Non Self-sufficient Elderly People and Foreign Care-givers:

Advantages and Limits of This New Model

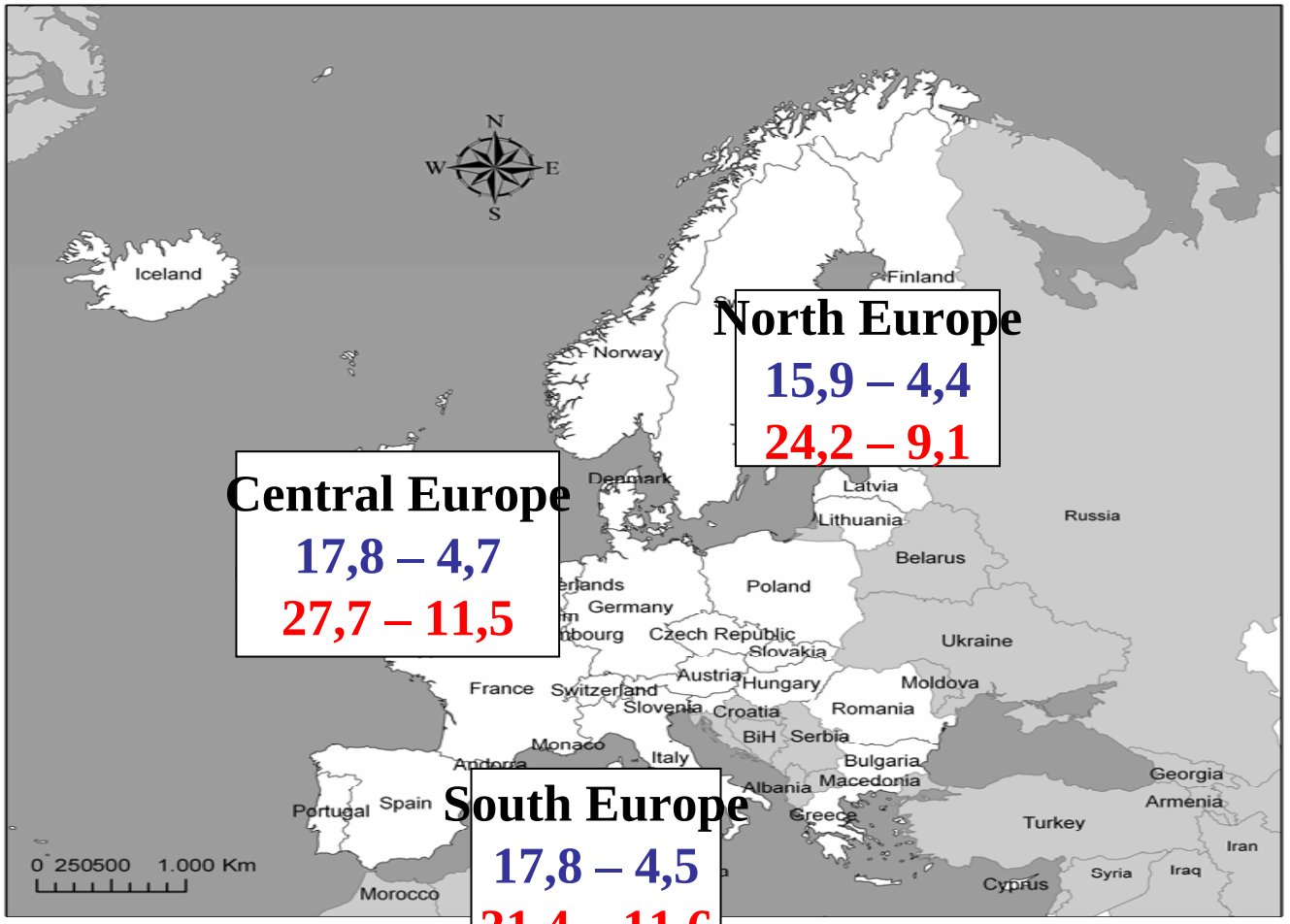
Carla Facchini.
Universidad de Milán, Italia.

Pamplona 11-13 may 2009 –
II International Congress
Long term care and Quality of Life

Demography, Health and Income

All Europe is aging, but with differences:

(% over 65 and over 80 in the tot. pop. . **2006 and 2050**)



Country	Birth Rate	Death rate	Rate natural Increase	Immigration Rate	Rate general Increase	*Ratio of Elderly*
France	**12,7**	**9,2**	**3,5**	**0,9**	**4,4**	**87,4**
Germany	8,7	10,4	1,7	1,7	-0,1	116,3
Greece	9,5	9,5	0,0	3,2	3,1	119,8
Ireland	15,4	7,2	8,2	7,8	16,0	53,0
Italy	**9,5**	**9,9**	**-0,5**	**10,3**	**9,8**	**127,1**
Lussemburg	11,1	9,0	2,1	4,4	7,0	74,5
The Netherlands	12,4	8,7	3,7	0,4	4,0	73,8
Portugal	10,1	10,0	0,0	6,1	6,0	105,5
United Kingdom	11,7	10,3	1,4	4,0	5,4	82,2
Spain	10,4	9,1	1,3	17,7	18,9	116,5
Sweden	11,0	10,0	0,1	3,2	3,1	95,2
EU	**10,6**	**9,8**	**0,8**	**5,3**	**6,1**	**98,2**
Norway	12,0	9,0	3,0	2,5	5,1	74,0
Poland	9,0	9,1	-0,4	-0,4	-0,7	71,8
Romania	9,1	12,0	-2,5	-0,3	-2,8	83,3

*Old people disabled and ill * gender and age*

age	*% disabled*			*% bad health conditions*		
	Total			Total		
		M.	W.		M..	W.
60-64	5,9	6,1	5,8	14,0	12,6	15,4
65-69	9,1	8,1	9,8	17,4	15,2	19,2
70-74	14,3	12,0	15,9	21,5	21,0	21,9
75-79	23,5	21,1	25,2	29,2	27,9	30,3
80 and over	**47,1**	**38,7**	**51,8**	**39,9**	**36,3**	**41,8**
60 and over	17,1	13,8	19,6	22,6	19,1	24,5

Rate of Poverty by age groups in some european countries (2006)

	Totale	0-17	18-64	65 e +
EU15	16	18	14	20
Italy	***20***	***25***	***18***	***22***
Denmark	12	10	11	17
Germany	13	12	13	13
Greece	21	23	18	26
Spain	20	24	16	**31**
France	13	14	12	16
The Netherlands	10	14	9	6
Portugal	18	21	16	26
Sweden	12	15	11	12
United Kingdom	19	24	16	**28**

Family Typology of the old and of the general population – Italy 2006

Family Typology	*Pop. > over 65*	*General Population*
Single	**27,3**	**9,4**
With non-relatives	**4,5**	**2,1**
Couple	**41,5**	**16,8**
couple with Children	**14,3**	**60,6**
Monoparental	**6,6**	**8,9**
other	**5,7**	**2,0**
Total	100%	100%

source: data Istat, census 2001

Important Points:

- Increase of

‘very old’ people

- Increase of disease

& need of:

cure (medical) & care (assistance)

- Increase of singleness

- Economic Conditions of the old

low, but better than in the past

Welfare State

Three principal models become evident in the EU Countries

- **Northern Europe (**Denmark, Sweden, Finland, Holland, Norway, and to a lesser extent the United Kingdom): **This model is one which deals with the problem by means of in-home and institutional social services which have been incorporated into their traditional and comprehensive social-democratic systems.**
- **Central Europe (**Germany, Austria, Luxemburg and France): **Lack of self-sufficiency is confronted by means of a new insurance program or universal social protection, that foresees a monetary payment for the purchase of assistance in the private sector, to pay institutional fees, or to compensate family members who provide care. The amount of payment depends on the gravity of the disability, income, and the type of solution adopted.**
- **Southern Europe (Greece, Spain, Portugal, Italy): The model followed in these countries delegates, above all, even required by law, responsibility to the family: the rate of institutionalization is limited. The users of these services are mostly socially disadvantaged people without family.**

% old people in Hospices or with Home-care

Denmark	**24,6**	**3,9**
Norway	**15,7**	**6,1**
Holland	**12,0**	**7,9**
Switzerland	**12,0**	**7,2**
Finland	**10,7**	**6,2**
Germany	**9,6**	**5,2**
Sweden	**8,2**	**7,7**
France	**7,9**	**6,1**
United Kingdom	**7,1**	**5,4**
Belgium	**4,5**	**7.7**
Ireland	**3,5**	**4,7**
Austria	**3,0**	**5,5**
Italy	**3,0**	**2,7**
Spain	**1,8**	**3,2**
Portugal	**1,0**	**2,0**
Greece	**0,3**	**1,0**

In the last few years this "Mediterranean" model, with the family at its center, has become more and more problematic (Work, Demography and Health; cultural models):

Work:

- Increased participation of adult women in the workforce

- Increase in the retirement age: less availability of middle-aged (children of the very old) for care

- Increased participation of adult women in the workforce, who need help for child care – competition with elderly care

Age	*Rate of female employment by age Goups – Italy – 2006*
25-34	**55,7**
35-44	**57,9**
45-54	**50,4**
55-64	**18,5**
Total	**34,4**

Demography & Health

- Decrease in the number of children who can share the work of providing care

- a long period without self-sufficiency requires the mobilization of considerable resources that may be difficult to maintain continuously over a long period of time

Changes in individual identity

- Models less and less ingrained with a sense of obligation and family ties and more and more permeated by a sense of independence

Families that have recevied aid from relatives–

rate %

	1983	1998	2003
With at least one elderly	**30,7**	**16,0**	**18,4**
With at least one child, but without elderly	**25,1**	**23,7**	**27,2**
With at least one child with a working mother	**30,9**	**31,2**	**33,7**
With at least one child and an elderly	**14,8**	**11,7**	**15,5**
Without children and without elderly	**17,4**	**8,7**	**9,7**

Increase in the request of care-assistance out of family :

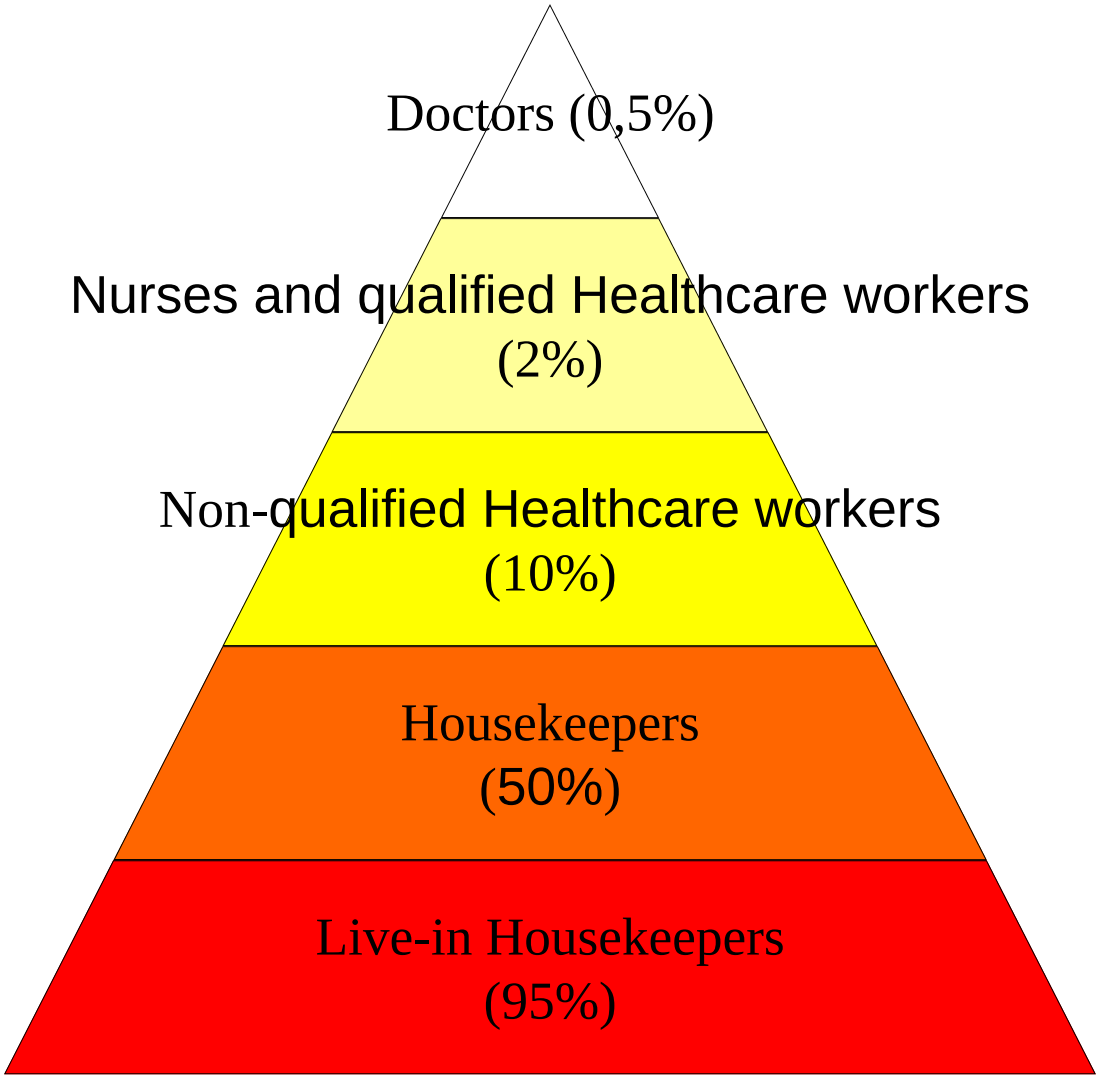
the alternative response to Welfare has been: Immigration

In the ‘80s and ‘90s this immigration came principally from Central and South American countries,
in the last few years, immigration has come principally from the Eastern European countries.
The enlargement of the European Union has eliminated or at least greatly reduced the barriers which stem the flow of immigrants from outside the EU: so it is much easier and less expensive to travel to and from these countries**.**
This has caused a strong increase in the influx of migrants interested in either permanent relocation or temporary work.

In Italy, Greece, Spain and Portugal it is estimated that 20% to 40% of the immigrants are employed in the sector of care.

The PYRAMID of CARE

(the colour tones indicate the percentage of immigrants)



In Italy, the overall number of foreign family care-givers (almost exclusively women) varies between one million and 1.6 million.

Of these, **600,000 to 800,000** concern people who assist the elderly in their own homes, "care-givers" **('badanti')**.

The inability to give more precise numbers is due to the fact that for various reasons the jobs in this field are consistently "under the table".

One must consider that in about half of the cases there isn't a regular working contract

It is estimated that today **the number of elderly who are cared for in their own homes by a care-giver is about 50% more than the total of both those cared for in institutions or that benefit from in-home programs**.

The phenomenon of the “care-giver” therefore assumes a growing importance and does not only concern the well-to-do, but also the middle class, and at times the lower middle class, given that, especially if the care-giver is working “under the table”, **the costs are contained – and on average less than that required for a good nursing home**.

The Characteristics of their Work and their Working Conditions

This work especially concerns **adult women, more and more often from Eastern Europe** (estimated today as 60% of the total).
The research reveals that:

- those who come **from Eastern European** countries are better educated, older, usually married or have a past marriage, often with children and are more interested in temporary immigration in order to overcome family or national economic difficulties.

- those who come **from Central and South America** tend to be younger, less educated, single and more apt to be interested in permanent immigration

The entry of these workers into Italy occurs mostly illegally and by "word of mouth" among family and friends.

Many later legalize their presence in Italy (often during general amnesties that have occurred in recent years),

but many return to illegal status once their residence permit expires – or in the case of the death of the person being cared for and they are unable to find another job immediately

The working and contractual conditions:

- the contractual conditions are varied: which may range **from a regular net salary of about 1,000 Euro** per month to **“under the table” situations with a salary of 600-700 Euro** per month;
- in most cases the care-giver has her own room (sometimes with a bathroom and television), in other cases she sleeps in the living room;
- at the same time, **the working conditions are defined by subjective characteristics, defined by the elderly and their families, rather than objective working conditions**

The specificity of their job, that is, living with the family being assisted, **implies it is not necessary to spend money for room and board** (provided, obviously, by the family for which she works and with which she lives) **so nearly all of their income can be sent home to their family of origin**,
allowing them to get out of extremely problematical economic conditions and/or the possibility to plan for their future and that of their families.

As regards **the medical condition and the assistance needs of the elderly**, these range

- **from the extremely problematic**, in which case it seems difficult to understand how the use of ‘badanti’ can be enough to deal with the situation;
- **to conditions** in which **the immigrant seems to be a means of giving the family peace of mind** because they know someone is always with their elderly family member – and perhaps to make up for the lack of direct care.
-At the same time it reveals that **usually the relationship** with the person being cared for and their families **is positive**, **but at times the relationship can be problematic.**

If working and living in a family **is strongly positive from an economic point of view** with respect to other working arrangements, it also has **enormous social costs**.
Living with a person who is not self-sufficient, who might also have serious mental (cognitive) problems, can be very difficult, especially if one doesn't have any specific preparation.
The work of care involves a presence and an availability that extends to a very wide work schedule.

Above all, the ‘badanti’ leaves one’s own family, one’s own partner, often one’s own children, who have to be entrusted to other family members: in each case she accepts the risk of loosening emotional ties and not being present during important moments in the life of her children.

In some cases there are problems with the members of the family who remain in the country of origin and care for the care-giver’s children and/or parents .

The research also reveals : exhaustion, guilt feelings and depression.

But **also problematic** is the picture as seen from **the point of view of the assisted elderly and their families**: resorting to a care-giver is not an inexpensive solution, especially if the elderly needs continuous assistance and therefore more than one person (one for the day, another for the night and/or days off), even more so if the work relationship is formalized and protected.

PROS & CONS

of this model

Micro-level: individuals involved

	PROS	CONS
Elderly	-Immediate access to assistance -Personalized care in the home -Lower costs as compared to a good Nursing Home	-Insecurity as to the length of time a badante will remain -Low level of professional responsibility -Relationship too intimate: risk of abuse -In the context of progressive increase in their needs, much higher costs that not all families can sustain
Care-giver	-Good salary that includes room and board allowing for substantial monetary savings -In some cases the work is not very demanding	-Emotional costs tied to the separation from the family -In some cases the work is very demanding -Relationship too intimate: risk of abuse -In cases of irregular employment, lack of insurance coverage for retirement

Macro level – Countries involved

	PROS	CONS
Countries of immigration	-Immediate savings for the welfare system -Opportunity for cultural exchange -allows native working women to remain in the workforce	-The scale of the problem is hidden preventing innovation in social politics -Liability for the balance of payments because of remittances (approximately 300,000 Euros per month) -Risk of future increase in the number of immigrant elderly without a pension and consequent social problems -Future depletion of traditional resources (nursing homes) and/or decrease in the pool of workers disposed to live and work in the home
Countries of emigration	-Decrease in local unemployment -Assets in the balance of payments from remittances	-Difficulties in caring for children and the elderly -Consequences for families

If therefore the use of ‘badanti’ is a good solution in the short term, it seems difficult however to hypothesize that it is a good solution in the long term:
The **“social costs” for the immigrants are too high**
The **“economic costs” for the elderly are too high**.

What can be done politically?

At the moment there are some experimental programs being tried at the local level::

- Financial aid for the elderly who need care (vouchers)
- Organization and professional training of care-givers (courses, registration, cooperatives, etc.)
- Integration of foreign workers into the local community

But these programs are heterogeneous, without coordination and not subject to comparative evaluation

What is required is serious consideration of these aspects but also better knowledge of the living conditions and personal histories of both the care-givers and the elderly. Even more important is consideration of the best means of protecting both the worker and the person being cared for.