2015).

This increase can be related to the strong decline in the birthrate that has been registered in Italy since the 80's, which has resulted in Italy being one of the countries with the lowest rate in Europe with 1.3 births per woman. In the meanwhile, the improvement of life expectancy has been even more relevant, now standing at 80.8 years for men and 85.2 years for women, in comparison with 77.2 and 83.2 in 2001 and 71.1 and 77.8 in 1981 (demo.istat.it) respectively.

As these data highlight, the aging process has been characterized by two factors in the last decades: gender differentiation (favoring women) and the increase of very older people, or rather, people aged 80 or older.

Suffice it to say, in 2000, the ratio of living people aged 90 years and over was 14.7 for males and 24.3 for females, while in 2018 it was respectively 30.2% and 39.5%.

While the increase of the older population affects the social system altering the ratio between working people and retired people (Natali, 2011), and more generally the consumption patterns, the particular increase of very older people, and particularly very older women, has a very strong impact on the welfare and healthcare systems.

Although the health conditions of older people, consistent with the age group, have improved compared to the previous decades, the specific increase of very older people tends to entail growing pathologies and loss of self-sufficiency (OECD, 2018), which eventually leads to an increasing need for healthcare services and other personal care assistance (Blangiardo and Pesenti, 2017), posing a major challenge to families and public policy makers.

As far as Italy is concerned, the latest ISTAT data (ISTAT, 2018) show that over 11% of the older citizens (1.4 million people), mostly over 75, report serious difficulties in at least one daily activity of personal care such as dressing or undressing, cutting and eating food, lying down and getting out of bed or sitting and getting up from a chair, using the toilet, and taking a bath or a shower.

The number of people in difficulty increases even more when considering daily domestic activities (such as preparing meals, using the telephone, shopping, taking medication, doing light or occasional heavy housekeeping, and managing one's own financial resources): almost one third of the over 65s and almost half of the over 75s have serious difficulties in doing at least one such daily activity. As a re-

sult, 58% of the older population with serious difficulties need assistance in their personal care activities (Guerrini, 2019; ISTAT 2019b).

At the same time, in older age groups, women are more frequently affected by various diseases, with the exception of heart diseases and diabetes mellitus, which mainly affect males. The higher prevalence of chronic polypathology in women, and especially of diseases such as osteoarthritis and osteoporosis, which have a high impact on mobility and functional autonomy in general, is also the basis for the higher rate of disability and dependence of the older female population (Facchini, 2016). The consequence of these trends is that while men at 65 have a life expectancy of 19.4 years and women of 22.9 years, the life span that is usually not burdened by any limitation is equal to 10.4 years for the former (similar to the average in Europe), and 10.1 years for the latter (slightly worse than the European average) (Rapporto Osservasalute, 2018).

3. Italian public policies for non-self-sufficient people

In Italy, certain features of aging are particularly accentuated: higher life expectancy, a higher rate of older people (and especially very older people) and a higher rate of loss of self-sufficiency; however, the problems that this country is facing are very similar to those of other European countries, which are all engaged in problems related to the aging process and in the emerging needs associated with the increase of people with ill health conditions and limited self-sufficiency.

Nevertheless, there have been several response strategies. Since the 1980s, the Central-Northern European countries have already developed substantial home support services and/or residential/semi-residential structures (Rodriguez et al., 2016; Gori, 2017). On the contrary, Southern European countries (Italy, Greece, Portugal and Spain) have long delegated the burden of care of the non-self-sufficient older persons to their families and, in recent decades, to private players and, more precisely, to people (mainly immigrants) hired as domestic workers with tasks ranging from nursing and personal care to housekeeping. Another specific characteristic of this model is represented by the cohabitation of the worker with the person cared for.

Even among the Southern European countries, Italy embodies a specific case. Despite having rates of access to home-care services and hospitalization in residential facilities close to those of the other countries, it offers substantial financial support in cases of non-self-sufficiency.

Before discussing financial concessions, it is advisable to give an overview of home and residential care services. Both fall under the competence attributed by law to the Regions, with a consequent geographical differentiation in terms of regulations on access, allocated resources (Network Non Autosufficienza 2017), and,

therefore, their rate of use by older people, which is higher in the North compared to the South.

Home services include both the Home Assistance Service (Servizi Assistenziali Domiciliari – SAD) and the Integrated Home Assistance Service (Assistenza Domiciliare Integrata – ADI).

SAD has a purely social welfare nature and offers support for daily life activities and personal care to partially self-sufficient and non-self-sufficient older people. It is a service provided by municipalities (based on regional indicators and available resources) and performed either by city employees or by staff contracted out to third parties; access to it is also subject to assessments of economic and family conditions, which are carried out by social workers.

ADI mainly involves healthcare services (injections, catheter replacement, etc.) and it is provided by the National Health Service and is managed by Local Health Authority units. As this is a service with a health purpose, it is not dependent on income or family conditions.

The percentage of older people (over 65) who benefit from these services is 5.8% for the ADI, and 1.6% for the SAD (ISTAT, 2019a). In both cases, the data show a remarkably low average use: for the ADI less than 20 hours per user per year (Barbabella et al., 2017); for the SAD, given that the average annual cost per user is about 2,000 euros (ISTAT, 2019), we can assume an average of 3-4 hours per week, which can unlikely cover the different needs of the older person who requires them. For both, but especially for the SAD that depends on the finances of the municipalities, there are also significant geographical differences, with higher rates of use in the northern regions compared to the southern regions (ISTAT, 2019c).

Residential care ranges from social-care structures to healthcare structures that allow for hospitalization (temporary or permanent) of older people in facilities that differ by management type (public, private or accredited-private), and by the extent of care intensity (self-sufficient, partially self-sufficient and non-self-sufficient).

The fee component that is assignable to the 'health' cost is covered, on a lump-sum basis, by the public, while the 'hospitality' part is borne by the patients or their families, unless they have a low income and the Municipality intervenes. The most recent ISTAT research study on residential structures (2018, 2015 data) shows that there are about 288,000 older people living there; more than half of them are over 85 years old and three out of four are women. That is to say, almost 3% of the older population live in a residential structure — about 4% in the North, and less than 2% in the Centre and in the South (Pesaresi, 2009). This rate is similar to the one recorded in the 1960s, when extended families, in which several generations were living together, were much more widespread; this suggests that, even if this co-res-

idency model has disappeared, families continue to play a decisive role in taking charge of those who are no longer self-sufficient. On top of these services, there are structures for intermediate care that include high intensity care services provided by non-health structures. Stays here are of a temporary nature, and the main objective is to guarantee functional recovery (after hospital discharge), or to prepare to return home. They are managed by the National Health System and their use is therefore not conditioned by income or family conditions.

With regard to financial support, there are two types.

On the one hand, there are financial allowances (cash or in the form of vouchers) of a variable amount, which are provided by the municipalities to allow the user to buy on the market the social or health services they need, according to the overall budget of the municipality and the number of applicants. The assessment is made by the Social Workers who, on the basis of the levels of autonomy, income and family conditions, decide the amount provided. The percentage of older people who benefit from these contributions is about 0.5%.

On the other hand, there is the 'Accompanying' allowance paid by INPS (National Institute of Social Security, the key Italian authority in charge of the pension and welfare system) in case of 100% 'civil' invalidity. Beneficiaries show a 'need for continuous assistance not being able to perform daily life activities'. The assessment is carried out by a medical team and access is not conditioned by specific income or family conditions; it is also provided for hospitalized patients, unless they are totally dependent on the public; the amount is the same for all and it is currently € 515 per month.

Given its characteristics, this allowance does not concern the older citizens only, even if they account for about 70% of the approximately 2,000,000 allowances paid. That is to say, there are about 1,400,000 older citizens who receive this support, which represent just over 10% of the whole older population (Jessoula et al., 2018). This is a higher rate compared to other European countries that provide similar forms of financial support for non-self-sufficient people (France, Germany, Spain, etc.) but the amount varies depending on income, family conditions and the way the allowance is spent (Da Roit & Le Bihan, 2019).

In 2018, the overall economic expenditure totaled 13.6 billion — equal to 0.8% of GDP.

Because the use of this allowance depends only on non-self-sufficiency, there is a very clear relationship with the age group: the rate of use is in fact about 3.4% in the 65-75 and 11.1% in the 75-84 years age groups, and almost 39% among the over-85s (Pelliccia, 2018). Also in this case, the majority of those who use it are women.

For both economic supports, there are significant geographical differences: the support provided by the municipalities is used more in the Northern Regions; the

'accompanying' allowances, provided by INPS, which is a national body, are instead more widespread in the Central and Southern regions.

However, the data show that the 'accompanying' allowance has become, at least for the last 15 years, the main tool to support the care needs of the older population in all areas of the country (Ranci et al. 2019), and contribute to reduce the risk of poverty, along with the improved working histories of the current older population (much better protected compared to those of previous generations) and the characteristics of the pension system (on average more generous than in other European countries) (INPS, 2018; Ragioneria Generale dello Stato, 2018).

In this regard, it is sufficient to mention that the ISTAT report, 'Poverty in Italy' (ISTAT, 2017), shows that the population aged over sixty-four years has the lowest percentage of families in absolute poverty compared to other age groups, going from 6.1% in 2006 (equal to about 707,000 older citizens) to 3.8% in 2016 (about 508,000 older citizens).

While in 2005 almost half of absolute poor people (44.9%) were older people, in 2016 only 17% were aged 65 years or older. Similar considerations can be made with regard to relative poverty, which takes into account the size of the family and its overall income; its incidence rate among the older population has, in fact, fallen from 13.8% in 2005 to 8.2% in 2016.

This does not mean, obviously, that the older population is protected from the risk of poverty, but that this phenomenon has changed: from a widespread phenomenon to a problem linked to precarious work histories and/or to specific conditions, such as non-self-sufficiency. Another research (Luppi, 2018) seems to validate this hypothesis, showing that older people with a moderate or severe degree of non-self-sufficiency have a higher probability of living in a family with an income below the poverty line.

4. The 'live-in careworker' model

The lack of public policies in terms of home and residential services and the substantial improvement of the economic conditions of the older citizens are two of the elements underlying the rise, in the last two decades, of the 'live-in careworker' (in Italian *badanti*') model, which is marked by the cohabitation of the older person and the carer (female in the vast majority of cases – 90%) and by a full-time commitment, at least generally, throughout the day and week (Da Roit & Facchini, 2010; Rusmini, 2019).

A third element is embodied by the social changes that have occurred in the past decades, which have affected family networks, women's employment and cultural models.

First of all, the declining number of children per woman, which in Italy began in the '60s and has been accentuated in the last decades, has led to a decrease in potential caregivers: if on average a woman who had reached the age of 80 years in 1980 could count on 5.4 children (including sons and daughters in law), an 80-year-old in 2010 can count on 4.4. This means that a growing number of older people (especially in the North where the birth-rate has started declining earlier) have few children to rely on and that an intensified demand for care is directed at a reduced number of potential caregivers. At the same time, as stated above, in recent decades the presence of extended families has decreased, while there has been an increase in the number of older people (especially women) living alone.

Secondly, although Italy is one of the European countries with a low rate of female employment, in recent years it has grown. In particular, the employment of women at an older age has increased, as a result of the greater involvement of adult women in the labour market in the previous decades, and the regulatory changes in the retirement age that have particularly affected the female population. Eurostat data show that, between 1995, 2005 and 2015, in Italy the employment rate of women aged 55-64 years rose from 13.5% to 22% and 36%. Therefore, there is an increase in the number of mature women (who have older parents, often non-self-sufficient), who have to reconcile employment, domestic work and their 'own' family care, which are still substantially performed by women. Hence, they tend to reduce the size of care support for their parents.

Finally, it is reasonable to believe that, even in a society traditionally focused on family solidarity, new social norms and cultural models are emerging (Leitner, 2013), which are much more based on targets of self-realization rather than on 'family duty' and willingness to provide 'direct' and continuous care (Gaymu et al., 2008).

Although it is not possible to establish the specific role played by the factors outlined above in the way the older citizens are supported, an historical comparison between different ISTAT surveys shows that, in fact, there is a downsizing of the informal aid received by older people. In 1990, about 20% of families with at least one older person still received unpaid personal care assistance, but by 2009 this rate had fallen to just over 15%. If we consider the families with at least one member aged 80 years or older, the rates go from almost 40% to just over 20% (Da Roit, 2017).

In the face of these 'endogenous' elements, the rise of the 'live-in careworker' (*badanti*') model has been strongly facilitated by an 'exogenous' element, which is the process of globalization that has occurred in the last two decades. The crises that have involved Latin America, the collapse of the social systems in Eastern Europe and the unprecedented possibility for their citizens of emigrating have

increased the number of people (especially women) available for domestic and nursing work in foreign countries (Ehrenreich & Hochschild, 2003; Catanzaro & Colombo, 2009).

The growing employment of immigrant live-in careworkers can therefore be traced back to the intertwining of the following factors: the increase in care needs due to the increase in the number of non-self-sufficient older people and very older people; the decrease in care services carried out by families; the lacking development of public policies for home and residential care; widespread economic support for non-self-sufficiency; and the availability of emigrant women to perform care work in other countries.

In Italy, this care work is carried out, in almost all cases, by women mostly from specific countries: Philippines, Peru and Ecuador, Belarus, Moldova, Poland, Romania and Ukraine). It is a job characterized by a considerable variety of wages, working conditions and heaviness (Da Roit & Facchini, 2010).

As far as wages are concerned, the average is around €1,100 per month, but the range varies significantly from €800 to €1,500. Above all, on the one hand there are situations characterized by a regular employment contract, and therefore by the payment of taxes, 13th month salary, paid leave and severance package; on the other hand, there are situations without a regular employment contract and therefore with less contractual protection (Ambrosini, 2018).

Also with regard to the heaviness of the job, the research shows a broad variety, which is related to the diversity of health conditions of the older person cared for. The large majority of cases is characterized by an average problematic situation. More specifically, there are two key extreme situations: older people with extremely compromised health conditions and a very high dependence, in terms of motor functions and/or cognitive functions, and older people who are substantially autonomous and for whom the presence of a person living at home works as a basic support and reassurance for the older person and their families. It follows that the burden of work can be very heavy in case of very limited autonomy (especially with cognitive problems), but more similar to generic domestic assistance and presence when the older person is instead substantially autonomous.

If the health and self-sufficiency conditions of the older person are very heterogeneous, their family type is more uniform, given that, as a rule, they are single — often female — older people, who are widowed or unmarried.

At the same time, while most '*badanti*' have a room at their disposal (in many cases even with a private bathroom), some have to sleep in the living room and therefore do not have any private space. What is interesting to note is that the salary and even more the contractual protections and the availability of private space seem to depend more on the socio-economic conditions of the older person

receiving care, than on their health conditions and the heaviness of the commitment required.

However, as undeclared work is frequent and about 80% of older people own their own home (and therefore do not have to pay a rent), it can be considered economically sustainable to employ a '*badant*' combining a modest pension, the 'accompanying' allowance and a small economic support by the children (Da Roit & Facchini, 2010).

Because of the substantial presence of undeclared work, or 'partially-declared' contracts, it is not possible to make accurate estimates. The data provided by INPS for 2017 indicate a total of 864,526 people insured under the domestic work or family care contract: 393,000 as '*badanti*' (90% of whom are foreign) and 469,000 as domestic workers (with a substantial, even if lower, presence of immigrants). Estimates on the spread of the phenomenon range from 800,000 to 1,500,000 (Censis, 2015), but it is reasonable to assume that the total number of '*badanti*' does not exceed 1,200,000 or 1,3000,000. Almost half of them are without a regular employment contract — or with a contract that underestimates the actual working hours commitment (Barbera et al., 2017).

Bearing in mind that some of these workers can assist two people at once, the number of older people over 65 who are cared for by an immigrant live-in careworker is certainly higher than the sum of older people who are cared for at home with SAD or ADI (a total of less than 700,000) and those who are cared for at residential facilities (a little less than 300,000).

On the whole, the '*badante*' model has represented a significant change to the traditional image of Italian families, and in particular of the daughters, who take care of their older person. At the same time, this is a solution that has avoided tackling the problem and taking charge of non-self-sufficiency in an innovative way by strengthening social services: a way, therefore, of maintaining a household-centered model even during the downsizing of the care work carried out by families.

5. Positive factors and critical aspects of the immigrant live-in careworker model

The development of this model of care is apparently a winning strategy for all stakeholders: for the older person and their families, for the '*badante*', and for the countries involved.

For the former, the '*badante*' is a valid alternative to both direct support from the state, and the use of residential services, which are usually more expensive and have a negative stigma, in the Italian cultural model, as they commonly imply poor living conditions and no family to care for their older people. Moreover,

there are no 'waiting lists' to respect and the times to find a carer are short, given the continuous availability of immigrant women to do this job. Besides, if you do not feel comfortable with the chosen person, you can easily look for a replacement. Finally, the fact that most of the caring takes place at home means that the older people feel less abandoned and their family feel less guilty for not taking care of them personally.

For immigrant workers, this work is, particularly financially advantageous because it does not require special training, and because, as you usually live with the 'employer', board and lodging are free. In fact, living together allows them to send most of their salary to their family (often in their country of origin), thus overcoming specific economic problems or achieving particular objectives (the purchase of a house, university for children) in what can be defined as 'purpose-emigration'.

For the countries of immigration, this model has reduced the pressure of the demand for social welfare services and has procrastinated the need for the development of public policies in this sector. For the countries of emigration, this phenomenon has contributed to reducing tensions in the labor market and to reducing the spread of poverty; moreover, the remittances that these women workers send home constitute an important credit entry in the balance of payments.

Nevertheless, this model also entails contradictions and tensions.

It is key to consider the consequences for the countries of arrival and the countries of origin.

Focusing on the countries of arrival, the whole system and the resources allocated to non-self-sufficiency encourage a model that sees "women who replace other women in an activity that confirms itself as a female-only destiny", as Sgritta writes (2009), and that does not foster quality employment and partially produce tax and/or social security revenues (Da Roit, 2017; Maino & Razetti, 2019).

Secondly, the increase in demand for care in the upcoming years (due to the absolute increase in the number of older persons in the older age groups), the reduction in the amount of pensions (due to the transition from the pay system to the contribution system), and the extreme difficulty in compressing the wages of '*badanti*' will probably make it more difficult to proceed with the current model of "private welfare" (Österle A, 2016; Da Roit & Le Bihan, 2019).

Besides, the economic and demographic evolution of the countries, from which the apparently inexhaustible flow of carers comes, is uncertain. Economic transformations (as happened in Poland, initially one of the countries of origin of '*badanti*') or demographic ones (as is happening in Romania) could reduce the availability of low-cost workers, thus making the Italian welfare state a "welfare without a future" (Sgritta, 2009; Ranci & Pavolini, 2013; León, & Pavolini, 2014).

Finally, the economic resources sent by '*badanti*' to their countries of origin constitute a not insignificant item on the liabilities side of Italy's balance of payments.

But problems will also arise (and in some cases have already arisen) for the countries of origin.

If, in a first phase, these countries benefit both from the remittances of immigrant women and from the improvement of the economic conditions of their families, the 'drainage of care' towards the countries of emigration (Guerrini, 2019) leads to an impoverishment of the resources of informal care in the families of origin and increases the demand — mostly unfulfilled — for educational support to needy children and for assistance to the older people, with negative social repercussions.

Regarding the older people who are being cared for and their families, it is important to bear in mind the great diversity of their health conditions and their care needs. Due to this variety, the employment of '*badanti*' constitutes a fairly adequate welfare response if the severity of the patient's conditions is 'intermediate', while it is difficult to believe that this applies even in highly compromised cases, especially if one considers that '*badanti*' do not normally have any specific training. At the same time, it is difficult to assess to what extent people who often have very limited knowledge of the language spoken by the older person can adequately play a role of reassurance and companionship. This means that if the older person does not feel 'abandoned', he or she may feel strongly 'alone': different languages, different life stories, often different cultural models (experiences, life and eating habits). It is a relationship marked by the ambiguity between the 'economic dimension regulated by law' and 'the emotional dimension nourished by the ethics of gift and solidarity', between strangeness and familiarity, between affection and the risks of abuse.

Then, if it is simple for the older people to dissolve the employment contract, it is equally simple for the '*badante*' who can leave at short notice, either because he or she is not well off or as a result of family problems, thus cutting off not only the welfare support (for which a replacement can be easily found), but also the emotional relationship that is normally created in a daily face-to-face relationship of two.

Moreover, since the '*badante*' obviously has a few half-days off during the week, it is also critical to find a temporary replacement when she or he is absent. This can be a family member, engaging one's free time, or another person.

Finally, the data on the spread of the care model based on '*badanti*' also among the lower-middle classes suggest that, in many cases, the income received by the older people (pension and, possibly, 'accompanying' allowance) is not always suf-

ficient to cover their overall needs. This situation makes it necessary not only to use their life-time savings, but also ask for support from their children, thus jeopardizing their economic conditions, especially if the care is prolonged over time. Furthermorea nighttime commitment may also be necessary, or to pay someone when the '*badante*' is on leave.

Finally, it iss necessary to consider the fact that '*badanti*' work and live with the older person they care for to guarantee a presence for almost the whole day and the whole week. In addition, they are usually adult women, often married, with children, older people with parents and in-laws who live in the countries of origin.

This situation raises a number of issues.

The first is the onerous nature of the work, which is not necessarily related to the work itself which can be quite reasonable. The main issue is represented by the incessant availability to take care of the different needs of the older people, who are often sick, non-self-sufficient, and sometimes have a problematic character. Despite this, '*badanti*' cannot come across (or at least not systematically) as 'sad'. The risk of an 'emotional dissonance' between emotions and feelings and the possibility to externalize them is particularly strong (Molinier, 209) and this dissonance contaminates the daily life and the overall experience of these female workers, thus fostering burn-out phenomena (Brotheridge & Grandey, 2002; Scottese, 2009; Facchini, 2018).

At the same time, the working condition of '*badanti*' is marked by loneliness, by a 'two-way' relationship, in which there are neither colleagues (with whom to discuss and share one's daily life), nor, frequently, other people other than the older people, who are often single, as previously mentioned. This loneliness is very similar to what the older person feels as they have in common the fact that they speak different languages and have different life histories and cultural models (experiences, habits and food).

There is a further difficulty, also shared with the older people, which is represented by the difficulty in building a true relationship in a context where the employment contract is overriding (Wharton, 2009).

The second issue is related to the fact that '*badanti*' are usually immigrant women, who leave their families in their countries of origin. It is therefore very difficult to assume that the distance, which often lasts for months, if not years, from their families does not affect the lives of these women and does not affect the way in which they live their daily lives, thus critically affecting their work of care (Facchini, 2018). This situation brings out the contradictions of a private (the term 'family' tends to appear less and less adequate) model of care based on mi-

grant women, who surely substantially increase the economic resources available to their families, but have their relational systems often massively disrupted.

Reading the interviews with '*badanti*' carried out in various studies, it is striking to note the connection they underline between the care of 'our' older people and the lack of care of 'their' children (or 'their' older people) and, more generally, they stress the association between the motivations behind their emigration (to respond to current family economic needs or to try to make a better future) and the slackening or the worsening of the relationships deriving from their emigration.

Of course, they are fully aware of the pivotal economic role undertaken in their family strategies, in which they are the main protagonists (Ehrenreich & Hochschild, 2003). But, they are also aware of the personal costs paid in terms of struggle, loneliness, hard work and distance from their families. Sure, this distance can partially be mitigated by the increasing access to low-cost and high-impact means of communication (Skype, Whatsapp…).

Nevertheless, the interweaving of all these aspects shows, in a completely new way, issues of identity and belonging, because of living simultaneously not only in two different societies (Parreñas Salazar, 2001), "here and there, members simultaneously of departure and arrival contexts" (Catanzaro & Colombo, 2009, p.49), but also as part of two different families: the one made up of their own family members, which is far away, and the one in which they live, which is outside of their family relationship.

It is necessary to understand if this being at the same time "here" and "there" is a form of 'double presence' for these women (defined as the peculiar ability of women to cross different time and cultural dimensions: the time of care, the time of work, the time of subjectivity) or if this situation implies the risk of a 'double absence' (Sayad, 2002): being, eventually, 'neither here', 'nor there', living an uprooted life in both contexts and both families (Facchini, 2018).

6. Conclusions: Is it still appropriate to consider the 'immigrant live-in careworker' model in Southern Europe as familialism?

While this analysis highlights current and upcoming challenges of the 'badanti' model, it inevitably recommends a further reflection on the persistence of a familistic model and the complex relationship between social policies and informal solidarity.

Up to 10-20 years ago, it was still correct to speak of three models of welfare and care for non-self-sufficiency (Esping Andersen, 1990); the first one is the Scandinavian model, which involves a wide network of public care services with quality standards associated to a high level of defamilization of care; the second

model is predominant in Central-Western Europe and it is characterized by public services for low-income citizens and financial aid to families to cover the assistance costs, which is described as a form of 'supported familism'; the third one is typical of the Mediterranean countries and is defined as familistic because care responsibilities are bestowed on families, given the limited presence of home and residential services (Le Bihan & Martin, 2006; Ferrera, 2010).

This classification is currently not appropriate anymore, at least for those countries that have adopted the 'badanti' model. In fact, the case of relatives (especially women) carrying out care work has become only one of the options, which is actually widespread only among low-income families (Degiuli, 2016).

This model still shares with the familistic one a few key characteristics: live-in care work, one-to-one and exclusive relationship between caregiver and caretaker, the leading role of the family from a decision making, organizational and economic point of view. What is completely different is the nature of the relationship between the older person and the caregiver. This relationship is no longer given by kinship, but by remuneration: no longer a 'gift' out of affection and/or obligation (with significant convolutions), but a contract-based relationship (with inevitable emotional implications). This model can be considered even less familistic if you look at it from the perspective of the live-in caregivers who give up a normal family life and are no longer able to take care of their own children, grandchildren and aging parents (Ehrenreich & Hochschild, 2003; Facchini & Da Roit, 2010; Kofman & Parcvati, 2015; Ranci et al., 2019).

This model, therefore, is marked by a double dependency: economic for the caregivers, but often relational for the caretakers, given that the older people, while formally making decisions on their life, can become subordinate to those who care for them. And, often, by a double solitude too, given that caregivers and caretakers have nothing in common, neither age, nor economic or family condition, nor even a language to communicate, but only the daily routine of living together combined with the relational ambiguities of care work.

Thus, this model cannot be defined as familistic anymore, as it is still centered on home care but executed by non-family members who perform a nearly servile work.

Finally, this analysis shows that the relation between social policies or, even better, between the lack of social policies and emerging care models is less linear than it was assumed. In fact, for a certain period of time the lack of social policies for the older population had stressed the role of family solidarity: within the couple and intergenerational, with a particular emphasis on women, as wives and daughters (Saraceno, 2008; Karamessini, 2009).

In the long run, this lack of public policies has triggered a model that is based on a one-to-one servant-like relationship rather than on family solidarity (Parreñas Salazar, 2001).

In other words, taking for granted a care model centered on solidarity has proven its limits, and now policy makers need to draw new paths that are truly innovative (Böcker et al., 2017; Greve, 2017).

To move in this direction, it is necessary that all public and private stakeholders cooperate. This is one of the most crucial challenges Europe is going to face in the coming years. Only if policy makers can question, share and integrate the knowledge and experience from the various models, will it be possible to manage one of the most significant socio-demographic phenomena of recent decades without devastating repercussions.

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