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Family, Market and Voluntary Action in the Regulation of the “Care System”: A Comparison between Italy and Sweden

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Abstract

In this article we focus on elderly care reforms in Italy and Sweden. According to Polanyi's theory, we analyze the process of change of welfare regulation in terms of the relation between public redistribution, familial and societal reciprocity and services provided by the market. The main purpose of the analysis is to outline the processes of convergence and divergence between these two welfare systems that have pursued different paths in their historical evolution. In the first part we compare Italy and Sweden in terms of social expenditure for the elderly and the relationships between female labour market participation and supply provision. In the second part we concentrate on the institutional process of change, focusing on the main reforms that have affected the relationships between local public administration, family, third sector and private market organisations.

KEYWORDS: Italy, Sweden

1. Introduction

In this article, we propose to study the changes in the regulation of welfare in Italy and Sweden with reference to the care system for non self-sufficient elderly persons. In particular, we shall concentrate on the relations among those social actors that interact in the territorial networks of services' delivery. However, we shall not focus on the traditional dichotomies used up to now to account for the differences between the two welfare systems – state/market; state/family. Rather, we shall pay attention to how the issue of elderly care has been spelled out in terms of relations of formal and informal assistance among the family and the network of public, private and Third Sector that are involved in the system of service supply. Methodologically, after a first statistical and comparative framing of the composition of the social expenditures and of service coverage rates (both outside and inside the home), the work has proceeded following an approach oriented towards the processes of institutional change. The questions that we have tried to answer revolve around three areas. First, the presence or lack of convergence between two countries so distant in terms of policy traditions, second the persistence or lack of persistence in the forms of path dependency. Finally, we looked at the type of change in the regulation of the supply that has come from the cycle of reforms that have been promoted in recent years.

2. The analytical approach. From welfare regimes to care regime.

The studies on the transformations of welfare systems in Europe (Ferrera 1998; Beck 2000; Esping-Andersen 2002; Castel 2004) have, for some time now, shown the connection between socio-demographic changes in Western societies and the growing difficulties that they face in keeping unchanged the levels of social services. Particularly evident among these changes are the phenomena of destructuring that have contributed to modify social demand, meaning the characteristics of the new social risks and of the new needs for social protection (Mingione 1997; Ranci 2002; Paci 2004; Gori e Pesaresi 2005). On the other hand, it does not seem that we have reached a sufficiently advanced state of knowledge in the area of the changes regarding the politics of supply. Here the traditional categorizations of welfare regimes that have appeared up to now (Esping-Andersen 1990'1999; Ferrera 1993; 1996) are having growing difficulties in accounting for the changes that have taken place in the criteria of regulation. The body of literature that refers to these has been developed from the configurations of the large social insurances (to protect against unemployment, accident, health, aging) that existed throughout the phase of consolidation of Fordist welfare. Today however, due to the qualitative change in social demand and of to the subsequent shift in the focus of social policies towards the ensemble

of socio-welfare services (Paci 2004; Esping-Andersen 2002), the literature no longer appears able to offer adequate answers with regard to the epistemic capacity of the factors of institutional change. Therefore, from the point of view of the analytical categories used in accounting for the differences among welfare regimes, these changes therefore, underline a difficulty that is first of all theoretical. The traditional dichotomies state/market and state/family do not appear sufficiently equipped to grasp the range of the changes that are situated on the side of the regulation mechanisms and on the side of the actors involved in the policy of supply. On the one hand, the importance gained by the assistance sector with respect to the traditional group social insurance programs signals the emergence of new systems of supply more connected to the territory. These follow logics of proximity and citizenship rather than of professional appurtenance. On the other hand, the multiplication of the actors involved in the demand and supply of services accounts for a transformation related to the relations between the systems of formal and informal care. Therefore, in the arenas of territorial governance of assistance are involved no longer solely the state, the market, and the families in their role of compensating for the lack of public redistribution of social protection (see here in particular Ferrera 1996). Rather, we find a more articulated set of subjects and supply channels that range from the public administrations, to the free-market, to the varied subjects of the Third Sector, to the family, in the role of care agency, but also as recognized and publicly supported, subject acquiring services.

From the novel modulation of such relationships, the Polanyian reciprocity area, meaning the space of solidarity bounds that develop in the informal family groups and of the community-associational bounds of the Third Sector, appears to acquire a new centrality in the explanation of the regulation of welfare policies. From this point of view, some recent studies (Milland and Warmann 1996; Bettio and Plantenga 2004; Bettio *et al.* 2006; Naldini 2006a; 2006b) have in fact contributed to a better articulation of the body of welfare research and to the development of new models that in part tend to deviate from the traditional categorizations of welfare regimes that have been considered until now (Esping-Andersen 1990; 1999; Ferrera 1993). The interesting data that emerges, beside the creation of new models (see especially Bettio and Plantenga 2004; Naldini 2006a), is especially the shift in the focus of the comparative analysis from the concept of 'welfare regimes' to that of 'care regimes.' As Naldini (2006a: 94) notes, the use of this concept allows to place at the centre of our reflection

... Not so much the care work undertaken by women within the family context, but rather the one undertaken in paid form within public and private services, and the one, which has much less defined boundaries, between informal and formal. Therefore,

analyzing the social care (caring) models or regimes means looking at how the different welfare traditions have solved the question of care in terms of recognizing the value of such work and the resultant development of a system of formal care (public, private or non-profit), that substitutes for or is complementary to the informal, unpaid one that is undertaken by women.

The perspective opened by 'care regimes' is important because it allows us to look at national welfare in terms of relationship with the different combinations of formal and informal care. In this re-examination of the debate on the relations between families and welfare, we can also bring Paci's (2007) most recent contribution. There the study of the changes of family models and welfare systems is associated to the emergence of socially recognized activities such as care giving, but also to the voluntary involvement of Third Sector organizations within the new supply policies. Obviously, this kind of transformations has an effect on the role and functions of the Third Sector in the supply of social services. This seems obvious, if we consider that these changes are more than ever open to individuating new models of interaction – between public and private, between public and social private, between for profit private and non profit private – that are able to redeploy the role and functions of associational reciprocity in their interaction with the families, and the public redistribution, but also in the competitive interactions with free-market organizations (See Saraceno 2004; Laville 2006; Ascoli and Ranci 2003).

On the strength of what we have said, we can better understand why it seems interesting to look at the change in care supply (in our case for non self-sufficient elderly people) in two countries like Italy and Sweden, that in the categorizations discussed up to now (Esping-Andersen 1990; 1996; Ferrera 1996) are on opposite sides with regard to the extension of formal care (public), the role of the family in the supply of welfare services, and in the role of associational resources of the Third Sector. In fact, if the evolution of Swedish welfare appears to be historically hinged upon a logic of defamiliarization and direct intervention of the public sector in the supply of social services, Italy showed welfare characteristics that, beside relying on the family, have also been hinging heavily on residuality of assistance policies and on an externalization of services (in a more or less formalized manner) towards the associational sector. Before analyzing the changes in the relationships between formal and informal care among social actors in these two countries, it is important to highlight the trajectories of change at a statistical-comparative level focusing on the rates of coverage and on the composition of social expenditure for the elderly.

3. The Policies for non self-sufficient elderly persons in Italy and Sweden. A framework of reference.

Among European Union countries, the phenomenon of aging of the population affects the various national systems transversally, with an estimated growth for the elderly over 75 from an average of 6.9% in 2000 to 10.5% in 2030. In Italy and Sweden this phenomenon appears particularly evident as they are the two European countries with the highest percentage of persons over 75 years of age in Europe. In Italy this percentage is 7.9% and in Sweden 8.9% against a European average of 6.9%. The percentage growth in 2030 is estimated at around 4.5% in Sweden and 6.2% in Italy (U.S. Bureau of the Census 2001). If in the area of demographic aging these two countries show some convergence, the same cannot be said with regard to the initial endowments in the supply policies. In Italy, in 2002 social expenditures reached 25.1 of GDP.¹ Among these, a full 51.5% was directed towards the elderly and in large part as financial transfers to families under the form of pensions. In Sweden, on the other hand, to a higher percentage of GDP spent on social programs (31.1%) is associated a more homogeneous distribution of the resources among the various categories of users. The percentage of expenditures destined to the elderly in 2002 reached 37.3%, with a clear prevalence of in kind services over cash ones.

As far as the relationship between home assistance and residential assistance is concerned, these two countries show a similarly evident difference in the percentage of elderly persons assisted at home or in residential structures.² If Sweden ranks among the first in Europe as far as home (8.5%) and residential (6.7%) services' coverage is concerned, Italy shows levels of service coverage (3.0% for home and 1.5% for residential) among the lowest in Europe. Only Spain (2.0% for home services and 2.7% for residential), Portugal³ (1.0% for home services and 2.0% for residential services), and Greece⁴ (0.3% for home services and 1.0 % for residential services) do worse. In a mirror-like fashion, the distribution of home and residential care services in the two countries also reflects two different approaches to the issue of women's employment. In Sweden, a high ratio of formal welfare services corresponds to one of the highest ratios of women's employment in Europe. In Italy, however, the low ratios of coverage of formal services are associated with a higher difficulty for women to participate in the labor market. These differences emerge clearly from figure 1, where we correlate the ratios of employment for women aged 15 to 64 and the coverage

¹ These data come from calculations undertaken using the Eurostat-ESSOROS database.

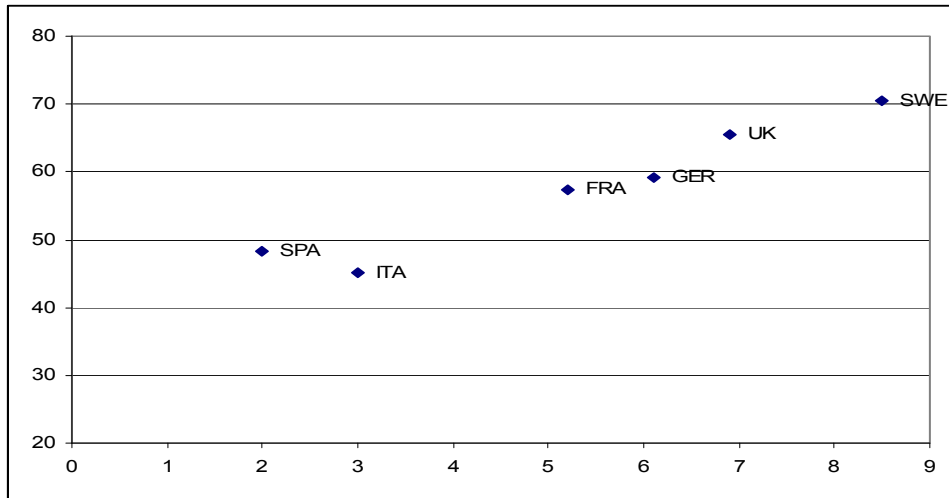
² The data presented here refer to Gori and Pesaresi (2005), Statistics Sweden (2005), OECD (2006).

³ Data refer to 1992.

⁴ Data for home services refer to 1998 and the data for residential services are for 1991.

rates for home care services extended to elderly person over 65 years of age in select European countries.

Figure 1. Correlation between the ratio of coverage of home care services and the ratio of employment among women between the ages of 15 and 64 (2004)



Country	Ratio of coverage of home care services	Ratio of employment among women between the ages of 15 and 64
GER	6.1%	59.2%
SPA	2%	48.3%
ITA	3%	45.2%
FRA	5.2%	57.4%
UK	6.9%	65.6%
SWE	8.5%	70.3%

Source: our calculations based on Eurostat-ESSPROS data (2006) for the ratios of female employment and OECD (2006), Socialstyrelsen (2005a), Gori and Pesaresi (2003) for the ratios of coverage of home care services.

When we first look at the statistical-quantitative image, the situation for the two countries appears in line with what emerges in the debate regarding the families of welfare in Europe. In the rest of this article we shall highlight the development of the reform processes in the areas of elderly care, focusing our attention upon the main factors of institutional change in the regulation of welfare.

4. Reform of the assistance to non self-sufficient elderly persons in Sweden.

Following what is highlighted in the literature (Korpi 1983; Esping-Andersen 1990; 1999), the Swedish social state is commonly identified with a higher degree of “defamiliarization” and “individualization” of welfare policies with respect to other European cases. In Sweden, to the development of a broad network of public services to persons has corresponded a more infrequent use to the responsibilities of informal care within the family. Hand in hand with this has gone a higher ratio of female employment. Therefore, in this case the solidarity of the intergenerational networks of care, in which women have a paramount role in the organization of care, has been replaced by a different social contract. In the latter, the state is responsible for the protection of the individuals in exchange for their participation in terms of their fiscal contributions. This situation is particularly evident in the assistance services to non self-sufficient elderly people, where, historically, the interventions have been characterized by the attempt at relieving families from the direct responsibilities of care through the development of public socio-welfare services. We can place the evolution of the Swedish system of social protection in the framework that we have just described. However, towards the end of the 1980s, it seemed to show increasing signs of crisis. This was due to a strong economic recession that hit the country between 1991 and 1993 and to the excessive bureaucratization of the public regulation, which was caught in a vise between budgetary limits and a social demand that was evolving rapidly. There is no doubt that the 1990s represented a period of strong turbulence for the Swedish system of social protection, which culminated in the defeat suffered by the Social Democratic coalition in the 1991 election. Radical reforms have been introduced to services for the elderly, which have redesigned the institutional architecture of the levels of government that are tasked with the distribution of social services. From the system of public supply and universal coverage of the policies, these changes have had important effects on the extension of the supply, on the relationship between public intervention and families, and (finally) on the composition of the actors, not only public but also private, that are involved in the demand and supply of social services. We shall concentrate our attention in the next sections on the effects of these changes in the regulation of the system of ‘care’ for the elderly.

4.1. Territorialization of the services, reorganization of public expenditures and internal restructuring of the local administrations.

Due to the economic crisis of the early 1990s, the regulation of the system of services for the elderly in Sweden underwent a process of deep reform that accelerated the implementation of the plans of reorganization of the welfare

system that had been started in the second half of the 1980s and that in their tenets already leaned towards reinforcing the tendency towards dehospitalization. After the *Adel* law was passed in 1992 the plans for the reorganization of the assistance system have finally been completed, by decentralizing the functions of regulation for residential and home services towards the local administrations. In the new framework of vertical subsidiarity, the articulation of institutional responsibilities has been organized in three levels. The national level was given the objectives and the creation of financial budgets. At the regional level, the 21 county councils (*Landsting*) are responsible for health care interventions. Finally, to the municipalities (*Kommuner*) have been transferred the responsibilities for residential structures and home services. The explicit goal has been to reduce the number of people receiving assistance from the national system and the level of public expenditures. In particular, this was achieved through the transfer of the financial responsibility for 35,000 beds in structures for long term care from the regional level (*Landsting*) to the municipalities.

From the point of view of the channels of financing, with the introduction of the *Adel* reform both regional and local subsystems have been granted broad autonomy with respect to the central authorities, through the ability to raise taxes to finance these services, to decide the priorities of the interventions, and the amount of the fees. The result, at least in the early years the implementation of the reform, has seen, beside a generalized increase in the cost of the services, the growth of the gaps in the level of assistance among various territorial areas. In particular, this phenomenon has become more strongly evident in the years immediately following the introduction of the *Adel* reform. At this point, as Trydegard (2000) highlighted, the municipalities in metropolitan areas that were endowed with better financial resources were able to offer to their residents home care services four times as abundant as those of more peripheral municipalities. Compared to the experience of the right-of-center governments (1991-1994), the biggest changes in the regulation of local welfare introduced by the new social-democratic governments (starting in 1994), attempted to maintain a higher degree of homogeneity in the level of services among the different territories through a tighter control on the financing mechanism by the central level. In 2002, to meet the problems created by the increase in fees, was introduced a maximum level for the cost of services that cannot exceed €150 per month.

However, the changes introduced by the social-democratic governments did not include bringing into question the tenets of the *Adel* reform. In fact, if we exclude the reorganization in the systems of financial redistribution, the law's regulative structure has been preserved and brought to completion. From this point of view, with regard to the financing functions, the system of services' supply has remained tied to local taxation even if within the context of strong redistributive mechanisms among the territories. In 2004, in the face of a cost for

the users of about 5-6%, the cost of the services for the elderly was financed primarily by fiscal levying at the municipal level (82-85%), with about 10% being financed at the national level (Socialstyrelsen 2005a). This same continuity is present if we examine the effects of the reform in the rebalancing between residential and home services. The process of progressive reduction of the rate of coverage of local public services has continued through the 1990s, with the effect of a significant reduction in the number of beds within hospitals and geriatric structures in favor of municipal ones. At the end of the 1990s, both the instances of home and residential care have progressively diminished. For elderly persons over 65 the reduction of the rate of coverage has gone from 10.6% in 1993 to 8.5% in 2004. The impact upon elderly people over 85 was smaller. For this category the level of home services rather than the residential ones have been progressively diminished, reaching 19.8% (Socialstyrelsen 2005b). The most interesting conclusion that we can draw here is that this is not a generalized reduction of services, but a process of reorganization of the services for the less dependent (or more self-sufficient) elderly. As shown in Table 1, in the period between 1992 and 1997, welfare services up to 9 hours per month (those linked to less intense welfare interventions) have contracted by 23%. In the same way, the hours of assistance between 10 and 25 per month were reduced by 20%, and by 10% between 26 and 49 hours per month. On the other hand, as we reach higher levels of non self-sufficiency, those associated with more permanent services, the number of hours has shown a growth trend (+15% between 50 and 119 hours and +17% beyond 120 hours per month).

Table 1. *Number of hours of assistance for elderly persons over 65 years of age 1992-1997, hours and percentage variation*

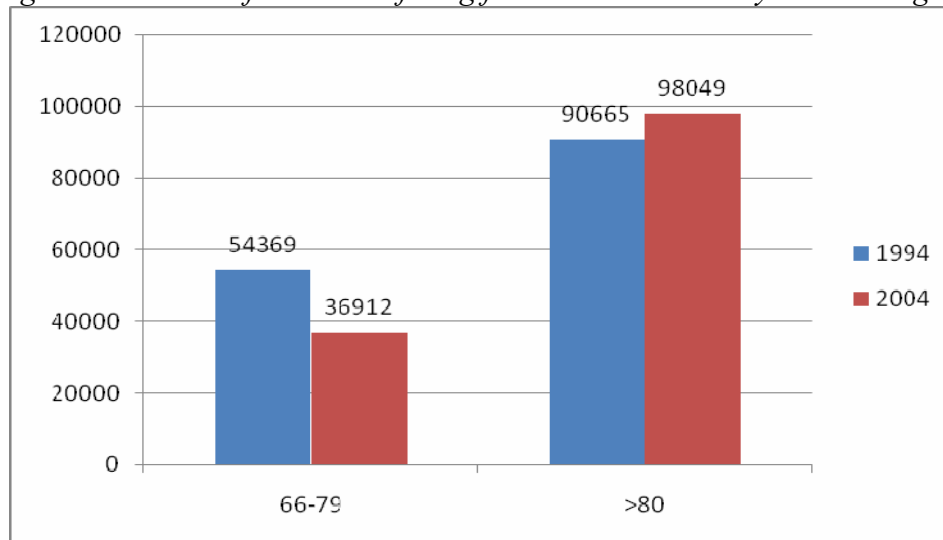
Monthly Hours	1992	1997	Variation %
1-9	74,935	57,651	-23%
10-25	48,633	38,869	-20%
26-49	30,599	27,445	-10%
50-119	26,197	30,024	+15%
120+	6,489	7,582	+17%

Source: Socialstyrelsen 1999.

This concentration of resources towards the group of elderly people who are more dependent appears even more important if we consider that before the reform cycle the greatest majority of welfare home services were concerned with 'light' services. These include help in home chores and personal care not necessarily tied to the conditions of non self-sufficiency, but provided for rather broad parts of the elderly population. As Sundstrom and Malberg (1996) note, through the 1980s, 80% of the hours of home care were devoted to these *home making* activities. However, the same authors remind us that between the 1980s and the mid-1990s these services have diminished until they accounted for 48% of home activities in 1993. To this we must add the effects of the process of dehospitalization and the consequent increase in the number of frail elderly taken under care by municipal services. As underlined by the *Swedish Welfare Commission* (2003:58), within the development of the process of dehospitalization the frailer elderly, who were previously dependent on the health care system, have come to represent the main users of municipal residential and home service. This has placed a limit on the supply of 'light' services, like help in cleaning the home and house chores, personal care, and so forth.

Figure 2 allows to better clarify the results of the processes of reform on the various groups of users. Between 1994 and 2004, the composition of the users who received assistance has progressively shifted towards the group of the frailer subject who are aged over 80. If in 1994 there were 54,369 men and women between the ages of 65 and 79 who received home care, in 2004 they had dropped to 36,912. On the other hand, from 90,665 users in 1994, the over-80 group rose to 98,049 in 2004.

Figure 2. Number of users benefitting from home services by kind and age



Source: our calculations based on Statistics Sweden 2007 data.

4.2 The reorganization of the supply of services between public regulation and market competition.

The effects of institutional change have also affected the modalities of management of welfare services. To the compression of the public supply of welfare services has corresponded the beginning of an important process of reorganization of the supply on the model of the competition between public and private and of quasi-markets. These are systems of supply in which to the separation between the functions of evaluation and financing (that fell to the public sector) and the management ones (regulated by mechanisms of public-private competition), corresponds the introductions of vouchers, through which the citizens/users are enabled in their choice among suppliers competing among themselves. On the basis of the management models inspired to the principles of *New Public Management*, the local administrations have proceeded with the reorganization of the public structures according to the goals of cost reduction, increase of labor productivity, and organizational efficiency (Swedish Welfare Commission 2003). To this end, the purchaser-provider system has pushed the public units that are delegated to supply services, both residential and home ones, to compete with private market organizations. Here we find the most important characteristics of the changes introduced in the management of the services: through the competition between the public and the private sectors, the experiment with the system of quasi-markets has first of all responded to the increased organizational efficiency of the public sector and to the reduction of the levels of bureaucratization.

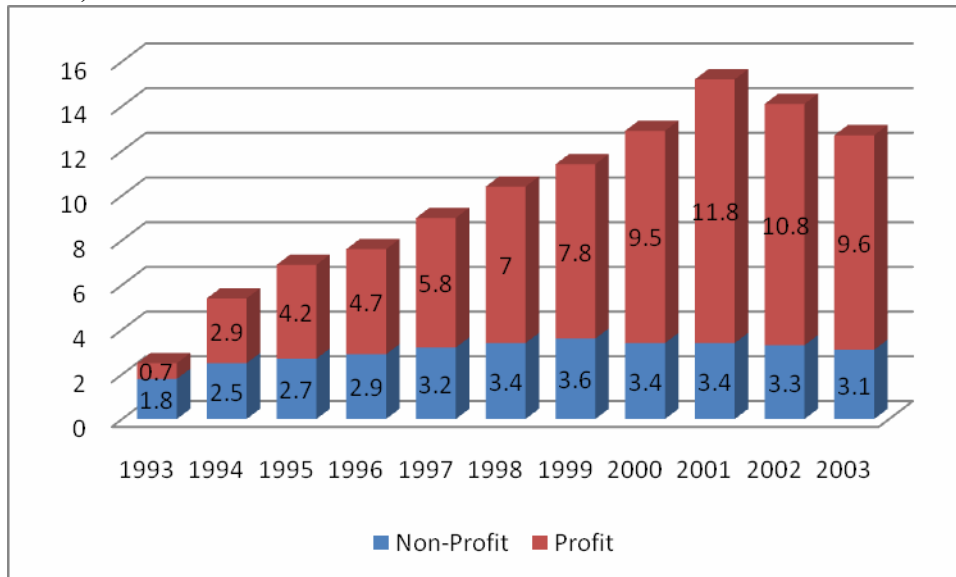
It was not, in this sense, a process aimed at increasing the levels of supply through the inclusion in the system of supply of new, profit or non-profit, actors. The Swedish administrations are traditionally rooted at the territorial level and this, notwithstanding the cuts to the levels of coverage, still allows a very high articulation of the services. On the other hand, notwithstanding the introduction of a management model devoted to the solvency of the demand, the local administrations still retain a high power in regulating the supply. In choosing the supplier, the users are not simply handed a sum of money or a voucher that they can use freely, but the choice is continuously monitored and intermediated by municipal operators, who in this manner maintain a central role in the regulation of the services and in the predisposition of the assistance plans. The user's reference remains the municipal operator, which monitors and is constantly present in the supply relation, in the evaluation of the service's quality, and in the choice of whether or not to change provider. On the other hand, we must not forget that even if more that 50% of Swedish municipalities has adopted a purchaser-provider model during the 1990s (Trydegard and Thorslund 2000), still the majority of welfare services for the elderly is supplied by the local authorities

(The Swedish Association of Local Authorities and Regions 2006; Trydegard 2005).

4.3 *The relations between public and private in the local systems of care*

In this sub-section, we shall focus on the characteristics of the private supply of services for the elderly. This represents a channel of supply that has developed only recently (because of this we see lower levels of supply with respect to the public sector) but that, exactly because it is directly correlated with the effects of the reforms of the 1990s, deserves a certain attention. In this case too – as noted above – we must look especially to the implications of the reduction of light welfare services: daily cleaning, help in domestic chores, personal care. Together with the increase in fees,⁵ this compression of the public supply is at the root of the increase in private care provided by the market (Swedish Welfare Commission 2003; Trydegard 2003), which since the introduction of competition mechanisms between the public and the private sectors increased more than four-fold. The percentage of private suppliers rose from 0.7% in 1993 to 12.7% of the total coverage in 2003 (Trydegard 2005).

Figure 3. *Providers of social and welfare services to the elderly by legal status, 1993-2000.*



Source: Trydegard 2005.

⁵ Between 1993 and the beginning of the new century, the cost of residential services grew by 22%, while that of home services grew by 7% (Statistics Sweden 2001).

The range of services covered by these organizations, even large ones,⁶ varies between assistance services related to help in home chores, to the provision of social and health services for residential and home assistance. On the whole, these large companies control about half of the services bought on the market. However, the entrance of the private sector in the area of services to the elderly has also brought about an obvious change in the labor market, where the operators employed in these organizations have gone from 2.5% in 1993 to 12.9% in 2007 (Trydegard 2005).⁷ On the other hand, for Third Sector organizations the opening of the regime of competition has not determined a significant increase in the supply of services. While it is possible for the administration to contract out a service towards non-profit subjects, their quota of services has remained at a decidedly low level: from 1.8% in 1993 to 3.1% in 2003 (Trydegard 2005). In other words, after the reduction of public services, it was especially the market, rather than the associative sector, that conquered quotas of services in the competition regime. Rather, what appears to be emerging for the Third Sector is a new space of action that straddles families and local administrations, in the supply of services (that are not subject to the competition regimes) supporting family *caregiving* (we shall return to this later).

With regard to the effects generated by the growth in market supply, some studies (Trydegard 2003) have highlighted how this type of supply is not homogeneously distributed among the various population groups, but has mostly involved the population segments with the highest level of education. On the other hand, for the segments with the lowest level of education, the increment of the fees seems to have determined an increment in the use of informal family care. If this latter group, has increasingly resorted to the market in the 1990s, from 4% to 8%, for the subjects with a higher level of education (and presumably of income) it has passed from 4% to 26%, with an increment of 22% (Swedish Welfare Commission 2003).

Notwithstanding the presence on non-univocal effects in this process, as the presence of a niche of for-pay services that seems to be accessed only by the subjects with higher education (and presumably of income) shows, the expansion of private supply constitutes an element to be considered in the change in the relationships between public and private actors in Sweden. However, to grasp its full meaning, this market expansion must be placed within the framework of the emergent ties that, in the field of services for the elderly, also involve the resources of family care and of the Third Sector in connection with the

⁶ Among these large companies we can point to cases of US multinational corporations ISS, CAPIO, and Attendo Senior Care.

⁷ The growth of employment in the private sector is a phenomenon common to all welfare areas, from 4.4% in 1993 to 9.6% in 2000. The larger growth has been recorded precisely in the services to the elderly, with an increment of more than 400% (Swedish Welfare Commission 2003).

intervention of the state. We shall focus our attention on these factors in the following sections.

4.4 The family and the support policies towards caregiving in the care for the elderly.

If the increment in market supply, notwithstanding the presence of non-univocal effects, represented one of the most novel factors in the process of reform in the welfare sector, the emerging relation between the reduction of light assistance and the increase of family caregiving, is just as important (Socialstyrelsen 2005). In other words, if the reduction of the supply for some secondary services like help on household chores, laundry, and personal care seems to have been compensated for, on the one hand, by the increase in the services purchased on the market, on the other hand the increase in family caregiving can be linked to the reduction of these services.⁸ As shown in a study by Johansson *et al.* (2003), on the relationship between family care and services to the elderly between 1994 and 2000, the reduction of public services of light assistance has determined an increase in the number of family caregivers. Between 1994 and 2000, the elderly over-75 who resorted to family care and to home assistance services funded by the administrations went from 13% to 16%. At the same time, those who used only public services dropped from 28% to 18% (Johansson *et al.* 2003). In the same vein, the *Swedish Welfare Commission* (2003: 41) has underlined how in the 1990s people aged between 75 and 84, who resorted to informal care alone, went from 49% to 53%. Szebehely (1998) has stressed how in many municipalities, the availability (or lack) of a partner within the family, and therefore of caregiving resources, has become part of the activities of evaluation and selection of the demand for the access to public assistance. In this way, resorting to public services has become conditioned not only by the assessment of need, but also by the presence (or lack) of family care resources.

As a matter of fact, in these changes we can find some important basic change trends that seem to have characterized the evolution of Swedish welfare. First of all the emphasis placed on the selectivity criteria of the demand. Along with the increase in the fees (even if these have been balanced by the expense ceilings that were introduced in the second half of the 1990s) and the reduction of the coverage ratios for the more self-sufficient elderly people, this redefinition of the selectivity criteria of the demand seems to foreshadow a change in the Scandinavian universal criteria, towards a more selective universalism. Second, the increase in the family care functions has had different effect on men and

⁸ See also the previous section. As noted by Trydegard (2003), along with the increase in the fees for home services, the contraction in light services has affected the increase in family caregiving for the groups with lower rates of education (and indirectly of income).

women. The increase in family caregiving has been felt especially by women, with an increase in the same period of 11% (Johansson *et al.* 2003).⁹ On this subject it is useful to look at Table 2, which highlights the source of daily help to elderly persons over 75 living at home, according to gender and marriage status.

Table 2. Elderly persons over 75, cohabiting or alone, who receive help from outside, percentages, year 2000.

	Elderly persons living alone		Elderly persons married or cohabiting	
	Women	Men	Women	Men
Help from spouse alone	-	-	52	76
Help from family/friends	63	51	33	9
Home Assistance	43	49	15	9
Private Assistance	21	27	7	6

Source: The Swedish Association of Local Authorities and Regions 2006.

As we can see from Table 2, three quarters of married men receive help from the spouse, while for women this percentage falls to around 50%. However, the most interesting datum is the one relative to the relationship between family care and formal home care. For persons who are married, resorting to home assistance is drastically reduced for the latter, especially for men. Only 9% of men over 75 who are married or are cohabiting receive formal assistance exclusively. On the other hand, 76% of them rely on the assistance of the spouse alone. However, elderly people who live alone resort especially to family assistance, after that they seek home care services, and finally private ones. In the case of married or cohabiting elderly persons, family help, especially among men, is reduced to 9% (also a marker of more rarefied family ties), arriving to levels close to those of private assistance (6%).

At this point, it is interesting to ask what kind of effects the increase in family care may have produced on female participation in the labor market. In fact, in this trend we could see the signs of progressive gender segmentation in the carrying out of some care services. Obviously, this would represent a rather large return effect from the reform processes if we consider the traditional defamilizing effect of Swedish care policies, because for women the growth of

⁹ On the relationship between the decrease in the services and the increment in female care work also see the recent contribution by Scarpa (2006).

informal care would foreshadow arriving at a more marked gender segmentation within the family.

However, looking at the rates of female participation in the labor market (the most important indicator to test this hypothesis), such idea of refamilization appears to be contradicted. In this time span, the rates of female participation in the labor market have remained constant, even within a decremental trend that, however, is also common to males, and rates are still above the European averages. Even if the female employment rates are declining, while staying well above the European average (71.8% against 54.5%), the gap between men and women has remained, in this period, basically unchanged. For women the employment rate declined from 81% in 1990 to 70.5% in 2004, while for men it fell from 85.2% in 1990 to 75% in 2004 (Eurostat 2006; Statistics Sweden 2006). In the age bracket between 55 and 64, the employment rate for women was 67% in 2004 (only 3.5% less than the employment rate in the bracket 15-64), while part-time employment was recorded at 38.1% (Eurostat 2006). These data confirm for this country the persistence of a model of income redistribution solidly hinged on the model of full-time male and female employment. To all this we must add that 90% of female employment is still mostly concentrated in the public sector of health and social services. Notwithstanding an increase of male employment, women still make up 90% of the workforce in these areas (The Swedish Association of Local Authorities and Regions 2006).

Therefore, while we see the introduction of new forms of demand selectivity that in the supply of the services also take into account the available family care resources, and also a growth in informal care (in particular as was highlighted in elderly couples above 75 years of age, and therefore in the population that is outside the labor market), these changes do not appear of such a magnitude to challenge female participation in the labor market. This notwithstanding, there is no doubt that informal care is an element that has become part of the system of regulation of social policies. On the other hand, this can be perceived not only from the introduction of new demand selectivity mechanisms, but especially from the emergence of programs sustaining family caregiving that at the territorial level place themselves in the perspective of making the social supply more complementary with family care resources (Pijl and Johansson 2003; Dahlberg 2006). This integration between services and family care can be traced back to the presence of a series of measures that range from the possibility to benefit from job leaves and grants for the recognition of family care (Johansson 2003), up to – see for more detail the next section – the more recent programs that are aimed at involving the associational sector in the development of 'dedicated' caregiving services.

Among the various forms of compensation that family caregivers can benefit from are money transfers granted by local administrations to the elderly

to finance assistance by a family member (based on eligibility criteria that vary from municipality to municipality),¹⁰ and the reimbursements for the caregiver being equated to the salary of public supplier of social services (Johansson 2004). Regarding the former, in 2004, 5,300 people benefited from this measure, with a growth of 13% when compared to the year 2000 (The Swedish Association of Local Authorities and Regions 2006). Regarding direct reimbursements, even if they represent a modest level of coverage, with about 3,300 caregivers reached in 1997 (Socialstyrelsen 1999), nonetheless they are an interesting program. Sweden, along with Finland, was the only European nation to have built into its legislation an economic contribution for the family member that is equated to the salary of a public provider. In the area of supporting family care we must also include the recent development of measures that are aimed at involving associative subjects in the supply of services for the caregivers.

4.5 The role of Third Sector associative actors between families and non-contractual care services

The changes in the relationships between the social actors involved in the system of care in Sweden do not involve only the state and families, but also Third Sector subjects. Even if at an initial stage, some characters of a (novel) cooperation appear to emerge between the associational subjects and the system of supply of welfare services (Dahlberg 2004). Here we should refer to the 'public' support given to these organizations in the functions of support to informal care, of help in daily chores and light assistance. This increased complementarity in the relations between public intervention and the Third Sector can be brought back to a change in the prerogatives attributed to the associative actors of the Third Sector. This change of perspective shows a certain relevance if we compare it to the traditional vocation towards the development of a type of associational structure essentially based on membership¹¹ and recreational activities, but also to the scientific and political-institutional debate that until the very recent past had recognized a low degree of importance to the volunteer and associational sectors in the Scandinavian welfare (Lundström and Svedberg 2003). It is not about confirming the growth of the functions of service provider of the Third Sector in a perspective of substitution of public intervention. Nor it is about stressing the changes towards the commercialization of the relationships with the public administration. Rather it is about underlining the progressive involvement of 'light' care in the

¹⁰ Many municipality have placed a limit on the reimbursement to 17 hours of assistance per week.

¹¹ During the 1990s, it was estimated that more or less half of the Swedish population between the ages of 16 and 74 undertook some volunteer activity, including social cooperatives, foundations, associations, and welfare organizations. It is estimated that 200,000 associational realities are in existence. Of these 1 50,000 are volunteer organizations (Regningskansliet 2001).

range of interventions of the public sector and of the families (Jeppsson and Grassman 2006). From this point of view, the reforms promoted foreshadow a system of interaction between the public sector and the Third Sector, within which the associational subjects can benefit from financial help to develop volunteer-type activities in the home setting. Among these are visiting ailing persons and help in daily chores, but also supporting and training family caregivers. Therefore, being mostly concentrated in activities of light assistance and receiving grants rather than ad hoc financing for service supply, the Swedish Third Sector presents a lower dependence from public financing and, in this sense, appears less affected by the process of growing commercialization that is evident today in other nations, where these organizations, especially in their most commercial components show a growing hybridization with market forms.

Regarding the emergent characteristics in volunteer activity in the Swedish system of care, it is worthwhile noting how during the 1990s, many municipal administrations promoted the creation of actual 'volunteer offices' aiming to facilitate the coming together of volunteers, the organizations that render services, the users, and the families in need. Between 1999 and 2001, in support of this type of initiatives, the Swedish government launched a special project for policies of assistance towards the elderly (as provided for by law 113/1997-98), *Anborig 300*, with the explicit objective of improving non-financial services for family caregivers. Through a distribution of the financing to all municipalities on the bases of the number of elderly people over 75 years of age, the project has provided for the development of *ad hoc* projects in the field of counseling activities and family caregivers training, with the involvement of the Third Sector.¹²

When compared to the 1990s, these non-financial activities of support, training, and orientation of caregivers undertaken by the Third Sector organizations have undergone a certain development. These can include the possibility to organize support groups for the formation of family members; the distribution of informational material; the substitution of caregivers in cases of temporary interruption of family care; volunteer activity at home. It is certainly not easy to evaluate the type of impact that they had in family care, due to the short period of time elapsed since their introduction. As shown by Lundsgaard (2005: 24) not all municipalities have implemented in a final manner this kind of activities after the experimentation phase. Rather, in some cases, these have ceased to be financed. In general, however, the whole of these support services for informal care has known a considerable increment in the period between 1992 and 2002 (Johansson 2004: 22). During this time span, the percentage of

¹² It is important to underline that the provision of funds by the central government has been oriented towards the direct involvement of Third Sector subjects in the development of initiatives providing caregiving support.

municipalities that created centers for the support and training of caregivers went from 7% to 43%. The percentage of municipalities within which support groups for caregivers are operating went from 28% to 74%, while formation activities for home care in municipalities went from 17% to 44% (Johansson 2004: 22).¹³

4.6 Policy-Making

Notwithstanding the small amount of financing – about 32 million Euros – compared to the total of the expenditure at the municipal level for elderly care, this type of initiatives goes towards the progressive involvement of Third Sector organizations in regulating supply. Among the Third Sector organizations that operate in Sweden in the area of supply of these services to the elderly we can list the National Association of People Affected by Dementia, founded in 1984 and comprised of about 12,000 members with 110 units at the territorial level. Also, the Swedish Association for Alzheimer founded in 1987, and Carers Sweden, a coordination organization founded in 1996 with the goal of promoting the coordination among the various associational groups and promoting the interests of family caregivers. Finally, the Swedish Red Cross, which besides directly promoting orientation and support activities for the family members that provide assistance to a dependent elderly person, organizes training activities for volunteers involved in the counseling activities and in the opening of centers to support family caregiving. Always in the field of elderly policies, we must mention the pensioners associations that at the central and local level undertake mostly lobbying and political pressure activities of public institutions. Among these the most important are the *Pensionarens Riksorganisation (PRO)* and the *Sverige Pensionarforbund (SPF)*.

The attempt at including the Third Sector in the system of services has not involved the phase before the actual management, with the development of consultation, or participation, mechanisms to local policy making. The programming of the intervention in this country remains strictly a public responsibility. The administrations are solely responsible for the planning of the services. There certainly are consultation relationships with trade unions, but these are to be referred back to traditional relations of cooperation between trade unions and public administration. Regarding the absence of forms of participation to policy making, this is not uncorrelated that many of the Third Sector associations operating in Sweden concentrate their activity in exerting political pressure on the institutions to promote the interests they represent. These are the markers of relations that unfold on the terrain of planning more

¹³ These data refer to two surveys undertaken between 2001 and 2003 by the Socialstyrelsen on 258 municipalities.

according to lobbying activities that through the involvement and inclusion in the planning arenas.

5. The non self-sufficient elderly care reform process in Italy

The Italian social protection system, like countries in continental and Mediterranean Europe, has historically followed the road of the construction of insurance institutes based on category- and professional membership of the beneficiaries (Esping-Andersen 1990; 1999; Paci 1992). In this insurance- and gender-based configuration hinging on the male bread winner family model (with its rigid gender-based division of care duties) emerges indirectly the other characteristic of the historical evolution of Italian welfare. This is the dualism between a welfare sector that is both residual and left to the responsibilities of family care (Ferrera 1996; Saraceno 1998), and a diverse mutual aid, with lay and religious associational initiatives that developed in the riverbed of local societies. The datum that characterizes this system of regulation is that in the set of interconnections among charitable and welfare institutions, among family care resources and monetary transfers, among a scarce public intervention and confessional or mutual aid associational initiatives, the Italian system shows a historical difficulty in bringing together the set of relations among the actors and the welfare channels (Paci 1989).

Given the fragmentation and the lack of coordination in social welfare policies (Vicarelli 2005), it was only with the framework legislation for welfare reform 328/2000 – about a century after the last legislative intervention on the subject – that Italy developed a strategy for the reorganization of the welfare sector. From this point of view, certainly the biggest novelty was the attribution to the actions of Third Sector organizations, of the same dignity as the public institutions in the programming and supply of social welfare services at the territorial level. Regarding this, one of the most important aspects of the change has involved the planning modalities of the services. These have been the forms of co-planning and social participation to the policy making process that law 328 promoted with respect to the Third Sector and of the associational networks within the local governance (Bobbio 2005; D'Albergo 2005). From this point of view, the reform legislation has undoubtedly represented an important watershed. It prefigures a new regulatory architecture aiming at promoting the planning arenas in which are involved not solely the local administrations, but a broader set of public and Third Sector associational actors that, in this way, see themselves being recognized as representatives of the interests of local societies (D'Albergo 2003; Paci 2008).

During the implementation phase, the blueprint that inspired law 328 did not follow a linear reform trajectory. At various levels, the goals of abandoning

category-based services and the definition of the new planning and management criteria, did in fact translate in a growing differentiation in experimentation paths (Mirabile 2005), that have led to the emergence of different regulative models within the same national context.

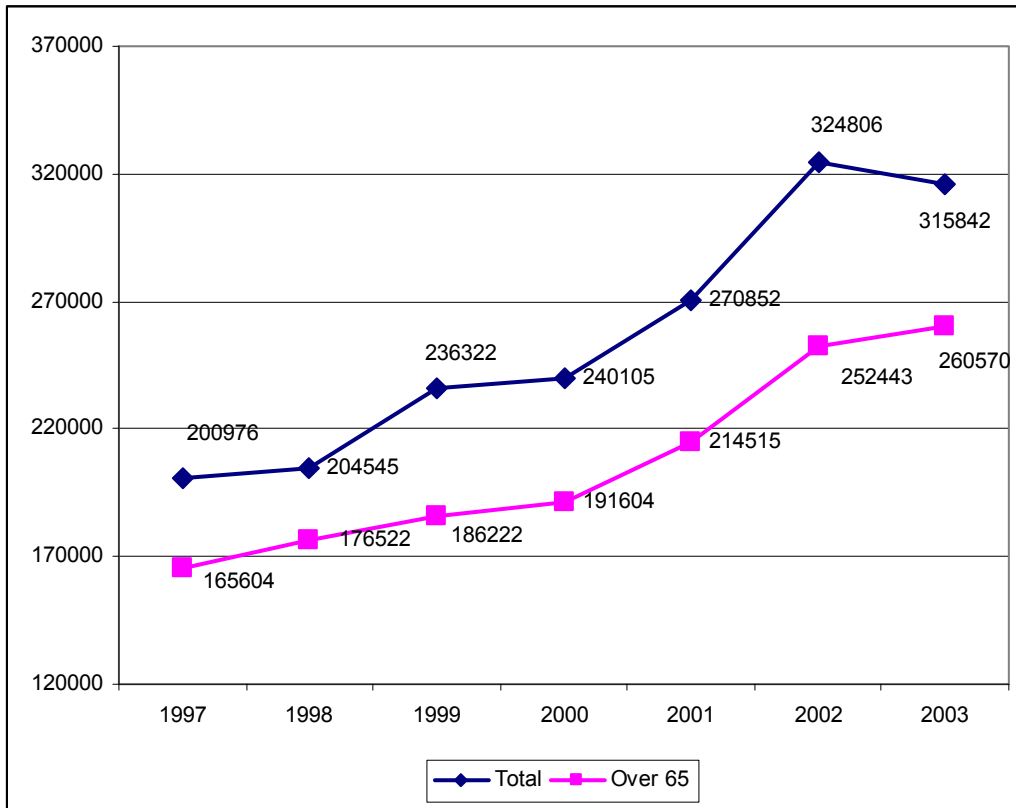
5.1 The effects of the reform processes on the supply of social services to the elderly.

Based on the available data, the reform process still appears characterized by an accentuated fragmentation of the reform experiences at the local level. Not all of the national territory has been exposed to the same push towards the creation of new, local-based welfare structure, showing instead different realities in different areas. Furthermore, because the national regulative framework for assistance to the elderly is tied to regional health policy (this is due to the reform of Section V of the Constitution), the development of the plans for the supply of social and health services has been affected by the still existing differences that can be seen in the models of health policy adopted by the regions. Today, the relation between residential and home services in Italy, while levels of coverage are, for both services, lower than those found in other European countries, shows a more accentuated balancing towards the latter (about 3% for home services as opposed to 1.5% for residential services). This is quite interesting, if we consider that traditionally social and health care were supplied within the residential context. According to recent data from the Italian Institute of Statistics (ISTAT 2005; 2007) on social expenditures of Italian municipalities, in 2003 44.9% of the expenditure for the elderly was absorbed by home services. This compared to 24.8% take up by financial transfers and 30% by residential structures (ISTAT 2007). Home services for the elderly are distinguishable in Italy in two separate types: *Assistenza Domiciliare* and *Assistenza Domiciliare Integrata*.¹⁴ The former is planned and supplied by the municipal administrations and generally involves interventions that fall in the area of light services (food preparation, help in house chores, and so forth), with a low connection to health and social-health services. On the other hand, Integrated Home Care is characterized by being a service that integrates social and health facets, with a larger role for the territorial ASL [Local Health Company] units and for the *Unità Valutative Geriatriche* [Evaluative Geriatric Units] that handle the definition of the treatment (Gori *et al.* 2003). Data on the coverage of Integrated Home Care (see figure 4) show a trend towards an increase of this home service between 1997 and 2003 from 165,604 elderly users aged 65 and over, to 260,570. Notwithstanding this increase, the rate of coverage remains very low (around 3%) when we compare it with the number of elderly

¹⁴ Home Care and Integrated Home Care respectively.

people who are not self-sufficient. According to Pavolini's (2005) estimation, the number of elderly persons over 65 who need assistance is between 11% and 20%. As he noted, in the broad gap between social demand and available supply we can glimpse the highly selective nature of Italian assistance services, which only reach the most grave on non self-sufficient cases (Pavolini 2005).

Figure 4. Integrated Home Care in Italy: total number of patients and patients over 65, absolute values, 1997-2003



Source: Calculations by Censis using Ministry of Health data, 2005

5.2 The relationships between public and private social actors in the supply of social care in Italy

In the past, in the relationships between the Third Sector and the local administrations, public administrators resorted to the Third Sector in economic terms, without recognizing to these actors a broader role in the system of municipal welfare (Pavolini 2003). The recent reforms have tended to promote a higher degree of involvement of non-profit actors in service management and in

the planning of social assistance. We went from a model of mutual accommodation (Ascoli and Ranci 2003), and from a conception of the relationships between public and private hinging upon the duality between state and society (Ardigò 1980), to the 'public' recognition of the function of the associational subjects in the system of assistance, and to administered competition in the provision of services. Both of the latter have affected deeply the characteristics and the organizational change of the Third Sector. However, even before law 328/2000, it was during the second half of the 1990s that the most important legislative interventions that would support the reorganization and the professional growth of the associational realities started to take shape. Here, we must refer to the changes, noted by many (Ascoli and Ranci 2003; Pavolini 2003), in the modalities of the financial relations between public and private, with the transition from a system of financing aimed at the contribution towards the operational expenses of the organizations, to a system of competitive contracts for the allocation of services and on the introduction of more transparent control mechanisms. On the one hand, within this framework, the role of local administrations has progressively diminished in favour of an increasing recourse to outsourcing and to the competitions 'to the lowest bid.' However, the innovations introduced by law 328 have aimed at extending the evaluation of the quality of the services and to dampen the tendencies towards the completion of bidding competitions based uniquely on costing methods. In practice, in many Regions we have seen the creation of Third Sector professional associations aimed at establishing the criteria needed to access these competitions and the practices to gain membership. The latter, in particular, was introduced as a supporting tool to systems of provision based instruments like vouchers and service coupons (therefore a strategy aimed towards the solvability of the demand and the power of choice of the families), and it has also progressively extended its functions to the forms of management that hinge upon invitations to tender. This is a first step in the creation of more stringent procedures at the level of financial and patrimonial solidity, of the levels of professionalism and qualification of the personnel that is required from the organizations that compete to provide these services.

The effects of these changes on Third Sector networks have been varied. Social cooperatives, more than other associative organizations, have followed as form of evolution aimed at strengthening both their internal organizational capacity and the levels of supply under a regime of competition. In this regard, Pavolini (2003) notes that the recourse to consortia and the Temporary Groupings of Firms¹⁵ (TGF), even if they were often constituted to limit competition, have

¹⁵ The raggruppamento temporaneo di impresa (or associazione temporanea di impresa) is a type of joint venture that can be constituted under Italian law to participate in public tender competitions. It was originally introduced with law 584/1977.

spread everywhere in Italy, shows for cooperatives a marked tendency towards organizational consolidation. This was parallel to the increase in the financial volumes that were mobilized by these associational actors in increasingly interdependent relationships with the public administration. As far as the level of coverage of the services is concerned, there are no available data regarding the respective numbers of non-profit, public, and private home interventions. However, we can reasonably assume that Third Sector actors, more than private organizations, are the main partners of local authorities in the externalizations.

The elderly represent the second category of users (after minors) for Type A cooperatives, at about 17% (ISTAT 2003).¹⁶ The data regarding the distribution of social cooperatives by area of activity and by type of services offered, confirm the social-health characteristic of this associational cluster (ISTAT 2003). Of Type A cooperatives, 58.5% operates in the field of social assistance. The most common services are home assistance (36.2% of cooperatives) and by assistance in protected residences (34.1% of cooperatives). We then find recreation services, entertainment and animation, with 32.6% (ISTAT 2003). The image appears clearer if we refer to residential assistance, for which we have data for supply in terms of the type of provider.

Table 3. Percentage of Elderly people in residential structures by provider, 2004.

	Total of residential structures			Total(a)
	Public	Third Sector	Market	
Total	40.4%	39.6%	17.8%	-

(a) The data relative to the total are not equal to the sum of the three sectors as for some structures no juridical nature was reported.

Source: our calculation on data from ISTAT 2004

The Third Sector and the public sector affirm themselves as the main supply channels for services (respectively 40.4% and 39.6% of the national total). The private market occupies a minority position, with a supply quota of 17.8%.

The Third Sector's organizational growth is a relatively evident result of the changes generated by the reforms. What appears more ambivalent is the role of voluntarism in the varied trends that are affecting the assistance sector. The data of the Italian Osservatorio Nazionale per il Volontariato (National Observatory of Voluntarism) (2006) help us to place into focus some of the emerging changes in this composite aggregation of associational realities. Between 1995 and 2005, volunteer organizations grew by 152% from 8,343 to 21,021. Among these, the majority continues to be concentrated in the areas of health and social assistance, providing recreational and cultural services, help

¹⁶ Type A cooperatives are firms, but their goals are social promotion and the development of society.

lines, support, blood donations, sensitization of the public opinion, and so forth. Self-sufficient elderly people account for 9.4% of the users, while the non self-sufficient are 2.2%. However, the most interesting datum that emerges is the increase in the quota of organizations that provide services not simply for the members, but also to non-members. These have increased from 5,650 in 1997 to 15,652 in 2003. This trend is connected with the increase in the number of paid personnel and to the growing formalization of management structures. If the number of volunteers during this time span grew by 71.4% that of the employees grew by 77% (Osservatorio Nazionale per il Volontariato 2006). At the same time, 96% of associations have adopted a formal organization (Osservatorio Nazionale per il Volontariato 2006). Therefore, the more magmatic and spontaneous organizations decrease in numbers, because of the creation of more structured associational aggregates, even if the realities with less than 60 volunteers drop in numbers (in 2003, there were 6.5% less than in 1995), while the small local units increase (in 2003, there were 6.8% more than in 1995). What can we gather from these internal changes of the world of voluntarism in relation to the social cooperatives in the area of services to the elderly? No doubt there are trends that contribute to making voluntary activities more professional. This is shown by the increase in the number of paid personnel (in perspective more than the number of volunteers); for some of these organizations it may already be time to move towards the creation of social cooperatives. However, in general we can notice the persistence of distinct spheres of activity between cooperatives and voluntarism, which tend to differentiate themselves along the type of supply of services, either health related or accompaniment, listening, transportation. Furthermore, the fact that among the users of volunteer organizations 9.4% is represented by self-sufficient elderly persons, but especially that only 2% are non self-sufficient elderly persons, well defines the limits of the reach of these organizations in the care for the elderly. In this sense, while we are in the presence of a trend that leads many associations to become more formal and to exit the sphere of pure associational spontaneity, there is no doubt that social cooperatives place themselves in the area of 'heavy' assistance, that relates to services with a high social-health integration (as is the case for the *Assistenza Domiciliare Integrata*, *Dimissioni Protette*,¹⁷ and the Alzheimer Centers). Vice versa, volunteer organizations, while experiencing an organizational and professional growth, remain within the sphere of 'light' services of support, help lines, transport and its relations of financing with the public administration is

¹⁷ The *Dimissioni Protette* are procedures that aim at reducing the number of non-necessary hospital stays for persons at risk. The risk here is to be intended in a medical sense and is supposed to be supplemented by a weak familial or economic ability to be cared for. Ultimately, the goal is often to have the person cared for in a family context.

largely based on the supply of grants rather than on procedures of administrated competition.

5.3 *The (informal) market and the family*

In comparison with the expansions in the levels of supply of the Third Sector, it is worthwhile to underline how the supply of formal market services, the set of services supplied by private for profit organizations, did not undergo an important development in Italy. More than the regular market it is the channels of irregular supply (*badanti*)¹⁸ that cover a large portion of assistance to the elderly. These are services supplied by individual providers, often immigrant women, who deliver services within the families according to contractual forms that are not always regular (Gori 2002; Spano 2006; Bettio *et al.* 2006). Furthermore, they are not in any way formally integrated in the system of the services that is managed locally. According to a recent estimate by Spano (2006), the number of *badanti* in Italy would be around 900,000. We must say that in many local administrations programs have been devised to regularize the *badanti*, but these are still isolated initiatives that suffer from the lack of reform projects of a national scope. In this system of supply, it is very interesting to ask about the role of the family and of familial obligations in the system of care. As a matter of fact, beside the functions that are taken over by Third Sector subjects in the provision of some welfare and social-health services, and the obvious expansion of the submerged market, we should stress the nature of the set of interventions that are provided in terms of support to family care. Among these, we must recall first of all the accompaniment indemnity – introduced with Law 18/1980 – a financial measure provided to citizens of any age to whom was recognized a permanent and total invalidity, and the various care grants regulated at the regional and local level. Regarding the accompaniment indemnity, it is supplied directly to the beneficiaries, who can use it to purchase professional assistance or pass it on to a family member. However, there is no homogeneous national system of evaluation of the needs of those who are being assisted, nor there is any tie with the regularization of informal care work. As a matter of fact, its utilization is referenced to the evaluations undertaken by the local health commissions that are in charge of distributing it, with the effect of increasing the spaces of particularism of the welfare system. Furthermore, we cannot forget the critical factors that trigger its actual use. The still unresolved mix between the (generic) welfare goals of the provision and its utilization, do not identify a specific welfare goal aiming at regularizing the informal care work, but more often (especially in

¹⁸ The phenomenon of the *badanti*, is relatively common in Italy. These are care-workers, most often from developing or Eastern European countries, who are hired often informally to provide some level of care when the family of the person in need cannot or will not do so.

some of the most disadvantaged areas of Southern Italy) become a measure to contrast poverty (Gori 2001).¹⁹

In 1997, the accompaniment indemnity was provided to 860,000 persons, 70% of whom were elderly (Gori 2001). In fact, if we consider the landscape of welfare interventions for the elderly, the accompaniment indemnity constitutes the only universal measure (meaning the only one provided to all non self-sufficient persons independently from income and age) available in Italy. In these years its incidence has grown consistently, arriving in 2004 to touch 900, 000 elderly people out of 1,270,000 beneficiaries (Inps 2003). On the other hand, it mobilizes, on its own, 48% of the financial resources of the whole social-welfare sector, with an incidence in 2002 higher than the expenditure endowments of the territorial governments (Inps 2003). From the point of view of a higher degree of integration between social services and family care, it seems to be of particular importance the growth that was registered in the last years of care grants. These are provided directly by the local institutions and are less subject to the mix of goals and to the use distortion that are common in minimal level integrations. In 2000, 30% of the Italian local administrations had directly or indirectly (through the Local Health Centers) provided this type of grants, mostly in the Northern and Central regions. The critical point is, once again, the extreme territorial differentiation of the provision and in the variability of the criteria for access and demand selection that the local administrations make provision for.

6. Conclusive observations. Convergence and divergence in the reform experiences in Italy and Sweden

We can now draw some conclusions regarding the processes of change in the regulation of the system of care in Italy and Sweden. First of all, we should underline how between the two countries from the point of view of the endowment of services there still are strong differences that we can generally trace back to different institutional traditions (path dependency). In fact, even within a trend towards the reduction of home and residential assistance services, in Sweden the rates of coverage remain much higher than in Italy. On the other hand, this must be correlated with the persistence of women's rates of participation in the labor market that are quite different in the two countries (see Section 3). However, in this article beside the statistical comparative analysis we have also proceeded keeping in mind an approach oriented to the analysis of the

¹⁹ We must admit that, in great part, this distortion is influenced by the fact that Italy is still one of the few European countries that does not have a national anti-poverty policy. In this sense, in the absence of specific organizations, the recourse to the only welfare instruments that are available has often seemed the only way to deal with the social discomfort that is created by poverty, especially in the South of the country.

changes in the regulation, to the emerging legislative frameworks, to organizational dynamics, and to the relations among the actors involved in the demand and supply of services. At this level, we can highlight the most important processes of change. They involve the system of relationships among public, private, families and the Third Sector in the various segments of elderly care. With regard to the comparison between the two countries we can refer to Table 4 where we have reported the relations among the various actors in the planning and management of the services. As far as the management is concerned it seemed useful to propose a distinction between 'heavy' and 'light' services.²⁰

Table 4. The system of governance of the social-welfare services in Italy and Sweden

	Planning of services	Management of services	
		Light Assistance	Heavy Assistance
Sweden	State	State; Families*; Third Sector; Market	State; Market
Italy	State; Social Cooperatives; Voluntarism	Families; State; Market (<i>badanti</i>); Voluntarism	State; Social Cooperatives

* In Sweden, the involvement of the family in the system of assistance is placed in a heavily regulated framework, with a strong role of the public administration in providing instruments and compensation for family caregiving.

From left to right, in the planning of services the two countries show different regulation structures. In Italy, one of the most important innovations that came on the heels of law 328/2000 that reformed assistance has been the promotion of participatory arrangements to policy making with the attempt at including in the planning arenas the different territorial subjects that are also involved in the management of services. This change is founded in recognizing that the action of Third Sector organizations has of an equal dignity to that of the public institutions in welfare regulation, and in general in the recognition of the role of Third Sector organizations not only as providers, but also as representatives of the interests of the users. On the other hand, in Sweden the policy making remains solidly in public hands. Notwithstanding the presence of associational organizations active in the promotion of the interventions and in

²⁰ As the reader may have noticed, with these two terms we wanted to refer to services that are on different planes with regard to the level of social-health integration and to the level of professionalization in their delivery. In the group of 'heavy' assistance are therefore all of the services with high social-health integration, while in the 'light' services are included the interventions tied to the support of family caregiving, home and personal care, home work services and so forth.

lobbying, the system of interventions' planning is an exclusively public responsibility. Looking at services management, here the most interesting changes regard the role of the family in the system of care, in particular in the Swedish case. As we have underlined before, in Sweden the reforms that were implemented have influenced the reduction of the levels of the public services. These, however, should not be interpreted as the end point of a privatization of care services or as a shift towards the familiarization of some services, but instead in the light of a process of rationalization that has by and large affected the ancillary services of light assistance. The effects of the process of de-hospitalization and the consequent increase in the number of frail elderly people that the system of municipal services has taken care of (along with the increase of the fees for the services themselves) have affected the reduction of the 'light' services (in particular the home keeping help and personal care), and at the same time have affected the intensification of the care towards non self-sufficient elderly subjects. In the light assistance services, these changes have been accompanied by an increment in the number of family caregivers (even if not to the point of affecting negatively the possibility of women to access the labor market), but also of the services purchased on the care market. Here, the most interesting datum is not solely the increase in the number of family caregivers, but rather the introduction of interventions aimed at compensating, and the social recognition of, the care activity provided within the family. As we noted above (see Section 4), beside the possibility of taking time off from work to care for a dependent elderly person, in this country there are various types of grants for family care activity. Among these are financial transfers provided by the local administrations to the elderly person to reimburse the assistance provided by a family member, and the reimbursements directed to the caregiver that are equal to the salary of a public provider of welfare services. More recently, beside these forms of compensation for the activity of family care, have been promoted programs aimed at reinforcing the assistance to the caregivers, in terms of formation, guidance, listening and psychological support, that see involved Third Sector actors. This represents an important restructuring of the prerogatives of these organizations in the Swedish and Scandinavian system where existed an associational tradition characterized by high levels of membership (Pestoff 2004), which however was not directly involved in the provision of welfare services (these were traditionally the prerogative of public actors). The recent changes seem to foreshadow a higher degree of involvement of the Third Sector within the system of governance of social-welfare services (even if outside of the competition between public and private and essentially within the light assistance services).

The fact remains that it was market organizations that showed the highest volumes of growth of private supply since the introduction of the purchaser-

provider system for the provision of the services (see Section 4). The range of services covered by the market goes from help in house-keeping and personal care up to the provision of residential and home social-health services. In Italy, the market supply has rather different characteristics. If, in fact, the formal market supply (provided by private organizations) remains a minority element, in recently there has been an obvious growth in light assistance services delivered by individual providers, often immigrant women, hired through more or less regular work contracts. From this point of view, as we highlighted before, in Italy market supply, rather than through the growth of services provided by large for profit organization (as is the case in Sweden), seems to present itself in the hybrid form of a combination between the role taken up by paid services offered by individual providers, often in an irregular fashion, and the activity of the social cooperatives, which tend to become more commercial and to compete among themselves for the provision of professional services.

If in Sweden the reforms seem to foreshadow a novel support function to the public supply and to family caregiving for Third Sector actors, in Italy the varied realities of associational life show signs of an obvious internal differentiation between the more commercial part of the social cooperatives (that operate mostly within the sector of social-health services), and the reality of voluntarism and associational life. The latter, even if they are subjected to an increasing formalization of their management structures and of their internal organization, tend to remain within the scope of light assistance services to families. As far as family policy in Italy is concerned, if here the role of the family has been central in the development of the system of welfare, the set of support interventions to the activity of informal care does not appear to be characterized by an organic vision. In this regard, we must not forget that in this country a traditional support to the activity of care of the family comes from the pension system that in many cases contributes within the family groups to 'generate income' to purchase (more or less regular) assistance. This is confirmed by the levels of social expenditure, which are grossly unbalanced towards the pension system in comparison with the welfare sector. The main universal assistance measure, the accompaniment indemnity, continues to be uncorrelated from a homogeneous system of evaluation of the needs of those who are assisted, and from a connection with the regularization of informal care work.

In conclusion, the two countries continue to show important differences in the system of regulation of their social policies. We underlined the elements of differentiation and territorial dis-homogeneity of the Italian reform system that have accompanied the implementation of law 328/2000. In this framework the relationships between formal and informal care do not hinge upon systematic interventions. On the one hand, the lack of family policies has a direct effect

upon the strategies of adaptation that are undertaken by the families in using the irregular market of the *badanti*. On the other hand, the relationships between the social cooperatives and the networks of volunteers along the border between 'heavy' and 'light' assistance constitute the fulcrum of the interventions that tend to be regulated within the sphere of regulation of the formal supply of services. In Sweden the background to the reorganization of the public supply (which is still paramount) has as a background the growth of the services purchased on the (regular) market and the attempt at including the associative sector in the development of welfare and support services for family caregiving, from the perspective of integrated and systematic interventions.

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