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## The governance of home care for the elderly in Spain and in Italy

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## 1. INTRODUCTION

The aim of the present research is investigating the governance of home care for the elderly in Italy and in Spain, drawing on the conceptual model developed by Bureau et al (2007). According to this approach, the governance of home care is strongly influenced by the interplay of two dimensions, namely ideas and institutions. The former refer to the culturally embedded beliefs and attitudes relating to home care, while the latter regard social practices and customs -e.g. gender arrangements, political institutions -especially the welfare and the political system- and, finally, the opportunities and the limitations that these provide in terms of governance.

Within this framework, my study attempts to further explore how public policies promoted in the elderly care domain can influence the overall mentality related to care in two traditionally family-centred countries. Moreover, it tries to evaluate to what extent the governance of elderly home care in the chosen territories has achieved a satisfactory level of integration between health and social care services, taking into account the notion of home care as a domain which “encompasses a wide range of tasks and activities and cuts across the boundaries between health and social care” (Bureau et al 2007, p.2).

The topicality of elderly home care appears evident from studying current policy-making and political debates. A recent article in *The Economist* has pointed out that increased longevity in industrialised countries will result in significant costs for the health care systems (The Economist, June 25th 2009).

Currently, home care for the elderly appears to be quite a relevant theme within the EU member states due both to the significant demographic change which the European population undergoes – progressive ageing population and drop in fertility rate – and to the massive entrance of women into the labour market over the past decades (Lyon, 2006). Furthermore, on the whole, the governance of this sector is still an unexplored and complex domain (Bureau et al., 2007). It is a field cutting across several sectors such as the social and health care domains and the private and public realms as well (Bureau et al., 2007).

The debate on the governance of home care occurs in a wider and highly topical discussion about the current shifts in the field of governance of the health sector. These changes entail a general reconfiguration of the regulatory bodies by means of the adoption of the principle of managerialism. This shift has resulted in the development of health care indicators, the promotion of performance- based funding schemes, and the establishment of benchmarks to be achieved by public health care services (Kuhlmann and Allsop, 2008).

Within this framework, the governance of home care appears especially significant since it has to coordinate different settings such as nursing homes, day hospitals and people's dwellings and distinct professionals such as nurses, social workers, GPs, physiotherapists and informal carers (Blank and Bureau, 2004). This multidimensional aspect of home care is particularly remarkable in countries generally considered family-centred such as the Southern European ones (Katragoulos and Lazaridis, 2003).

According to some scholars, the welfare regime of the Southern European countries –Portugal, Spain, Italy and Greece – fits into a fourth model (Ferrera, 1996), initially not covered by the taxonomy elaborated by Esping-Andersen (1990). This model is characterised by rudimentary systems of social protections, limited functions of the state, the low trust in the market's capacity of self-regulation and the key role played by the family as a welfare provider. Furthermore, the Southern European countries have common historical and socio-economical traits: they all underwent a long period of dictatorships and have experienced industrial delays with the exception of some Italian and Spanish territories. Next, religion plays a key role in these areas also in terms of welfare provision (Moreno, 2008). And finally, all these countries registered the lowest fertility rates in the EU during the last decade (IDB) . Taking into account these common features,

home care for the elderly appears to be a highly relevant issue, especially in two of the main Mediterranean countries, namely Italy and Spain. The latter are both Catholic countries with a strong culture of familism (Ferrera, 1996). According to this concept family is considered a if not *the* key welfare provider within these societies. That implies, historically, Spanish and Italian households did not rely on strong state support for the performance of caring tasks in terms of funding and of services.

In this paper, first of all a review of the literature about long term and home care for the elderly will be provided making reference to key concepts such as governance of public services, of health and social care services partnership and of cash allowances as an opposing logic to the delivery of formal services related to elderly home care. The description and operationalisation of these theoretical categories allows giving account of different empirically found manners of organization and regulation of this particular domain.

Secondly, an overview and justification of the research design and methods selected is given. In this section a list of the data collected – namely, key legal and regulatory documents and health experts interviews – is provided.

Next, the main findings of the two case studies are forged into a comparative analysis drawing on the theoretical categories selected at the beginning of the paper. Finally, conclusions from this comparative study are drawn as well as some suggestions for further research in this respect.

## **2. LITERATURE REVIEW**

### **2.1. Elderly home care in the health care literature**

The progressive ageing of their population represents a crucial problem in Europe not only in relation to its immediate consequence – that is the sustainability of the retirement pension schemes of the EU Member states – but also with reference to the sustainability of their health care systems. Indeed, there is a strong correlation between disability and old age (Gledding, 2006): the likelihood of falling ill grows with increasing age and thus a larger use of health care services by elderly people as compared to the rest of the population. In consequence, European health care systems are increasingly under pressure, especially so in the context of the cost-containment policies carried out by all the countries of the region from the 1990s (Callens et al., 2007). In as far the public financial resources available to pay for public health care assistance are continuously decreasing, the re-arrangement of this sector becomes urgent.

In this tension-load framework the issue of elderly home care stands out. Its importance within the realm of European health policy making has grown over the last years. The EU pressures towards a de-institutionalization of the care services delivered to dependent people (Directorate-General for Employment, Social Affairs and Equal Opportunities, 2008). With reference to this, there has been a trend in EU Member States to reduce the resort to institutionalization. From the analysis of the Member States' National Action Plans (Naps) on social inclusion in the context of the Open Method of Coordination a tendency becomes evident: the necessity of personalised care – possibly home based and delivered at the local level and suited to the needs of the people who are not self sufficient – is considered more appropriate than the residential one in order to proficiently address the issue of ageing. This type of assistance seems to be considered preferable to institutional care. The latter option appears to be too expensive for Member States pursuing an overall cost-containment strategy in relation to their health care services. By contrast, the necessity to promote home care – especially for the elderly – is deemed so crucial by the European Union that its

promotion has been supported institutionally by the European Union Council which recently aligned the resort to the Structural Funds (Directorate-General for Employment, Social Affairs and Equal Opportunities, 2008).

Taking into account its increasing relevance in the European policy agenda, health care scholars have started to study and analyse home care of the elderly in depth. Nevertheless, the topic is still quite an unexplored sector within the traditional literature on health care. Conventionally, classic health care studies are more focussed on what happens in the clinical environment where hospitals are the main settings and doctors the main actors involved (Blank and Bureau, 2004). However, long term care activities such as those related to older people take place in different locations such as nursing homes, day hospitals, sheltered accommodation and people's individual home more often than in hospitals. Moreover, long term care involves more and different types of professionals such as nurses, physiotherapists, care assistants and home helpers. These blind spots of health studies have yet to be addressed and this research aims at offering a small contribution to the growing academic awareness paid to home care of the elderly.

Home care focuses specifically on the care provided for the elderly in their own dwellings (Bureau, et al., 2007). As Leichsering and Alaszewski, (2004) state, because of the particular combination of tasks to be performed within this framework -support in daily activities, medical care and sometimes counselling -the governance of home care services requires the integration of several professionals belonging to different sectors thus making the coordination of this type of service particularly challenging. Furthermore, home care is framed in a broader context regarding important changes introduced in the health care sector over the past years (Kuhlmann and Allsop, 2008).

## **2.2.The concept of governance in the framework of health care studies**

The health care literature has explained these shifts drawing on of the concept of governance (Newman, 2005). The introduction of this notion in the realm of public policy is quite innovative; traditionally being a concept developed and employed in the field of international relations in order to describe the control over interdependent relations taking place without the regulation imposed by an overarching political authority (Rosenau, 1992). Janet Newman (2005) draws on governance in order to explain the wide reconfiguration of the regulation activity which has been experienced in the public sector since the middle 1990s. In this respect, the notion of governance alludes to a set of changes that occurred in the way in which government regulates and controls particular activities. Above all, these changes refer to the shift of power from the central level to the lower administrative layers – which has taken place within nation state. At the same time, in the international arena, changes involved a continuous delegation of power from the nation state towards transnational institutions such as the EU, and regional and sub regional governments.

According to Newman (2001), these changes were due to the emergence of the market as a main driving force in the 1980s and 1990s and to the associated rise of a new ideology that recognised the importance of networks and partnerships for the regulation of the public domain. Both components have resulted in the formulation of the core idea at the basis of the theory of governance: the promotion of network-based methods of coordination such as partnerships and the adoption of the principle of demand and supply typical of market dynamics by the public sphere (Newman, 2001). Nevertheless, this structural shift in the organization of the public services does not entail the complete dismantling of the central authority: hierarchical structures of power still count, but the conceptualization of the state as a unitary subject is questioned (Newman, 2005). In this respect, the concept of governance is opposite to government which, on the contrary, refers to vertical regulation of the public sphere without any component of participation (Cesari, 2004).

Accordingly, as a response to this fragmentation of its structure and power, the state had to find new methods of control such as performance indicators, framework documents, contracts, targets, customer charts and the establishment of benchmarks for the evaluation of the services quality (Newman, 2001).

The present research holds that the concept of governance as elaborated by Newman can be fruitfully applied in order to explain the current arrangement of elderly home care in Spain and in Italy. Especially so since the latter are considered two countries who share the Southern European type of welfare regime (Ferrera, 1996) which is characterized by rudimentary systems of social protections, limited functions of the state, low trust in the market's capacity of self-regulation and a key role played by the family as a welfare provider (Katrougalos and Lazaridids, 2003). The mix of public, private and family provided care is particularly interesting in that context for the analysis of home care governance. As far as their NHS are concerned, their services are principally supplied on an universal basis and predominantly financed through taxation (Katrougalos and Lazaridids, 2003). Since they belong to the same type of welfare regimes, the analysis and comparison of the governance of home care in these countries is deemed particularly desirable: cross-country learning is more effective if health care delivery between the systems under consideration features similarities (Bureau, 2007).

Another significant aspect to be explored in relation to home care governance is the degree of partnership existing between the health and the social care services. The latter is a highly topical issue in the framework of current health care studies (Rummery and Coleman, 2003; Gould and Kendall, 2007; Milano, 2009). It is echoed within the discourse of governance since it represents a new form of organising and coordinating community-based services, especially the ones targeted at older people. My research has attempted to identify to what extent this partnership is promoted in Spain and in Italy with reference to elderly home care.

### **2.3. The application of the theoretical model elaborated by Bureau, Theobald and Blank about home care governance**

Considering the important role played by the family regarding home care governance in these territories, the theoretical model guiding the research design of this study draws on the conceptual framework developed by Bureau et al (2007). According to them, the governance of home care is the result of the interplay among three fundamental dimensions: the institutions (social and political), the ideas understood as beliefs and traditions deeply-rooted in a certain community in relation to the care for the elderly and finally the key actors involved.

As far as the second aspect is concerned, it is clear that beliefs and traditions refer not only to the family itself but also to the gender arrangements reproduced inside the households.

Accordingly, this research adopts a gender sensitive approach, thereby following Lewis's argument that care as is a cross-cutting issue which implies several domains such as "formal and informal provision, paid and unpaid work and Welfare State services and cash benefits" (2007, p.273). According to this scholar, the delivery of care is one of the main issues at stake within the framework of the welfare restructuring debate. Radical changes within the European families structures (Bonoli, 2007) have deeply affected the traditional models of care provisions. In particular, the spread of the adult worker (or dual-earner) family pattern -probably the major outcome of women's massive entry into the labour market - has simultaneously led to the increasing defamiliazation and a commodification of care (Lewis, 2007). This process should have resulted in a major support provided by the public sector to the families in terms of care delivery. Nevertheless, a significant recasting of European welfare states has taken place over the last 20 years contemporaneously (Lewis, 2006). This change resulted in a significant modification of the logic underpinning the provision of social protection. Nowadays, the objective of European social policies is no longer the provision of social support but rather the guarantee of social inclusion

through employment.

As far as the service delivery is concerned, the welfare restructuring has entailed the introduction of market principles which introduced greater choice of provision as well as leading to a substantial fragmentation of services (Lewis, 2006). This appears to be particularly true in the case of Southern European countries, which seems to have failed more than the Nordic ones in recognising the nature of the new social risk triggered by the female inability to reconcile work and family life (Bonoli, 2007). In this respect, the Southern European response to the rapidly ageing population and the lack of care resources - traditionally provided by women - appears to be quite weak. As Bettio and Plantega (2004, cited by Bureau et al 2007) state, in the Southern European countries, both care activities and the organization of care are assigned to the family and the support provided by the State in terms of money and services is somewhat scarce. This situation has resulted in a heavy burden placed on women who are traditionally considered the main carers inside the household.

According to Bureau et al home care is a “highly gendered area of governance” (2007, p. 49). Both formal care – provided by institutionalised health and social care systems – and informal care – delivered by relatives, friends or neighbourhoods (Bolin et al., 2008) – are mainly provided by women. Accordingly, the different types of what Simonazzi (2009) calls care regimes – the manner in which both the funding and the delivery of care are arranged in different countries – are highly influenced by the modes of participation of women in the private and public spheres in the society.

According to this view, there are different family models and corresponding gender relations which deeply affect the governance of care giving in different territories. In particular, there are four basic typologies of care models which have been elaborated by Bureau et al. (2007) drawing on the taxonomy developed by Pfau-Effinger (2004 cited by Bureau et al, p.49):

- *the housewife model*: it is the typical care pattern existing in the male breadwinner family where women staying at home are the primary caregivers;
- *the dual breadwinner/ institutional care model*: both men and women work on a full time basis and care responsibilities lie first of all with the state, the market and the non profit sector;
- *the female part-time carer model*: women work mostly on a part time basis, they are in charge of care delivery but such a responsibility is partly shared with the state, the market and the non profit sector; and
- *the dual breadwinner/ female carer model*: care responsibility lies primarily with the family and women are supposed to integrate care work with full time employment.

On the whole, as far as Southern European countries are concerned, few attempts have been made to study the organization and regulation of home care comprising the importance of a gender dimension (Lyon, 2006; Bettio and Plantega, 2004, cited by Bureau et al. 2007; Rivera et al, 2009). Eventually, this study tries to analyse this dimension in more detail: its perspective is based on the assumption that the collective meanings attached to specific systems of welfare provision – grounded on the principle of familism and clear different roles of men and women in the Mediterranean countries – are crucial to the promotion of certain types of social policy. In this respect, cultural change affects potential shifts in the institutional domain (Bode, 2008). Briefly: the collective sense-making relating to the notion of the family as key welfare provider seems to have affected the organization and the regulation of the formal and informal sector of the governance of home care in Italy and in Spain.

## **2.4. Cash transfers versus services delivery**

One of the purposes of this research is the exploration of the extent to which the increasing

individualization and the progressive entry of women into the labour market have affected the care arrangements inside Spanish and Italian households. Up to this moment, scientific literature on care has shown that most of European policies promoted in this domain have supported the process of de-familization and commodification of care (Lewis, 2007). Interestingly enough in that context, as far as the two Mediterranean countries are concerned, the research carried out so far (Da Roit, 2007; Lyon, 2006) indicates that care has been commodified without being de-familialized especially by means of cash transfer either to the older people or to informal carers.

The idea that cash transfer can be seen in opposition to service delivery has been developed by Daily and Lewis (1998). According to them, such a dichotomy is particularly important for women due to the gendered division of labour with women carrying out most of the unpaid caring work. As one consequence, women incomes are (often significantly) lower compared to those of men also because they can work shorter hours and are thus are paid less than their male colleagues. For this reason, there is a significant reduction in their capacity to purchase services on the market so that some form of state subsidy becomes crucial for them to ensure all necessary care work is provided.

But due to the dramatic cut in social spending which has taken place in all European countries over the last 20 years, the public sector appears to be keener on financing private caring than on providing institutional formal services. One of the arguments in favour of cash benefits is that they give the recipient greater choice in deciding how to meet her/his own care needs, thus safeguarding the central idea of the principle of marketisation where patients/recipients are considered as consumers .

But payments for caring usually belong to the less generous groups of cash benefits. They might partly relieve the caring burden placed on families with elderly members-and hence on care-working women; but they are clearly not sufficient for changing social structures which deem the family as the main pillar of elderly care as in the case of Southern European countries.

Despite important commonalities it is possible to notice some significant difference between the Spanish and the Italian public initiatives carried out in elderly home care. As demonstrated by the findings of the following study, while Spanish policies appear to have considerably advanced the development of formal services for the elderly alternative to cash benefits, Italian measures in this respect are still limited to pure financial aid. At the same time, however, the data retrieved while examining these two case studies indicate that Italy is slightly more advanced than Spain as for the integration of health and social care services (Milano, 2009; Parlamento Italiano, 2000).

## **2.5. The added value of this research**

To sum up, the novelty value which this research attempts to provide to existent literature is

- the examination of what type of care policies have been promoted in countries where families often substitute the public sector as a key welfare provider and frequently perform a function of social shocks absorbers. My study of two prominent cases of Mediterranean welfare state adds further knowledge to the contribution made by Bureau et al (2007) which is limited to the analysis of the Italian case. The latter is presented as an expression of a particular care model, the dual breadwinner-female carer model, according to the typology elaborated by Pfau-Effinger (2004 cited by Bureau et al., p.49). As stated by this scholar, in the dual breadwinner-female carer model the family is in charge of care provision and women are assumed to integrate care responsibilities with full time employment (Bureau et al., 2007). Within the work by Bureau et al (2007), Italy is grouped with Germany and Estonia as cash- transfer oriented country placing significant emphasis on family as a primary caregiver. This approach puts countries such as Germany and Italy on the same level in terms of welfare regime. On the contrary, my research embraces the idea that the Italian welfare regime presents some peculiarities typical of the

Mediterranean welfare model as theorized by Ferrera (1996). According to the latter, family is the main partner of the public sector in the realm of the social policy, whereas the state play a residual role, intervening only when familiar networks are not capable of operating. By precisely focusing on the analysis of the different type of policies promoted and implemented in two Mediterranean welfare regimes I will show how the welfare regime assumption cross-cuts the cash-transfer logics and significantly determines the Mediterranean care mentality and governance.

- This study adopts the public policy perspective (Bureau et al., 2007) which gives particular attention to the way in which public delivery is organised in each of the countries taken into examination. In particular, I analyse what type of support to informal care –supplied by relatives or friends (Bolin et al., 2008) – has been established in each of the two countries examined. More specifically, particular attention is dedicated to the promotion of formal care services as a tool to relieve the burden placed on family in terms of care delivery – as occurs in Spain -opposite to the wide spread of cash benefits. Those, on the contrary, are instruments which indirectly perpetuate and reproduce the traditional Mediterranean beliefs and assumptions about the key role played by the family and women in elderly care delivery. Findings suggest this is particularly the case in Italy, where the state limits itself to perform a residual function in this realm (Simonazzi, 2009; Da Roit, 2007; Key informant 4, Rome, female, 6th July 2009)
- Finally, this project also pays attention to the degree of partnership achieved in the framework of elderly care between primary health and social care services in both countries. It embraces the theoretical framework elaborated by Bureau et al. according to which “home care thus encompasses a wide range of tasks and activities and cuts across the boundaries between health and social care” (2007, p.2) and applies it to two countries that have not yet been studied with that analytical focus.

In this respect, my study adds further knowledge to research since no comparative analysis of Italy and Spain has been carried out in this field so far.

### **3. METHODOLOGY**

As already mentioned, the purpose of this research is fundamentally exploratory: it intends to explore the arrangements of home care governance in Italy and in Spain. In this respect, the study aims at identifying key issues relating to this phenomenon in both countries in the first place, rather than testing an explicit research question. In order to identify and establish the main features of home care governance in Spain and in Italy the adoption of an open approach using qualitative inquiry, at least at the beginning, is deemed most suitable (Tritter, 2007). In particular, the employment of a case study research design appears to be markedly appropriate.

Case study methodology is required to count on multiple sources of evidence (Yin, 2003). As a result, the employment of mixed methods in a triangular design can be helpful. The data collection relies on two kinds of sources: documents and interviews. To start with it draws on documentary analysis- using sources such as health and social research studies, government reports, research articles, bills and law enacted on the issues examined as well as official statistics (Green and Thorogood, 2004). Documentary analysis has been considered an appropriate method especially in the first phase of the research, since it helps to provide a general understanding of the governance of home care for the elderly in the two countries under exam. Once a comprehensive picture of the organization of home care for the elderly in the two countries has been drawn via

document analysis, further details relating to some peculiar and more specific aspects are explored by means of semi-structured interviews with health experts, researchers, and civil servants working for the social and health care departments of two Spanish and two Italian local authorities.

## 4. FINDINGS

In this chapter findings of both cases are presented and analysed. I will first offer some demographic details typical of each case. This is important as it defines the scope of the problem which actually needs to be ‘governed’. Then I will specify some institutional patterns which are important to understand the structure of the policy field. They represent the scope of action government policy has to deal with the issue of elderly care. Then, the legal background for elderly care will be delineated as a basis for content analysis of policies. Finally, on the basis of the previous, I will provide a more detailed analysis of the governance framework in each country. Particular attention is paid to the degree of partnership that can be established between the health and social care services in each case.

Coming from a governance perspective, the role of the State and public policies in changing mentalities and behaviours in elderly care – such as the role of the family as caregiver – is the main criterion structuring this research’s analysis.

### 4.1. The governance of home care for the elderly in Spain

As demonstrated by table below, the elderly represent approximately 16 per cent of the whole population of the country. Although almost steady from 2002, this percentage is quite significant.

Years	Overall Population	Elderly people (>65)	Elderly as a percentage of the whole population
2008	46,157,822	7,633,807	16,5%
2005	43,398,192	6,943,610	15,9 %
2002	41,314,020	6,610,243	16%

Data source: IMSERSO, INE and European Health for all database

As far as the fertility rate is concerned, the latter has increased, passing from 1.2 children per woman registered in 2002 to 1.4 recorded in 2008 (IDB). Such a rise has been presumably caused by the attempt to promote some women-friendly policies over the last four years which renders the Spanish case particularly significant “as the one Mediterranean EU country which has gone further in incorporating inputs and traits of the social-democratic Nordic world of welfare capitalism”. These shifts have regarded above all the promotion of a labour flexibility strategy and the reduction of corporate payroll contributions (Moreno, 2008).

However, such slight increase has not been so marked to compensate for the growth of the Spanish elderly population. In fact, Spanish women largely participate in the labour market mostly on a full time basis. This makes the matching between domestic work and working life very difficult for them and society as a whole. As a result, younger women experience a persistent postponing of first births. This difficulty in balancing work and family life is seen as a consequence of the “extended kinship model that relies on women's unpaid care work”, as stated by Prince

Cooke (2009, p.7).

Not surprisingly so, the significant increase in elderly population and simultaneous high labour market participation of women has produced and sustains a veritably growing care deficit in Spain: the traditionally female caregivers have much less time to dedicate to caring for statistically many more older relatives. Facing this dual deficit, the institution of a sustainable system of elderly care in Spain appears to be quite complicated to solve, especially in the context of a general absence of major structural reforms (Moreno, 2008).

Nevertheless, significant steps forwards to tackle these difficulties have been taken during the last decade. Before giving a full description of this evolution, it is important to point out that Spain is a highly decentralised state with a very dynamic meso-level, the so called *Comunidades Autónomas* (i.e. Autonomous Communities). These are particularly active in the field of policy innovation, especially relating to the delivery of social services (Moreno, 2008).

#### **4.1.1. Institutional arrangements**

The Institute for the Elderly and Social Services Institute of Migration and Social Services (IMSERSO) is the institutional body assigned the responsibility for elderly care at national level, with particular responsibility for dependent individuals. The main task performed by IMSERSO is the elaboration of national guidelines for the planning and the delivery of social services; nevertheless, the responsibility for the actual development and implementation of social services is assigned to the 17 regional administrations (*Comunidades Autonomas*). At the same time, the municipalities are legally charged with the delivery of these services (Rodríguez García , 2007).

Currently, elderly care in Spain is delivered both by the health and the social care systems. The former provides a double service for the elderly: universal access to health care and the delivery of free pharmaceuticals for those over 65. However, the latter usually provides its services for older people on a means-tested basis, often demanding users' co-payments according to their financial capacities (Rodríguez García , 2007).

It is important to point out that the governance of care for the elderly in Spain has undergone significant shift over the last 20 years: from an arrangement in which the care burden was almost exclusively placed on the families -with isolated public policy interventions often in the shape of beneficence- to the establishment of the current system for the promotion of autonomy and care for the elderly, named SAAD (Rodríguez García , 2007).

The incorporation of ageing in the Spanish political agenda is quite recent and mainly linked to EU pressure. A first significant step towards the new attention paid to elderly care was the launch of the Old Age Plan in 1992 (*Plan Gerontológico*), which represented a coordinated answer provided by public administration to the problem of ageing. This initiative attempted to adopt a coherent approach to this issue by developing four action lines: pensions, health care, social services and culture and leisure (Rodríguez García , 2007)

This experience was replicated in 2000 with the introduction of a five-year strategy for the elderly, the so-called Action Plan for Old Age. The latter established the delivery of assistance to those in situation of dependency and the possibility of implementing public long term insurance, the support of carers and the improvement of the juridical status of dependent elderly. The latter achieved a full recognition in 2006 through the enactment of the law 39/2006 promoting Personal Autonomy and Care for Dependent People.

To sum up, multi level governance in elderly care is quite well-defined in Spain: while the central level develops national guidelines for the planning and the delivery of social services, regional governments are in charge of the services implementation and provision.

#### **4.1.2. Legal developments**

Most probably the most crucial shift in Spanish governance of care more generally and elderly care in particular so far was established in 2006 with the enactment of the above mentioned law 39/2006 (Jefatura del Estafo, 2006).-This has been pointed out by all Spanish health expert interviewees as well (Key informant 1, female, Oviedo, 28<sup>th</sup> May 2009; Key informant 2, female, Oviedo, 28<sup>th</sup> May 2009; Key informant 3 female, Aviles, 29<sup>th</sup> May 2009)-. According to this bill, dependent people's care is acknowledged as a social right. This shift can be referred to as historic since the recognition directly implies that provision of care for these individuals is compulsory for the Spanish State.

The main actors promoting the enactment of this law according to Sánchez and Martínez (2006) were:

1. the government -in particular, the Ministry of Labour and Social Affairs ,
2. the Autonomous Communities which had to deal with an increasing share of elderly population in their territories,
3. the associations of patients and consumers- such as the Spanish Society of Family and Community Medicine,
4. the Spanish Confederation of Elderly Organizations
5. the Spanish Society of Geriatric and Gerontology.

In this respect, this bill was supported by all the stakeholders involved and thus created a broad consensus.

The law 39/2006 has established a universal entitlement for care not only for older people but for all those citizens who lack personal autonomy. In particular, the bill defines dependency as the permanent situation of people with physical, mental sensorial and intellectual deficiencies who lack personal autonomy and need permanent assistance in order to perform daily activities. Such a condition can be due to age, illness and either physical or mental handicaps (Jefatura del Estafo, 2006). The law considers the condition of dependency not only as an individual handicap but also a new social risk (Moreno, 2008). Considering that most of dependent people are elderly (Gledding, 2006) it appears clear that this legal document has significantly changed the system of attendance to frail older people and the provision of their care.

First of all it, this document establishes the reorganization of social services for dependent individuals on the basis of three criteria, that is universality, high quality and sustainability of these services (Jefatura del Estado, 2007). The inclusion of these principles in the architecture of the SAAD manifests the public character of the services delivered, the universal access to these services by all dependent people without any discrimination, and the attempt to adopt an integrated approach in care delivery (Jefatura del Estado, 2007). As far as the latter is concerned, an important aspect emerging from the document analysis is the importance attached to the collaboration between the social and health sector in the SAAD framework. This is significant with reference to the theoretical framework used in this dissertation as it supports the idea of home care as a cross-cutting issue, especially across the boundaries between social and health care (Bureau et al. 2007).

On the institutional level, the establishment of the SAAD has entailed the reconfiguration of the multi-level governance of the Spanish state in relation to the services for dependent people care, setting up a clear division of competencies in this domain among the different layers of government. The implementation of the services envisaged by this system is carried out through an agreement between the central level of the state and the regional governments (the so-called Autonomous Communities). The former is responsible for securing the funds necessary to the Autonomous Communities in order to deliver the minimum levels of protection established by the law. In other words, it ensures the universal coverage of this social right - care for dependent people - and regulates the basic conditions for the promotion of the self sufficiency (Jefatura del Estado, 2007). On the other hand, the role played by the Autonomous Communities comprises four main tasks.

First of all, they co-finance the implementation of the SAAD: the proportion of the funds allocated by the regional government varies according to what is established in the annual agreement. Second, they are in charge of the planning and the coordination of the services in their own territories. Next, they are responsible for the certification of the private services providers by means of an official register in which they must be enrolled. Finally, they can penalize those providers who do not meet the quality standards envisaged by the law or who do not respect the rights of the recipients.

As for institutional coordination, a new method of dialogue among the different levels of the state has been set up by the law 39/2006 of promotion of Personal Autonomy and Care for Dependent People, that is the SAD Territorial Council . The latter includes one representative of the Ministry of Labour and Social Affairs and representatives of each regional government. The Territorial Council meetings take place each year; on the basis of its results, the central government establishes a minimum level of protection in favour of SAAD beneficiaries which must be ensured according to their degree of dependency. Moreover, the General Administration of the State is in charge of the funding for this level of protection; the funds for these services are allocated each year in the national annual financial bill. Then, specific agreements are signed between the central level and each Autonomous Community (Jefatura del Estado, 2007).

The services provided for the law 39/2006 regard the prevention of dependency situations, tele-assistance and finally home care. The latter is regulated in article 23 of the law which defines home care as a set of initiatives carried out in dependent people dwellings in order to help them to face their daily activities. In this respect, home help includes housekeeping activities and personal care for the dependent individual . In terms of access criteria, priority is given to those claimants who present a higher degree of dependency and who are more economically disadvantaged. The assistance can take the form either of access to formal care services or of provision of financial assistance (Jefatura del Estado, 2007). The former can be delivered through the public supply - *Red de Servicios Sociales* - of the Autonomous Communities. In case the beneficiary should prefer to choose a private agency to purchase the care services, he/she is provided a special financing by the municipality on condition that an accurate accounting is presented to the local authority. As far as financial assistance as the second option is concerned, another particular type of fund in favour of the dependent individual is provided by the law 39/2006. This concerns cash payment for care delivered by informal carers. This form of financing is provided only under exceptional circumstances and it is subject to the demonstration of appropriate and habitable conditions of the dependent individual's dwelling (Jefatura del Estado, 2007). Furthermore, informal carers require to be affiliated to a social security scheme and are offered some professional support by the *Consejo Territorial de Sistema para la Autonomía y Atención a la Dependencia*, especially in the form of training activities for those who are not professional carers (Jefatura del Estado, 2007).

It is important to point out that the role played by the regional governments in the implementation of the law 39/2006 is fundamental; in fact, the Spanish State features a high decentralisation: a system of fiscal federalism has been established which entrusts the regional governments on the one hand with a considerable tax-raising power and on the other hand with competencies which entail a 20 per cent transfer of the overall national budget (Meneguzzo M. et al., 2001). In this respect, the implementation of the SAAD is highly dependent on the economic capacity of each Autonomous Community and it is thus thinkable that public provision for home care of the elderly means something different in Catalonia than in the Principado de Asturias or Andalusia, for example.

#### **4.1.3. Case study summary: the Spanish combined coordination approach**

From what has been described above, the Spanish SAAD resembles a network which integrates both private and public services by means of coordination, thus producing a combination of different modes of coordination which includes both public and private provision (Bureau et al.,

2007)

It represents a significant shift in the organization of elderly care in Spain. This innovation comprises both an integrated and clear framework where the interaction among the different levels of public administration is better coordinated, as well as the acknowledgement of care for dependent people as a social right to be guaranteed. Up to now this law has not deeply affected the structure of the Spanish care model which still draws significantly on the role of family as primary caregiver. According to the interview with a Spanish civil servant (Key informant 3 and 4, females, Aviles, 29<sup>th</sup> May 2009), dependent people's families still seem to prefer to have access to cash transfers than choosing to receive formal care services. Cash benefits are opposed to service provision as for their capacity to promote families release from caring tasks (Daly and Lewis 1998). In this respect, the option of receiving care vouchers rather than formal care services appears as a choice of perpetuating the traditional Mediterranean welfare model which significantly relies on family care. In this sense Spanish legislation seems to be avant-garde compared to the broader care mentality and the success of this attempted paradigm shift remains yet to be seen.

Another feature which stands out in this bill is that elderly care in Spain mainly falls into the social care domain with a low degree of connection to the health care sector (apart from the promotion of disability prevention measures) (Jefatura del Estado, 2007). As explained by civil servants in interviews, even though there is always a form of coordination among social and health workers relating to home care delivery, this takes place mainly on an informal basis but without specific official agreement signed by the local authority and the hospitals. There are some exceptions like in the case of the *Autonomous Community of Castilla y León* where operational health and social care coordination structures have been established (Casado, 2003), but such an arrangement was established prior to the enactment of the dependency law and was independently adopted by the regional government.

The lack of partnership between the health and social care sector has also been pointed out by an organization which supported the law's enactment: accordingly, the bill does not clearly define the duties of pharmacists and of geriatric doctors inside the SAAD (Sánchez and Martínez, 2006). As will become clear in respect of the second case study, Italy appears to be slightly more advanced than Spain with reference to the social and health care partnership.

To sum up, in institutional terms the decentralised feature of the Spanish State is preserved and manifests also in the structure of home care governance. Except for the elaboration of general guidelines, the national level performs a mere function of coordination among the regional governments whereas the latter are the administrative level in charge of the policy making in the field of elderly care. It regulates the basic conditions for the promotion of self sufficiency for dependent people, by guaranteeing and carrying out in practise the universal coverage of this right.

Following from the regional responsibility for care service organisation, home care quality is highly dependent on the economic capacity and political commitment of each Autonomous Community: it is clear that the wealthier the regional government is the wider the range and the better the quality of the services delivered.

One of the more significant innovations introduced by the 2006 law has established an effective "drive belt" among the different administrative layers: the SAAD Territorial Council. This institutional mechanism has permitted the establishment of a continuous policy dialogue among the different administrative bodies involved in elderly care governance, thus facilitating coordination and monitoring. As will be explained in the following chapter, such a committee does not exist in the framework of Italian elderly home care governance (Key informant 4, female, Rome, 6<sup>th</sup> July 2009; Key informant 5, male, Modena, July 19<sup>th</sup> 2009).

In terms of policy innovation, the acknowledgement of care for dependent people as a social right has entailed the commitment by all levels of Spanish public administration to ensure an universal coverage of this right, in accordance with the principle of safeguard of regional governments autonomy. The assistance provided can take the form either of provision of financial

aid – cash benefits- or of access to formal care services delivered through the public supply of the Autonomous Communities. The latter are provided by means of network-based methods of coordination – e.g. *Red de Servicios Sociales*, social care services network - in accordance to the currently debated theories of governance of the public services (Newman, 2001). Nevertheless, up to now the promotion of formal care services has not had a deep influence on the behaviour of the elderly and their relatives. Family caregivers still seem to prefer having access to cash benefits (either to buy care on the private market or to partly compensate the relative who acts as the primary carer) thus continuing the traditional Mediterranean dual breadwinner/ female carer model as described by Bureau et al. (2007).

We have to bear in mind that the law 39/2006 came into force only in 2007 and therefore not leap to hasty conclusions relating to such a short phase of implementation.

#### 4.2. The governance of home care for the elderly in Italy

As demonstrated by the table below, the elderly represent approximately 18 per cent of the whole Italian population. Such a percentage is extremely high even though it has slightly decreased over the past three years.

Compared to other European countries, the ageing of the Italian population occurred later but has since the 1990s risen more dramatically. In this country- the decrease in the fertility rates has not stabilized yet. Nevertheless, over the last years such a drop has been quite significant (Censis, 2005). Currently the Italian fertility rate is at 1.3 children per women (IDB, 2009), while the crude death rate accounts for 11 per 1000 population (IDB, 2009). Both appear extremely low.

Years	Overall Population	Elderly people (>65)	Elderly as a percentage of the whole population
2008	58,145,000	10,696,88	18,4%
2005	58,103,000	11,295,765	19,5%
2003	57,604,654	11,014,010	19%

Data sources: IDB, ISTAT and European Health for all database

This shift has resulted in a radical change of the composition of the Italian households and familiar networks. The former have taken the form of a rhombus with few young people at the bottom, few great grandparents on the top and several adults- parents and grandparents- at the centre; whereas, the latter have become smaller and more vertical because of the coexistence of a number of generations . According to the Italian research institute on social studies- Censis (2005)- care for the elderly essentially managed by families. In this framework, the importance of the intergenerational solidarity clearly stands out but, at the same time, the burden placed on adult children is quite heavy since they have to look after both their parents and their children. This reflects the cultural tendency of this country to consider family as a main welfare and care provider. As Gori and Da Roit (2007) state “Italy has been characterized by an attitude which places great importance on the family's role in the care for older people and considers care to be a private matter” (p.61).

Yet, nowadays Italian families are not capable of supporting elderly people as in the past; even though several highly dependent people still live at home. This represents a serious challenge for the public actors still appearing unprepared to face it. Therefore, policies targeted at the elderly in Italy are still underdeveloped (Gori and Da Roit, 2007). Moreover, like in other public policy domains, there is a significant territorial variation in terms of services delivery between the North

and the South of the country . Also, within one region, the quality of services provided by the different local authorities and municipalities can vary significantly (Gori and Da Roit, 2007).

#### **4.2.1. Institutional arrangements**

In Italy, the history of governing formal home care services dates back to the 1980s when the relation between the public and private sector started being re-shaped. An implicit agreement between local authorities and private organizations about services delivery has then been established (Pavolini, 2001). This agreement envisaged the distribution of public funding to private actors without any evaluation of their performance. At the same time, it established either a partial or a total delegation of responsibilities for the services management to private organizations, without providing for their involvement in the planning phase (Pavolini, 2001).

Such an arrangement of care services has immediately exhibited several weaknesses: no clear coordination among the two sectors had been established and the quality of performance is not taken into account. In order to overcome these shortcomings a dramatic shift towards improving the delivery of elderly care services took place during the 1990s (Pavolini, 2001). This change referred above all to the so-called territorial services which provide home care, rather than to residential in-care. It is important to underline that this shift has not been emerging from national legislative reform but rather constitutes an innovation introduced at local level, at the discretion of the single regional governments and municipalities.

This new arrangement of the public and private sector connection with reference to home care delivery was characterized by the *contracting out* model (Pavolini, 2001). It entailed public payments to private organizations for the provision of home care services to the frail older people. Public administration -generally the municipality- was in charge of coordinating these services and, most importantly, eventually also evaluating the performance of private providers.

From the beginning, this model has been criticised for two main reasons: on the one hand it features an incapability to offer users a possibility to choose care providers since this is the task of public administration. On the other hand, it appears inadequate to promote the growth of a private market of services provision (Pavolini, 2001). Accordingly, some alternative instruments have been elaborated in the last decade to overcome the *contracting out* model: the certification system and a voucher or care cheque (*assegno di cura*). These have a common feature: they move the regulation of the services delivery from the public sector to the user. In fact, public action is now limited to

- a) guaranteeing a minimum level of rules to be followed by all actors involved
- b) monitoring the quality of the services delivered (Pavolini, 2001).

Regarding the certification system, the role of the public sector involves the establishment of structural and qualitative standards to be met according to the characteristics and needs of a certain territory. Accordingly, public administration in particular on regional and local level officially approves and thus certifies the providers meeting the requirements deemed necessary for the delivery of care services. This means that the role of the public sector is limited to the selection of potential providers, while users are given the alleged opportunity to choose the preferred one (Pavolini, 2001).

The vouchers are directly allocated to users by the public authority. They allow the purchase of a certain amount of care-related services (Pavolini, 2001). Providers receive the voucher by the user after service delivery and can then ask for public refund. One of the main assets of this method is believed to be the strengthening of users' capacity of choice. Moreover, the recipient is obliged to put into effect funding only after having purchased social services so that an improper use of resources and fraud shall be prevented (Pavolini, 2001).

It is important to point out that the administrative level in charge of the planning and the implementation of this networked social care system in Italy is the local authority. Even though, as explained in the following chapter, recent legal developments (*Law 328/2000*) have tried to

establish an unitary framework of reference for the delivery of social services among all administrative levels, local authorities are still held the main responsible for the governance of this sector. Such a situation often results in wide territorial disparities -frequently even within a same region- in terms of quality of the services; a fact that has been underlined by all the experts interviewed.

Regional governments define the procedures for the management of the locally networked social care system. By virtue of resources allocated by the central government, local authorities who cannot afford the full development of such activities are being supported. Moreover, regional authorities also define the criteria for the accreditation and supervision of services delivered by the third sector (Parlamento Italiano, 2000).

Lastly, the role played by the central state is limited to the definition of the overall social policy objectives through the National plan of Social care services – *Piano Nazionale degli interventi e dei servizi sociali*. This facilitates the identification of the essential levels of service performance, the establishment of minimum requirements for service provision and the details concerning allocation of resources to the regional governments from the National Fund for social policy -*Fondo nazionale per le politiche sociali*. It is only in the case of regional governments' failure that central government is charged with the substitution of tasks (Parlamento Italiano, 2000).

#### **4.2.2. Legal developments**

Unlike in the Spanish case, the governance of home care in Italy does not present a single legal framework at national level but it rather appears fairly fragmented. Care for the elderly in Italy is a mix of cash allowances and social and health care services provision which are not clearly connected and coordinated like in the case of the Spanish SAAD. As Da Roit (2007) states, currently the most relevant policy carried out at national level in favour of frail elderly people is a national allowance named *indennità di accompagnamento*, established by a law enacted in 1980 (Parlamento Italiano, 1980). That scheme consists of a grant paid to disabled people -not only elderly- who need permanent support for the performance of daily activities (Da Roit, 2007). In particular, according to the law, the claimer has to demonstrate that he/she is unable to walk without permanent assistance (Parlamento Italiano, 1980) This allowance is not means tested and amounted to 450,58 Euros in 2006. However, this amount is updated each year by means of a specific bill (Presti, 2007). In order to obtain this grant the disabled person has to submit an application to the so called *Aziende Sanitarie Locali (ASL)*, public enterprises legally controlled by the regions and in charge of health care delivery in a certain territory (Mattioli and Ghetti, 2006). After the evaluation of the claimer's condition of disability, the Italian state pays out the cash allowance on a monthly basis (Lyon, 2006). Besides this grant, a number of regional and local authorities have recently established new allowances for dependent elderly people, which unlike the *indennità di accompagnamento* are generally means-tested (Da Roit, 2007). The objective is twofold: on one hand subsidizing elderly people in difficult economic conditions and on the other hand avoiding heavy demands of the residential care facilities. Nevertheless, these grants are far less advanced than the *indennità di accompagnamento*. One of the main results of the set up of all these cash allowances is the top-up of elderly people's monetary resources in a context where retirement schemes are already deemed particularly generous for an insider group of now pensioners that enjoyed standard full-time employment (Da Roit, 2007). However, while the cash allowances for care are particularly advanced in Italy and more so than in Spain, the provision of formal home care services is quite underdeveloped.

The possibility for local authorities to give cash benefits to the elderly and their family to purchase services from credited subjects is provided for by law 328/2000. The enactment of this bill has represented a significant shift in the Italian elderly care governance. It is the first legal document which shapes the organization of the social care sector after almost one century: the last law on the delivery of social services dated back to 1890 and was still in force before the approval

of the new law in 2000.

This bill is a *legge quadro*, a framework law, which according to Italian legislation defines priorities and indicates guidelines. Policy implementation draws on that framework basis but requires other kinds of legislative initiatives and concrete measures intended to put social care plans into practice (Ferrera, 2006). In this respect, the success of this reform of the social assistance domain is highly dependent on the mentioned concretisation and implementation of guidelines (Ferrera, 2006)

According to law 328/2000, social services and interventions must be provided in the form of an integrated network like in the case of the Spanish SAAD. This choice is in line with the new trend in public sector governance which seeks to promote network-based methods of coordination such as partnerships between different institutional bodies or between the public and the private domain (Newman 2001).

The Italian integrated social care system provides for the planning and the organization of care services on all administrative levels of the state; the delivery of services instead can be carried out both by the public sector and by private organization, while the supervision of the institutions has to be guaranteed. Like in Spain, the access to care services for the elderly is universal and priority is given to individuals with lower income (Parlamento Italiano, 2000). This constitutes an important legislative innovation contained in the law.

There are three main features of the *Sistema integrato di interventi e di servizi sociali*:

- the intention to establish forms of coordination and integration among the social care sector, the health care and education domain, as well as labour policies
- the promotion of cooperation among the different institutional levels contributing to the establishment of the integrated system of social care services with their own resources
- the key role played by local authorities in the funding and organization of social services. This aspect has led several authors to define the Italian social policy as ‘local welfare’ (e.g. Colombo, 2008).

As far as the third point is concerned, one of the major novelties introduced by law 328/2000 is the set up of the new governance tool of ‘zone plans’ (*Piani di Zona*)

Those are defined by local authorities which have been established by the regional governments. The zone plans identify the social care interventions to be carried out through social and health care partnership (Parlamento Italiano, 2000). In particular, they establish:

- the strategic objectives of social care initiatives at local level
- the organization of the services, the financial and human resources necessary to arrange them as well as quality requirements
- the procedures to be followed in order to sign agreements and carry out joint initiatives with the local health authorities (*Aziende Sanitarie Locali*)

Certainly the zone plans point out the importance of Italian local authorities not only in relation to social care delivery, but also for the establishment of partnerships between the social and health care sector. These partnerships are normally carried out through three forms of governance: coordination among different administrative bodies, the proxy of functions, and the institution of unitary organisms for the management of integrated services (Tilli, 2009)

Another important element that arises from the analysis of Law 328/2000 concerns the explicit acknowledgement of the role of the family in caring activities (Parlamento Italiano, 2000). Accordingly, social workers involve and make the families aware of their responsibilities in the services organization while the necessity to promote intergenerational solidarity is underlined. Concerning social assistance, eventually, priority is given to allocation of care voucher both for child and elderly care at the expense of public service provision. In particular, the law allocates cash benefits especially to families where elderly people live.

Unlike the Spanish law on dependency, the Italian bill does not use the general notion of informal caregivers but explicitly names the family as a key subject to be supported in the implementation of caring obligations. In this respect, the assignment of cash benefits represents a tool to sustain the household function of primary caregiver, thus implicitly claiming that the public sector should play a residual role in this respect. This, again, can be taken as an example of how the Mediterranean welfare state with its important emphasis on family ties and service provision is determining the mentality and governance of elderly home care as well.

#### **4.2.3. Case summary: *The Italian uncompleted reform status***

The main feature to be pointed out in relation to the new arrangements of elderly care refers to the strong role still played by the family as fundamental care provider. Although partly supported by the public sector in financial terms, the family is still expected to be the main subject in charge of the care delivery. In this respect, cash benefits for home care provision can be referred to as a compensation for the individual -usually a woman- who spends time caring for the elderly of the family.

These initiatives aim to ensure a wider protection to care worker and a best control of the services delivered by the public sector. The latter can play a problematic double role. It can orientate the behaviour of both providers and users through the promotion of their interaction and the effective monitoring of the providers' performance, but it can also release on the users the responsibilities relating to the control of the services delivered (Pavolini, 2001).

The legislation of the voucher and the certification was established with a law enacted in 2000, which has radically changed the Italian social care system (Parlamento Italiano, 2000). One of the main innovations introduced by this bill refers to the division of competencies among the different administrative levels of the Italian state. This division has been significantly altered by the reform of the fifth part of the Italian constitution in 2001 regarding the competencies delegated to regional governments. However as far as the governance of social care services is concerned, the enactment of law 328/2000 and the reform of the constitution resulted in a re-articulation of the competencies among the different levels of the public administration. As a main novelty the functions performed by the central level are now limited: the State has only been reserved the right to determinate essential aspects of the supply of social services, which must be guaranteed across the national territory (Cesari, 2005).

Rather the actual governance of social services is a regional government responsibility. The Italian Regions can enact laws or guidelines for the delivery of social and health care services, with particular reference to the relations to be established among the municipalities and the third sector. Moreover, regions can provide a co-financing of the services offered by the municipalities. Another very significant novelty introduced by law 328/2000 is the acknowledgement of the responsibilities of Italian municipalities for inaugurating social services as those related to care.

Municipalities are given the authority not only to plan and organise social care services but also to promote the health and social care sector partnership. This is an element of distinction of the Italian case compared to Spain where this kind of partnership is provided only with reference to the prevention activities. But this represents also a shortcoming of the Italian model of home care governance: the concentration of financial and legal responsibilities on the municipality level makes the delivery of services highly fragmented across the country. As pointed out by an Italian health scholar (Key informant 3, female, Rome, 6<sup>th</sup> of July 2009), this situation causes significant differences in terms of quality of the services provided not only on the Italian peninsula but sometimes also within the same territory administrated by a singular regional government. This fragmentation is a phenomenon we have already discussed in the Spanish case.

Regardless of the abovementioned novelties, law 328/2000 seems to perpetuate the traditional Mediterranean caring model which marks the Italian welfare arrangement. The priority given to the delivery of cash benefits rather than to the establishment of a wide range of formal care services preserves the idea of the family as the key partner of the Italian welfare state (Saraceno and Naldini, 2003). Another characteristic of the Italian case – which differentiates it from the other European countries- lies in the scope of family obligations which are not limited only to the parents-children relationships but include also a much wider range of relatives (Saraceno and Naldini, 2003) as pointed out in the law under scrutiny itself.

All these characteristics described above -highly fragmented delivery, only slightly binding legislation, particular stress laid on family responsibilities- make the Italian home care governance a kind of uncompleted reform.

#### **4.3. A comparison of two Mediterranean home care regimes for the elderly**

From the comparison of the two case studies analysed, a few issues arise:

- both the Spanish and the Italian care regimes heavily rely on and policies even further support (especially in the Italian case) the key role played by the family as a key welfare provider. Moreover both countries appear to be characterised by a chronic *statelessness* typical of the Mediterranean welfare regimes (Ferrera, 1996).
- as claimed in the institutional arrangements sections, both Spain and Italy for a long time considered social assistance policies as charitable measures (Rodríguez García , 2007; Cesari, 2005). Just over the last 15 years a significant rearrangement of the social assistance sector has taken place in both countries. These reforms were intended to modernise this domain and make the policies implemented more effective in addressing the new social risks, among which the progressive ageing of the population stands out (Bonoli, 2007). The basic idea which propelled these reforms was the universalization of social care services (Rodríguez García , 2007; Ferrera, 2006).
- However, within this process of restructuring of this sector, the principle of familism continues to play an important role in shaping social assistance measures. In Spain this is confirmed by the importance attached to the role played by informal carers in elderly home care: law 39/2006 provides on one hand for the process of cash payments to informal carers under exceptional circumstances, and on the other hand promotes training activities for the providers of care (Jefatura del Estado, 2006). The Italian case offers even more substantial evidence in this respect: the Italian care regime is fundamentally based on the delivery of cash allowances- both conditional and unconditional- issued to informal carers. Moreover, the main bill which regulates the integrated system of social care services states the necessity to promote intergenerational solidarity as a pillar of elderly care (Parlamento italiano, 2000).
- Regarding the degree of social and health care partnership achieved in the framework of elderly home care, the Italian system appears to be slightly more advanced. In Spain, no formal agreements between the bodies in charge of social and health care delivery is provided for with law 39/2006, except for prevention activities (Jefatura del Estado, 2006). Although there is a coordination among health and social care professionals relating to home care services, the latter is implemented in an informal way – e.g. after a report by social workers pointing out elderly health problems (Key informant 3, female, Aviles, 29<sup>th</sup> May 2009). On the contrary, Italian legislation has attached great importance to coordination between health and social care by charging municipalities with signing specific agreements with hospitals in order to provide joint performance in elderly care work (Parlamento italiano, 2000; Key informant 5, male, Modena 19<sup>th</sup> July 2009).

Applying the theory by Bureau et al (2007) we can to a significant extent account for the care arrangements and policies of the two countries taken into exam.

Care policies are seen as a result of an interplay among ideas and institutions. From the analysis of the two case studies, it is evident that ideas – in this case the key role played by the family in elderly care delivery- have certainly affected the home care governance in both countries. The institutional question that deserves to be tackled here in more detail is whether and to what extent public policies have contributed to strengthen this belief as well.

My view is that social policy and its governance is conducive to maintain a certain view about family as primary caregiver to which the state can choose to delegate caring responsibilities – partly or completely. Daly and Lewis (1998) have described cash allowances as a tool to commodify care without de-familiazing it. This pattern seems to prove true to some respect in the Mediterranean practice. In fact, instead of paying cash benefits, the same authors consider the delivery of formal care services more effective in relieving the care burden from families and thus partly defamilizing home care. In this respect, public sector institutions can contribute to set up and govern the belief that home care is not exclusively a family duty but rather a joint responsibility shared with the state.

This is exactly what is demonstrated by the Spanish case: in the SAAD framework, cash benefits are provided only in exceptional circumstances (Jefatura del Estado, 2006; Key informant 3, female, Aviles, 29<sup>th</sup> May 2009). Instead, greater emphasis is placed on the delivery of formal care services which can be provided through the network of public supply of the Autonomous Communities(Jefatura del Estado, 2007). On the contrary, the Italian home care governance with its focus on cash benefits leads to the reproduction of the idea of family as the primary care giver which can only be substituted by the public sector in case of provision failure. This is confirmed by the priority given to the allocation of cash allowances to informal caregivers as a kind of remuneration for the hours spent looking after the elderly. Furthermore, as already mentioned, Law 328/2000 officially states the exigency to promote intergenerational - and therewith intra-family rather than public - solidarity as a pillar of elderly care.

Nevertheless, taking into account what has been stated in the literature review section as being the main tasks required in elderly care (i.e. medical support, home help, counselling), my view is that this domain cannot be completely subsumed under family responsibility but should be more significantly supported by the State. The tendency to provide households with cash benefits and delegate care work to families is postponing one of the biggest challenges most Western states are going to face over the next decades: the need for structural changes in the welfare regimes in order to deal with a dramatically ageing population in need of care. That means that governance of care should be used to establish paradigm shifts in the ideas underpinning care work and making them fit to suit a reality of many more elderly and frail citizens. The attempt to promote a mentality shift in Spain with public service delivery has been discussed as avant-garde example of this target.

Another policy inference which can be drawn given the complexity of home care emphasises the necessity to promote social and health care partnership. As stated by Blank and Bureau (2004) home care presents a multidimensional sphere which involves distinct professionals such as nurses, social workers, GPs, physiotherapists and informal carers. The multidimensional feature makes the coordination of health and social care sectors essential. However, the division between these two domains in terms of governance appears to be rather deep (Rummery and Coleman, 2003) and difficult to overcome at an operational level (Hudson, 2002; Gould and Kendall, 2007).

According to a number of health care studies (Milano, 2009; Rummery and Coleman, 2003 Hudson, 2002) coordination between the two sectors represents a necessary measure to be undertaken within the different European health care systems, especially in a context of cost-containment policies. The latter have led to the questioning of hospital-centred health care provision and the tendency of most health care systems to promote tertiary care, which has frequently resulted

in a fragmentation of services (Polillo, 2009)

Instead, especially in elderly care, the establishment of a stable relationship between health care workers and patients appears crucial. For this reason, apart from the necessity of strengthening primary care (Deckers G.M.J. et al., 2006), it is essential to promote a specific approach to address the multidimensionality of chronic ill care (Polillo, 2009). In this case, the institution of steady partnerships between the health and social care sectors is considered being one of the main aims to be achieved (Polillo, 2009)

Drawing on evidence from the case studies, the partnership approach appears to be particularly effective in Italy. In autumn 2009 the Italian Ministry of Labour, Health and Social Policy will be establishing the new *Livelli Essenziali di Assistenza* (essential levels of assistance), implying mainly minimum standards of health care to be supplied by the public sector. According to press reports (Del Bufalo and Turno, 2009), this standard setting will result in a significant de-hospitalization process and will provoke a substantial shift towards out-patient care. In such a framework, the domestic setting is likely to become increasingly important especially with reference to elderly care. Accordingly, the joint delivery of health and social care will definitely become essential if Italian social policy governance wants to effectively support chronic ill patients in their own dwellings.

## 5. CONCLUSIONS AND POLICY IMPLICATIONS

This research aimed to explore elderly home care governance in Italy and Spain, drawing on the conceptual model developed by Bureau et al (2007). This maintains that care governance is shaped by the interplay of ideas and beliefs about care in general as well as the institutions operating in a particular community. I have adopted a public policy perspective (Bureau et al., 2007) paying particular attention to the way in which public delivery is organised in each of these countries with special reference to support mechanisms for informal care. Moreover, I have investigated in the degree of partnership between primary health and social care services achieved in the framework of elderly care in both countries.

Since the purpose of this research has been essentially exploratory, the employment of a case study research design appeared to be particularly appropriate. The data collection has relied on two kinds of sources: documents and interviews. The former -health and social research studies, government reports, research articles, bills and laws enacted- provided a general understanding of the governance of home care for the elderly in the two countries. After this document analysis the semi-structured interviews added further details thus helping to account for some peculiar and more specific aspects of elderly care governance in Italy and Spain.

Findings indicate that both in Spain and in Italy the principle of familism continues playing an important role in shaping social policy. However, regarding elderly home care governance, Spain is attempting to overcome this model by proactively promoting the delivery of formal care services for the elderly, provided through public supply networks. On the contrary, Italy appears to be more inclined to perpetuate the idea of family as the primary care giver which can be substituted by the public sector just in case of failure of performance by the caring family. This is underlined by the tendency of the Italian state to provide cash benefits to informal carers instead of setting up a steady system of formal care provision.

Interestingly, when it comes to health and social care partnership, the situation turns round: Italy appears to be more advanced than Spain in this respect. Italian legislation attaches great importance to this aspect by charging municipalities with the establishment and coordination of joint performances in elderly care with the hospitals. Such agreements have been implemented at

local level in several regions. On the contrary, in Spain no formal agreements between the bodies in charge of social and health care delivery are provided by national law so far, except from prevention activities.

My study has considered in a comprehensive and explorative way the current arrangements of home care governance in Italy and in Spain. It has attempted to capture its essential features and thereby establish which ideas and institutions matter in that policy field and how they set up a framework of governance. Nevertheless, the topic revealed to be quite extensive, thus requiring still much more dedicated time to data collection than initially expected. For this reason, it is worthwhile considering this paper as a platform for further research.

As far as the policy implications are concerned, the issue of social and health care partnerships requires additional investigation – maybe also in other countries - as it appears to be highly topical in the context of current shifts – in particular the ones related to the promotion of community based services (Evans, 2009; Means et al., 2003) -in health care systems governance.

This shift is likely to significantly affect the home care domain since a number of medical activities will be performed in older people dwellings. The current discussion in Italy about the re-arrangement of hospitals responsibilities points into that direction as well. According to several scholars (Hudson, 2002; Rummery and Coleman, 2003; Gould and Kendall, 2007; Milano, 2009) coordination between the social and health care sectors represents a necessary measure to be undertaken within the different European health care systems, especially in a context of cost-containment policies. As Polillo (2009) explains, these measures have led to the progressive questioning of hospital-centred health care provision – particularly the one focussed on tertiary care- which has frequently resulted in a fragmentation of health services.

In the framework of the current European health care policies, there is a tendency towards de-hospitalization which is dramatically affecting elderly care (Bureau et al., 2007). The promotion of a specific approach to address the multidimensionality of chronic illnesses - together with the strengthening of primary care- is therefore essential (Deckers G.M.J. et al., 2006). For this reason, the institution of steady partnerships between the health and social care sectors is considered as one of the main aims to be achieved in the current re-arrangements of the health care systems (Polillo, 2009).

More generally it is fair to say that the topic of elderly home care is relevant not only in Mediterranean countries but also in the other European welfare states: in fact, the current economic crisis may result in further cuts in health care budgets. Ever more limited resources will be available to confront the inevitable ageing of the population with all merits and problems that comes with it. Providing for increasing care needs is certainly among the most pressing, especially in a time of demographic change with ever fewer children being born to potentially support the elderly both financially and with their care work.

An experience of governance of home care which can be examined and partly applied in the Mediterranean countries is represented by the British case. Alike Spain and Italy, UK relies on a National Health Care System mainly financed through general taxation and providing universal access to health care services.

In this country home care has a long tradition which goes back to the end of Second World War (Pappadà and Baldauf, 2005). As just as in Spain and in Italy the role of care delivers is played by local authorities, profit and non profit organizations, But, in contrast to the approaches adopted by the two Southern European countries informal carers play only a marginal function in the governance of this sector (Pappadà and Baldauf, 2005). This is due to the lower pervasiveness of informal economy in British society compared to the Spanish and the Italian one. Actually, in these countries, as far as home care is concerned, informality is also encouraged by the cash transfer system: for example by means of the provision of care vouchers and national allowances (Pappadà and Baldauf, 2005).

On the contrary in UK the governance of home care is mainly based on the direct delivery of

care services. Cash transfers have been introduced only recently and they still cover a limited quota of the overall public home care system. Another important feature of the British home care system refers to the monitoring of the services. In fact, in 2003 the government introduced the National Minimum Standards for Home Care. These quality indicators have become a crucial factor in the policy making related to this sector. Besides, in relation to social and health care integration, despite the existing problems in terms of inter professional working several forms of health and social integration- such as joint projects, pooled budgets, integrated delivery or promotion of Care Thrusts have been carried out over the last years (Weiner et al., 2003)

Let us now turn back to the Spanish and the Italian case. By the examination of the British experience, significant suggestions can be advanced in relation to the governance of home care in the two Southern European countries..

As far as the Spanish case is concerned, it is undoubted that the lack of institutionalised mechanisms of health and social care integration do represent a major problem to be overcome in the framework of home care governance. The different types of approaches to integrated care which have been established in UK can represent a good example to be followed in order to promote a specific approach to address the multidimensionality of chronic illnesses which affect the elderly.

As far as the Italian case is concerned, the element which definitely stands out is the lack of a national home care system equipped with homogeneous requirements for the overall territory. Accordingly in Italy it is fairly certain that different territories offer different home care services both in terms of quality and quantity. The certification system itself is established and administrated at local level and it is circumscribed to the determination of the minimum requirements which have to be met by the profit and non profit care providers.

Taking into consideration that Italy relies on the same type of health care system (NHS) of UK it would be important to set up mechanisms of control and homogenization at national level such as the e National Minimum Standards for Home Care in order to avoid further fragmentation of services.

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