

Kaja Kvaale

**Combining work and elderly care:  
a comparative analysis of care arrangements in Italy and Norway**

© CIRSDe (Centro Interdisciplinare Ricerche e Studi delle Donne)

Via S. Ottavio 20, 10124 Torino

tel. 011/6703129, fax 011/6709699

[www.cirsde.unito.it](http://www.cirsde.unito.it)

[cirsde@unito.it](mailto:cirsde@unito.it)

## Premise

Reconciling work and family has become a critical issue in Europe and the US (Jacobs and Gerson, 2004; OECD 2005). Combining employment and care of children is now the experience of the majority of mothers across Europe. The proportion of mothers in this situation is likely to increase further even in countries such as, Italy, Spain and Greece in which the proportion of dual-earner couples is currently less than half that of other central and northern European countries, such as France, Denmark, Sweden and Norway. Among the younger cohorts, in fact, also in the Southern European countries the majority of mothers are in the labour force.

However, most attention in work-family conciliation discourses and policies is drawn on parents and in particular on mothers with young children and in what ways they could be supported to keep their position in or return into the labour market after child birth. In other words, discourses and policy attention focus on caring needs and obligations arising in the first phase of family life. Much less attention has been devoted to caring responsibilities towards dependent elderly people and to ways of combining care work with gainful employment (Hessel and Keck, 2009).

The aging of the population is producing an enormous growth of care needs, which social policies have troubles meeting. In all European societies an increasing emphasis is put on informal care, often provided by adult relatives, namely the children of older people. This can be seen, for instance, in the new attention, all around Europe, towards cash-based system (direct payment and/or personal budget) instead of services for old frail people (Ungerson and Yeandle, 2007). At the same time, social policies together with the transformation of European societies are fostering women's and senior citizens' employment, these two groups being the most important potential informal care providers of older dependant people.

Despite this possible contradiction, working and bearing care responsibilities towards older relatives have been rarely considered – in the policy and policy analysis domain – as a conciliating issue.

It is a “conciliation” problem which usually appears in the second half of the working life, at the time parents or relatives become frail and need somebody to care for. This asymmetry in research and policy interests mirrors the asymmetry in the incidence of those two experiences within the working age population. According to the *European Labour Surveys*, while about half of the workers have some caring responsibilities for a small child, care for a non child disabled or frail

elderly relative involves about 7% of workers (with great differences both between the sexes and across countries) (Villosio, 2007). Yet, given the triple phenomena of ageing of the population, increasing women's labour force participation, and regulations raising the pension age, this proportion is bound to increase in the next years.

Kvaale's study compares and explores this relatively new, at least in the European context, issue, i.e. how senior workers combine work care for an older parent.

The analysis - based on qualitative interviews with adult children of older dependent parents, previously collected for a broader comparative project titled "Worker Under Pressure and Social Care" - looks at the care and work arrangements and trajectories, and at the attitudes towards work and care in two very different welfare states: Italy and Norway.

Several points make this a particularly interesting paper to those who want to understand not only the differences and similarities between different welfare state regimes (Esping-Andersen, 1990), social care traditions (Daly and Rake, 2003), and policy orientations. It is a new perspective of analysis which allows the reader to look at the dynamics of changes undergoing in the work-family system (Pleck, 1977).

The two national cases chosen to illustrate the intersection - and tension - between working and caring, as the author well illustrates, belong to two very different European contexts. These two countries are different with regard to: the definition of care, mainly as a private (family) issue in Italy, and a public and collective responsibility in Norway; the women's employment participation (very low rates in the Italian case, compared to the "dual earner" model of family, widespread in Norway). They differ in the legal and social definition of family obligations as well (with a high level of family obligations in Italy and very low in Norway). Finally, as widely discussed in Kvaale's paper, Italy and Norway differ in values, norms and attitudes towards care, gender and women's work. Although, this study shows that the two countries vary less than one could expect, being Norway the more "different" state among the countries belonging to the Scandinavian welfare state model, the distance in care policies and care practices are vast.

The first part of the paper, especially the analysis of the combination of formal and informal social care, illustrates how the two national traditions in long-term care and conciliation policies for frail elderly are different. Norway can be seen in this respect as a "pure" example of the Scandinavian model of welfare state: high level of publicly financed services and of individual social rights, which reduce family responsibilities and dependences and produce a high level of what "de-familization" (Leitner, 1994, Saraceno, 2010). More recently, Norway undergoes, as most other Central and Northern European countries, a "de-institutionalization" policy process, with a decrease in bedpost in institutions and the attempt to increase care homes "*omsorgsboliger*".

Otherwise, the Italian case shows that frail elderly care was in the past, and remain nowadays, highly familiarized, notwithstanding the strong role played by the market strategies – based on the recourse to privately paid migrant care workers. The increasing incidence of migrant workers among care-workers(→) is a strong innovation in the Italian caring system and mirrors not only the meagre presence of public financed services, but also the fact that in Italy the private nature of care giving is partly compensated by the public transfers, mostly distributed through the *Indennità di accompagnamento*.

The presence of a large irregular market has rendered paid care affordable also to the middle (and to some extent to lower) classes, with scarce economic resources. Institutional care – where long waiting lists remain – is targeted to the totally incapacitated, bed ridden, often also with modest economic means.

This “*family-migrant care model*” (Naldini and Saraceno 2008) provided by migrant in the Italian case does not undermine the traditional gender division of care labour in the family in so far as the private carers are all women (a migrant one) and primary care-givers daughters much more than sons. Having a *badante* – the prevalent care arrangement among the Italian interviewees – who is living at home guarantees continuous care, the fulfilment of a wide range of tasks, and, above all, permanent supervision of the older person. In this context, working caregivers profit from very flexible care arrangements. In terms of gender system this new “family-migrant care model” shows, however, a strong change in women’s employment attitude and labour market behaviour.

Although within a context of strong differentiation in terms of caring policies and care practices, Kvaale’s paper illustrates that working carers in Italy and Norway tend to develop complex care arrangement patterns and trajectories, which might have a temporary and unstable nature. What make the two cases similar, however, is the impact of being care-givers on family and work. Working and caring are extremely demanding for the interviewees both time wise and emotionally. Family time and free time are dramatically reduced by the combination of work and care responsibilities in many cases. This very often reflects into a reduction or cancellation of holidays and into a limitation of free time during week-ends in both countries. But against this background, the results of the Kvaale’s qualitative study underlines that the impact of care responsibilities on work is quite limited. From this point of view the paper seems to support the hypothesis that work might have a buffer effect against the strain of caregiving. The interviewees not only show very high work oriented preferences, but especially in the Italian context, opposite to what one could expect, clearly experience (and use) employment as a way to reduce the demands and to ‘protect’ themselves from overwhelming care responsibilities. It seems that in both contexts work is uncompressible while family and private life is compressible.

Several elements can help understand this unexpected outcome in the Italian case (Da Roit and Naldini, forthcoming). First, in the Italian case, almost all the interviewees belonging to the larger sample of the project “Worker Under Pressure and Social Care” consider work as an inalienable principle: this means that they tend to use the degree of flexibility that is formally or informally available, exploit the resources accessible at work (information, knowledge, instruments), and negotiate their position within the limits of what they know to be acceptable within the work place. The interviewees are experienced workers who have been employed for the same company for several years, they know by heart the implicit rules and tend not to go beyond them. Second, as senior workers have achieved the maximum of the career possible within their organisation or conceived by themselves in relation to their educational credentials. A temporary, even if prolonged disengagement from work, is therefore unlikely to produce negative effects. Third, as they have a long lasting working record and tend to be *insiders* in the labour market - even more so for public sector and big company workers - they enjoy strong rights associated to employment of which they are aware. If these characteristics found in the interviewees in Italy are likely to be representative of the current cohort of senior workers, the Italian welfare state will face new challenges in the next future. In this respect we may put forward the idea that the conciliation issue in the later stage of working life will be of growing importance and will be increasingly problematic not only because of higher care demands due to population ageing, but also because of the reduced availability of potential (unpaid) care givers. The number of potential care-givers is likely to decrease because of stronger orientation towards paid work (next to changing rules with respect to the retirement age of women and men).

Manuela Naldini

## References

Da Roit, B. and Naldini, M. ( forthcoming) “Should I stay or should I go? Combining work and care for an older parent in Italy”, in *South European Society and Politics*.

Daly M. and Rake K. (2004) *Gender and the welfare state. Care, work and welfare in Europe and the USA*, Cambridge, Polity Press.

Esping-Andersen, G. (1990), *The Three Worlds of Welfare Capitalism*, New York, Polity Press.

Hessel, P. and Keck, W. (2009) How caring for an adult person affect employment? Equalsoc State of the Art Report, August 2009, [www.equalsoc.org](http://www.equalsoc.org)

Jacobs, J. A. e Gerson, K. (2004), *The Time Divide. Work, Family, and Gender Inequality*, Harvard University Press, Cambridge, Massachusetts.

Leitner S., (2003) “Varieties of familialism. The caring function of the family in comparative perspective”, *European Societies*, 5 (4), pp. 353-375.

Naldini, M. and Sarceno, C. (2008) “Social and Family Policies in Italy: Not Totally Frozen But Far From Structured Reforms”, in *Social Policy & Administration* Vol. 42, issue 7, p. 733-753.

OECD (2005), *Babies and Bosses, Reconciling Work and Family Life*, vol. 4, Paris, OECD

Pleck, J. H. (1977), "The Work-Family Role System", *Social Problems*, vol. 24, pp. 417-427.

Saraceno C. (2010) Social inequalities in facing old-age dependency: a bi-generational perspective, in: *Journal of European Social Policy*, 20, 1, pp. 1-13

Ungerson, C., Yeandle, S. (eds) (2007), *Cash for Care Systems in Developed Welfare States*, Palgrave Macmillan.

Villosio, C. (2008) Working conditions of an ageing workforce European Foundation for the Improvement of Living and Working Conditions, Dublin.

## Table of contents

Introduction	1
1. The welfare state and how it affects gender relations and care-giving	3
1.1 The role of the family in the welfare state	4
1.2 Gender equality and female employment in the two countries	7
1.3 Formal, informal and social care	10
2. Background on elderly care in Italy and Norway	16
2.1 Elderly care in Italy	16
2.2 Elderly care in Norway	22
3. Research presentation and objectives	25
3.1 The sample and the performed collection of data	26
3.2 The analysis	29
3.2.1 Types of Italian care arrangements	29
3.2.2 The Norwegian care arrangements	35
3.2.3 How do they become the main care giver?	38
3.2.4 What kind of care do the main carers perform?	41
3.2.5 Combining care with work: work attachment and leaves	43
3.2.6 Implications of care on main carers private and social life	46
3.2.7 Norms and values: how can elderly care improve and with what measures?	47
4. Conclusion	51
References	54
Abstract	60

## Introduction

The subject of working and caring has gained much attention in the last decades, but most of the research done on the field is concentrated on childcare and the work and life situation for mothers of young children. Only recently has caring for an elderly and the impact this has on employment and individual choice been given more attention. This sudden interest for elderly care is not accidental since we live in a time where the older generations are increasingly becoming the biggest cohort, while the younger generation are constantly decreasing and thus creating a care deficit. This gives problematic visions for the future in almost all European countries and resulting in various coping strategies from the individual and national perspective.

This study is based on the international research project Workers Under Pressure (WOUPS), where I had the honor of participating by interviewing a part of the Italian respondents, i.e. couples with stress and pressure due to their dual role of being both workers and carers. Finally I performed identical interviews in Norway and analyzed and compared the results.

More specifically, I explore the situations where working couples in these two countries, have an adult parent who needs some kind of care and how they cope in their everyday life. One important factor for their organizing is state policies and the welfare core attitude towards helping out in care needing situations. Other influencing elements are the individual and family resources and the existing norms and values on the national level. Taking a dive into the structure and background of the diverse welfare states and modern theories around care and work are therefore prioritized in the first chapter. I have chose to give special attention to the theories of Pfau Effinger and Geissler when addressing the importance of a state's culture models and values, which contribute to shape the choices being made in the care arrangement and the further implications for social policies. My goal is to describe the care arrangements in Italy and Norway so as to convey what the problems are for caregivers and how it may be possible to improve their situation in combining care with work. The second chapter gives us an insight in the background of elderly care and policy developments in the two countries in question. As presented in the last chapter, by interviewing persons in two such diverse parts of Europe, one may be able to comprehend more of which problems are present due to country specific policies and traditions and others which may be seen as more universalistic issues. Coloring and being colored by all the subjects involved in care taking for an elderly, namely:

welfare state, family, care and work, is the gender variable. I therefore wish to reflect and investigate how care giving and working relates to gender and gender roles in the two countries and how or if it diverts from pre-existing cultural categorizations. Through the semi structured qualitative interviews I wish to convey the respondents' attitude and emotions related to the subject care and how it should be organized in public and in private. By analyzing the respondent' reflections surrounding state and family, they reveal to us cultural norms and values when it comes to gender and the actions inhibiting or enhancing gender equality.

## 1. The welfare state and how it affects gender relations and care-giving

In his work *The Three Worlds of Welfare Capitalism* (1990), Esping-Andersen separates between 3 types of welfare states: the liberal, the conservative and the social democratic model. The first type consists of countries like USA, Canada and Australia and is recognized by their non-universalistic aid to their inhabitants. The second type is the conservative or corporalist regime which is adopted by Austria, Germany, France, and Italy. It consists in maintaining class and status differences and controlled distribution of goods. The expression 'Mediterranean Welfare State' was introduced by Liebfried in 1992 seeing similarities in the 'Latin rim', hence Italy, Spain, Greece and Portugal. The discussion is whether this group of countries has their own specific welfare development or if they are examples of less developed welfare states. The Mediterranean countries are considered by Liebfried (1992) as having residential social policies like the Anglo-Saxon. Others place the Catholic Church as explicatory for the developments of these countries especially concerning family organizations. The main principle of the Catholic Church is the *subsidiarity*, which means that the main provider of the wellbeing of the citizens should in first hand be the family, the local community and the voluntary organizations. The state and public services hence comes as a secondary and subsidiary element (Naldini 2006). Not surprisingly Norway is placed under the social democratic model along with Sweden and Denmark. To an extended degree the Scandinavian social politics has been known for its universalism, meaning that in principle the whole population is included in welfare arrangements. They have these rights because they are a part of a nation and not because of some criteria they possess, work participation or effort. Public engagement is at its strongest in these countries and through the so-called citizen-principle, meaning that the taxation and finances are organized more egalitarian and sharing than other welfare regimes. For feminist researchers gender relations lies as a background coloring the entire welfare state, and therefore one cannot understand a welfare state without looking at the gender relations in each country and how public policies creates or modifies these. As authors Daly and Rake puts it: "Welfare states help to determine the form and meaning of social roles by, for example treating men as the providers for their families. Welfare states also affect the choice of roles available to people, not least because they help to set out the rewards and penalties attached to particular roles. Their effect on social roles

is therefore an important aspect of the agency of the state.”(2003:38). The welfare state can be seen as socially reproducing and reinforcing pre-existing gender roles and relations. More recently, there has been a greater focus on the ways in which state practices constitute gender. Thus, some (Gordon & Fraser 1994, Knijn 1994, Saraceno 1994, Cass 1994, Pateman 1988, Lister 1990) have focused particularly on the construction of gendered citizenship of male “independence” based on wage-earning and female “dependence,” and associated gender-differentiated social provision (Orloff 1996). The welfare state not only determines where care is being performed but also what is paid and unpaid and the general conditions for care work.

## 1.1 The role of the family in the welfare state

Before going in to deep, an overview of the literature describing the relationships between welfare state, gender, and care will be done in order to find out about the state role in defining the family’s responsibilities, public benefits and expenditures. This will give the needed background to understand care-giving system for the elderly in Italy and Norway. First, a look at the social protection given to the family in the welfare state will be given.

One way of measuring social protection is the concept of *decommodification*. It is defined as: “the extent to which individuals and families can maintain a normal and socially acceptable standard of living regardless of their market performance” (Esping-Andersen 1987:86). During the 20<sup>th</sup> century the welfare state *decommodified* labour because of the development of civil rights including life standards and the decreasing reliance on the market for day-to-day survival. Under capitalism the degrees of *decommodification*, hence, “degrees of protection from dependence on the labour market provided by the welfare state in the form of cash benefits” (Bambra 2005) progressed. Esping-Andersen started his analysis criticizing earlier welfare state research stating that too much concerned was given to the total expenditure of each country. He, therefore, used the expression *decommodification*, meaning how the welfare state acts instead of how much money it has or spends. The Conservative regime, for example, put more emphasis on cash benefits than welfare services, while the social democratic regime emphasizes both highly. Esping-Andersen’s use of the term *decommodification* in his welfare state typology has been under debate and has been criticized from several perspectives, range, methodology and the lack of focus on gender. The *decommodification* concept has for many writers (e.g. Lewis 1992, Lewis and Ostner 1993, Orloff 1993, O’Connor 1993, Saraceno 2000, Leitner 2002, Daly and Rake 2004, Pfau-Effinger and Geissler 2005) been difficult to approve since he does not include women enough in his discussion.

His concepts are from the beginning gendered since his preference for a worker is a man whose wife takes care of home and children, thus making it possible for him to fully commit himself to his work. The relation between women and men is creating changes and/or stagnation in the different welfare regimes depending on the cultural roles and norms. In all welfare states the family, and often the women in the family, are service providers to a high degree that must be acknowledged during welfare state analysis. The constant border between paid and unpaid work, the formal and domestic sphere is crucial for the understanding and improving the situation for women, families and the welfare states. There are numbers of ways in which women are unprivileged in social rights and possibilities as a result of being set aside from the public workforce, and at the same time being a resource for the welfare state through informal work. This gives the man the possibilities he has to work and make choices without having to worry too much about childcare, care for the elderly, social security or unemployment. There must be stated as Lewis (2006) that the repeated use of Esping-Andersen in almost all works concerning welfare state must be reflected upon since the objective, the Welfare State, is so dynamic and prone to rapid changes so that it cannot be viewed strictly by typologies made in the early 90s. Here I, as many others would like to use his typologies not as “a factual reference point”, but as a place to start the discussion around welfare states.

Many writers engaged in the study of family and gender in the welfare state have developed theories and typologies that comes to use for the subject care. An important term frequently used is the level of *defamilization* created by the state in question. The definition of *defamilization* here used is: “The degree to which individual adults can uphold a socially acceptable standard of living, independently of family relationship, either through paid work or social security provision” (Lister 1994:37). In other words, it aims to describe in which way the state can guarantee its inhabitants autonomy and wellbeing independent of their family status or otherwise. It is obvious that this definition is closely linked to the care arrangements developed in each state, so as to which demands the state puts on the family in the organization of care (Bambra 2005). The expression *defamiliazation* is in other words important for the analysis of care organizations in each country and the gender-relation in general. By applying ideal breadwinner-types of family organizations we can use them as instruments to explore both the gender-relation and the inter-generational relation defining the roles, functions, obligations, cultural norms and *defamilization* in each country or group of Welfare State. The male-breadwinner, which is recognized by its clear gender division as the man works fulltime and the woman takes care of the domestic and care work. Using Esping-Andersen’s typology, the liberal regime would apply to this ideal type organization. It implies, in addition, to the concrete work sphere, a weak importance of the generational relation, medium importance of marriage, the presence of legal obligations between parents and children as well as

between the individual in the couple. Further, there are high levels of universalistic benefits to wife and children, slow development of child support and medium to low support for elderly care.

The second ideal type is the dual-earner model, which is linked to the Social democratic regime implicating a situation where both sexes have a paid job. By applying Norway as an example to this type it should be recognized by the equal division of labour as can be noticed by Figure 4. Besides, the social security arrangements in Norway reflect the universalism described earlier as the guaranteed minimum of social security to all habitants in the country irrelevant of their work activity or citizenship. At the core of social security lies the *grunntryggheten* i.e. *base-safety* for those who persistently are unable to create their own income due to: health, old age, loss of provider or being alone with full responsibility to take care of a child. An economic minimum standard is defined by law and given to these groups irrelevant of their former work participation or social security payments. There are no legal obligations between the two persons in a couple, there are a medium level of family benefits, medium to high level of child support and high levels of elderly care development. Pfau-Effinger and Geissler (2005) places Norway under the social democratic regime because of its focus on social and financial rights and possibilities for the individual and not for families. This makes it possible for couples to be more autonomous in their choice for family- and care organization. The cultural change that created the development of the dual earner-model was facilitated by increased employment and in more recent years the generous rights concerning informal care, parental leave and part-time work, which makes it possible to pursue a more gender equal family model (Pfau-Effinger and Geissler 2005).

The last ideal type is recognized as the family-solidarity model and the Mediterranean regime, here represented by Italy, as example where there is a high level of work division both between the man and woman and between the generations. The employment is seen as dominated by men female employment subsidiary to the male as shown in Fig. 5. Its close inter-generational relation and a high inter-generational relation and legal obligation characterize the Mediterranean regime. The family benefits are at a low level since the main provider is seen as the male and the child and elderly support is low for the same reason since the wife has the main responsibility for domestic and care work. Inter-generational obligations as they are framed in civil code and social security law has been a studied topic and Millar and Warman (1996) defined obligations to include a relation both financially and care –wise, where the latter implies the obligation to look after another person. According to Millar and Warman, all the Scandinavian countries are based on individual autonomy where cash benefits and taxations are mostly individualized and it seldom includes provisions for dependent family members, with exception of underage children. The caring for an elderly is not

defined as a family obligation, although the right to receive care for the elderly is a more incomplete social right than in the case of children Italy is by Millar and Warman (1996) placed under the so called Extended family group of countries along with Greece, Portugal and Spain. In these countries there is legal obligation within the nuclear family (not necessarily co-resident) and public social care is normally given to those without a family or the poor ones.

## 1.2. Gender equality and female employment in the two countries

We will now have a look at the countries' gender equalities and employment, even though the quantitative description and measuring of such a complex field cannot in any way be a complete presentation.

The United Nations has created two indexes: The Gender-related Development Index (GDI) and The Gender Empowerment Measure (GEM). Both indexes aim to compare the differences between men and women in a country, but they are criticized for being weak when dealing with so complex issues. Yet, they are also considered as one of few indicators measuring gender equality on an international level (SSB 3). Norway is generally placed in top 3 on both scores while Italy generally is ranged at place 16 and 21.

In the year 2000 the Lisbon Summit aimed at increasing the European level of female employment to 60%. The numbers were at that time 54% female and 72.5 % male. Female employment in Europe has been increasing, in 2007 with 1.8% rate (Eurostat), and the numbers of female part time workers (at 31.2% in 2007) has quadruplicated and compared to male workers. There could be personal reasons as to the choices made for part time or flexible work hours, but the unequal share of domestic and family responsibilities leads to the conclusion that women struggle with time schedules to engage in both activities.

In 2007 more than 6 million women in the EU countries said they worked part time or not at all because of family responsibilities (The European Commission's Directorate-General for Employment, Social Affairs and Equal Opportunities 2009). Reconciling policies are defined as those grips made to facilitate men and women to combine work and family needs. On the supranational level, there are policies aiming at promoting equal participation and decision making for the two sexes and the European Commission's Directorate-General for Employment, Social Affairs and Equal Opportunities underlines the importance of better reconciliation of work and private life for both sexes and to combat stereotypes (Commission of the European Communities Report 2009).

The development of the welfare state is an important reason to why more women have paid work in

Norway. There was an increase to almost the double of employees in the Norwegian health and care section between 1980 and 2000 and 80% of them being women. It is to be said though that 50% of these work part time (Hatland, Kuhnle and Romøren 2001:121). None the less, the Norwegian welfare state is an employing machine and jobs that were earlier non-paid care-tasks exercised by the family for elderly, disabled and children, are now taken over by the public and transferred into paid labour. Women are, to a smaller degree, dependent on men and more dependent on state and the job market. By delivering or receiving welfare women have increased their importance and presence in the Norwegian society in the last 20-30 years.

Looking at Table 1 we can see that Norwegian women's work participation in their most active years is more or less at the same level as the men in the population.

*Table 1 Male and female labour employment in Norway*

Population aged 15-74, by labour force status, sex, age, time and contents 2008	
	Persons (per cent)
<b>Employed</b>	
Total 25-54 years	86,8
Males 25-54 years	89,5
Females 25-54 years	84,0
<b>Unemployed</b>	
Total 25-54 years	2,0
Males 25-54 years	2,0
Females 25-54 years	1,9

2009 © Statistics Norway

After decades of admiration for the gender equality in Norway and the Nordic countries, critics analysing more in detail the societies and numbers, conclude that there have been gender equality improvements on many areas in the Scandinavian societies, but there is still much work to be done concerning the gender pay gap, labour market segregation and inequality in old age pensions and immigration (Borchorst and Siim 2008).

Italy has never been and is still not considered gender equal. Although several gender-equalizing policies have been activated on external pressures from the EU (for example Legge 903/1977 Equal

treatment between men and women on the workplace, EC Directive transposition, Legge 125/1991 Positive action for the gender equality and Legge 215/92 Specific Action for female entrepreneurship), they are seen as halfway efforts without markedly results. EU works as a motivator and pressure organ for the Italian gender equality policy that is seen as lacking a true commitment to gender equality and a supporting gender sensitive culture. Italian women are the least likely in the OECD to be in paid employment and the Italian female employment rate is at 45%, amongst the lowest in the OECD. The labour market participation of Italian women is slowly increasing and one reason for this is the increase in women's educational attainment. Higher qualifications provide people with the opportunity to access more interesting and well-paid forms of work. Almost 70% of Italian women aged 25-34 had an upper secondary education in 2004 compared to only 60% of males (OECD Babies and bosses 2007).

*Table 2 Male and female employment in Italy*

Unemployment and employment rates by sex and age group, 2007 (%)				
Age group	Unemployment rate		Employment rate	
	Women (%)	Men (%)	Women (%)	Men (%)
25-34 years	10.0	5.3	59.5	81.7
35-54 years	6.2	2.7	59.5	90.5

(Istituto Nazionale di Statistica, Istat 2007)

As mentioned, the Italian fertility rate is one of the lowest in the world and it seems that Italian women have to choose between paid work and caring for children and the elderly. In the first part of the 1970's Italian fertility rates were relatively high. Since then the decline has been very rapid and although recently birth rates in Italy have risen fractionally, the total fertility rates are amongst the lowest in the OECD and well-below replacement levels. Despite an ongoing awareness and activities, especially in academic sectors, the political regime in the country seems to slow the progress of the Italian gender equality.

### 1.3 Formal, informal and social care

The concept of care has been debated upon for decades in Anglo-American literature and in Scandinavia where feminist movements have analyzed the term in context by discussing the care work, gender relations and welfare states' care organizations and the relations between the family, the state and the market. Therefore, a developed definition of care could be: "Care is both the paid and unpaid provision of support involving work activities and feeling states. It is provided mainly, but not exclusively, by women to both able-bodied and dependent adults or children in either the public or private sphere and in a variety of institutional settings" (Thomas 1993:665).<sup>1</sup>

Formal care is often described as public and private care given by the state or by private or volunteer organizations. A gender-neutral definition of informal care could be: "care given without compensation by private persons closely related to the senior citizen" (Hatland, Kuhnle and Romøren 2001:173). The difference between formal and informal care is both monetary and relation-wise between the giver and the receiver of care. Expanding the definition of care to include the social aspect of the term one may say that "care includes the provision of daily social, psychological, emotional, and physical attention for people" (Knijn and Kremer 1997:330). Social care is here understood as the assistance that takes place in the public or in the private sphere and performed as paid or as unpaid work, by professional or non professionals in order to help children or frail adults with big or small activities in their daily lives. The social part of care is visible to us exploring the carers since they have been and still are performed to a greater extent by females as paid or unpaid work. Although welfare states has focused on social inclusion of women through labour integration for some time now, the problem of low social recognition for care-work still remains. Above all in what Esping-Andersen considered liberal and conservative regimes, the low value applied to child-and elderly care is seen in all levels of professions seen as 'feminine'. The combination of an ageing society and low fertility rates (with exception of the Nordic countries), the welfare state struggle to meet the care needs of its inhabitants. As to why the fertility rates are still high in the northern countries, theories focus on the states acknowledgement of the issue of reconciling work and child rearing. Earlier research shows that there is a high correlation (0.80) between women's employment and home help services for the elderly, which may explain why female work participation is not higher in the southern European countries (Anttonen and Sipilä 1996). This could also be interpreted as to why not more focus is put on developments in that sector: there's already someone there to perform the services, namely the wife or daughter of the

---

<sup>1</sup> The care concept is useful while analyzing the welfare states since it shows how social policies answer to the increasing demand for care, but it has to be mentioned that comparing services and comparing countries is a difficult task since it is complex and fragmented.

care needed elder. By examining a states female work participation and it's formalization of care work, one can interpret the result as that specific countries' 'woman-friendliness' (Siim 2000). Hence, formal care is seen as belonging to the modern and woman friendly welfare state, which focus on giving the woman relief from her in house care work and into a compensated job. In contrast, informal care describes the more traditional family organization where care is unpaid work performed by women who are excluded from the benefits that comes from the work market. Some writers, such as Pfau-Effinger and Geissler underline the simplification of placing the formal and informal organization as opposites. The dynamic development of care takes a variation of ways in each country and creates new forms of informal care work: a) Semi-formal family based care work and b) Informal care employment (Pfau-Effinger and Geissler 2005.) The first form, the semi formal family based care work, is closely related to paid parental or care-leave developed in European Welfare states which puts forward a right to give care, hence "the right of parents, relatives or friends, during temporary life phases, to provide care for their children, frail elderly relatives or friends in the household" (Pfau-Effinger and Geissler 2005:8). Informal care, consequently, is paid household work where the household is the employer of an (normally female) employee outside the formal network, meaning the employee is hired without benefits such as law and security rights. The 'care deficit', meaning the lack of persons to give care as a result of increased female employment, the ageing of the population and low fertility numbers, has resulted in different regulations or innovations from the welfare state. During the 1990s, one particular method was proposed which was meant to put more autonomy in the hands of the carers by cash payments given directly or indirectly to carers. The carer, depending on the implications following the provision, can in some countries decide to get paid themselves to care for an elderly parent or relative or they can hire someone to do it. These benefits are given directly or indirectly (via the care needed) to the carer in addition to formal care if it exists in the specific welfare state. The consequences of these cash payments are multiple, but most of all and as we will see specifically in the Italian case, it concerns the relationship between formal and informal care and therefore the relationship between carer and cared for and carer and life and work-situation (Ungerson in Pfau-Effinger and Geissler, 2005). The cash provisions have met various critiques and acknowledgements. On the pro-side one could say that paying a carer for nursing a parent or relative, creates a tightening of the inter-generational bonds and maintains the family as an important institution for care, since care-work demands not only physical, but emotional and cognitive attention. It has, though created critical voices on the basis of *commodifying* something that was used to be informal and *uncommodified*. This means that the care that was earlier seen as natural to do and not necessarily seen as work per se is now suddenly defined within paid work. It

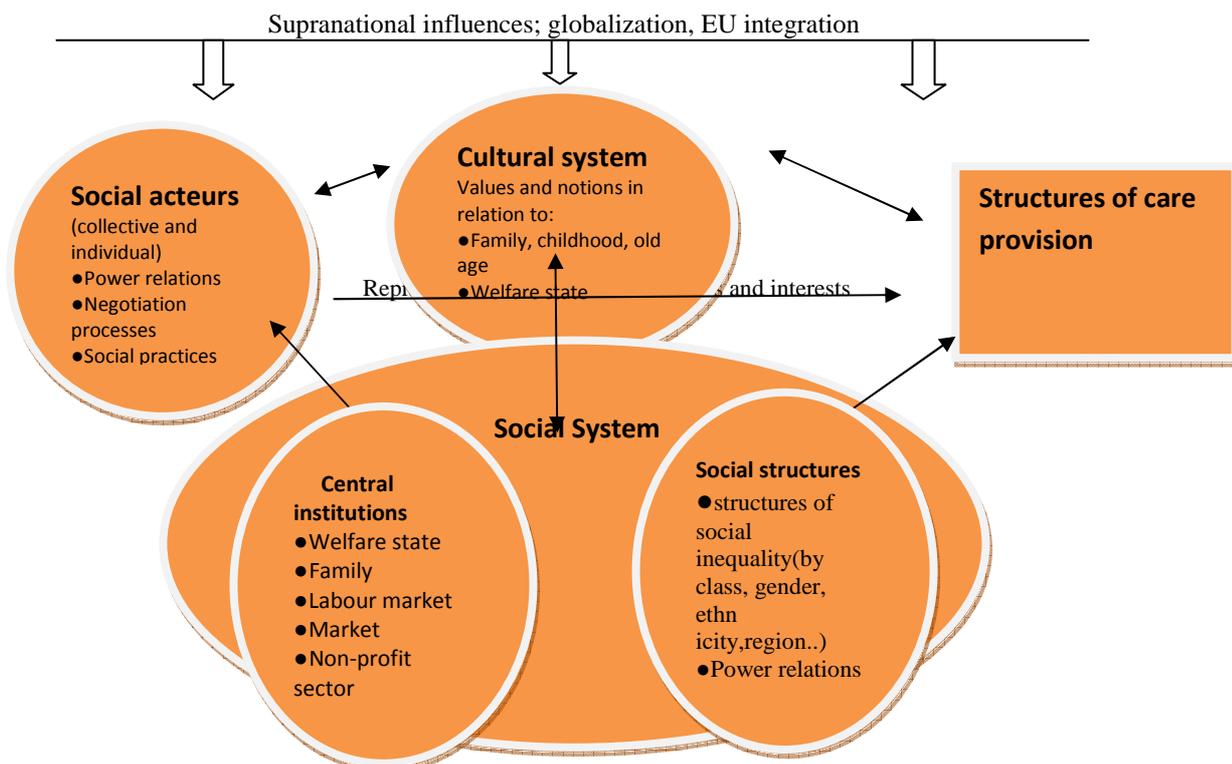
could also happen that the money that was intentionally given to cover care-needs, are instead blended in with the general household-spending that has nothing to do with the care itself. Another issue revealed by the cash payments is the continuing facilitation of grey market carers consisting mainly of unskilled and untrained care persons<sup>2</sup>. The undocumented grey market worker solution is though a two-sided sword; it helps there and then as a substitute for incapable welfare services, but it works as a massive break for changing the gender contract or for demanding further developments in care solutions on a stately basis. The ‘Cash-for care-systems’ existent in several welfare states therefore elicit the development of private, foreign hired help since the household can decide where and how to spend the subsidies. Since the 1970s where especially in Scandinavian there was a weakening of the family-based concepts of social care, has resulted in changes in the welfare state policies all over Europe the following decades. The results are a variation of combinations of formal and informal care specific for the country and also for regions within countries, but they do share the same feminist influence where the women’s movements fought for equality both work-wise and politically. Their influence had an impact in different ranges depending on the country, but their program was an alternative to the familial one and criticized a situation where women were depending on a male provider, and the consequences of this thinking can be seen where female informal care more and more has lost its place as a taken for granted part of the marriage and is brought into the light of national and international debate. Geissler and Pfau-Effinger (2005) underline the constant and at the same time dynamic relationship between socio-economical and socio-cultural on the one side and the choices made in welfare provisions on the other. They are linked and influence one another. Each culture has its ideas for social organization both when it comes to different institutions, but also ideas about gender and gender roles influencing how they see an ideal family or societal organization. What is seen as good or optimal division in one culture may be seen as the opposite in another cultural perspective. These reflections cannot be ignored and should, according to Pfau-Effinger and Geissler (2005), always be included in the analysis of different welfare states. A difference between two countries when it comes to families’ involvement in care does not necessarily reflect the local welfare policy, but instead the diverse cultural ideas of what is ‘right upbringing’ or ‘seniorship’ in that particular country or culture (Pfau-Effinger and Geissler, 2005:15). In this paper I will try to elaborate and fulfil this concern. In the period after Esping-Andersen’s (1990) known description of welfare states, many writers have developed definitions and classifications considering the gender roles that makes the background for choices and possibilities for care in each country. A classical cross-national analysis

---

<sup>2</sup> . As we will see, this is the case for many Italian choices and has implications both at short and long hand for the cared for and for the carer.

(Pfau-Effinger and Geissler, 2005) focus on to what degree each element is involved in care-provision: the state, the market, the family or volunteer organizations. The recognition of other factors besides welfare policies as important to the differences in care organization, could bring an explanatory complex model:

Fig.1 Care Provision within the care arrangement



(Pfau-Effinger and Geissler 2005:23)

Pfau-Effinger explains the idea of this ‘care arrangement approach’ this way:

It is based on the idea that, besides institutional, social and socio-economical factors, values and cultural models regarding the role of different spheres of society for the provision of care also contribute to explaining the way in which care policies and their transformation into social practices develop (Pfau-Effinger and Geissler, 2005:22)

Culture is here seen as the sum of our ideas, meaning our knowledge and values and makes the foundation for action when the interest is present. Two types of values are by Pfau-Effinger and Geissler (ibid) seen as the base for care arrangements: a) family values and b) welfare values. The first type regards the gender structure and culture values of the family where ideals are shaping the choices being made. More concretely, it gives ground for in what way and to what degree the family should be the main care provider. Internally in the family the family values influences on who should be the main carer. One culture does not necessarily have only one type of family model, but there can be many types influencing. The second type concerns the care part outside of the family and sets ground for the preferred institutions or arrangements supported by the welfare states

re-distributive role or private institutions.

Making use of Esping-Andersen's (ibid) typology, the cultures whose main welfare value is the market are recognized in the liberal welfare regimes. The conservative welfare regime divides the responsibility outside the family between non-profit organizations and the state. Finally, the social democratic welfare regime issues the state as the main responsible for care provisions and organizations outside the family. When the culture or social part of a society changes, this may influence in diverse ways the underlying care arrangement. These changes may appear from political actions or from moral ideals being transformed after influence from theories, trends and ideals. Many European countries are at this point renegotiating their welfare values as a consequence of globalization, which creates awareness and often criticism of ones former values or organization. This may change the way of the care arrangement, even though not completely, but normally bit-by-bit or adapting to the former values of the specific country. In relation to the care arrangements, the welfare states' social services and involvement in the caring for elderly could be expected to have impacts on the intergenerational solidarity in the two countries in question. In the media, the inability of families to care for dependent elderly in developed countries has been widespread, but studies show that as social support, the strength of the family-ties in all European welfare states has not diminished, but is instead still close and warm (Rossi and Rossi, 1990). Being a Mediterranean welfare state one expects to find a strong relation and solidarity between the generations in Italy. An important question is: in what way is this visible in the care organizing and which motivations lie underneath the choices individuals make? Is it due to legal obligations incorporated in the social norm or is it the lacking public services that 'forces' the family to engage and care? These questions are difficult to answer due to the complexity of measuring intergenerational solidarity, but still interesting to have in mind while reading the analytical part of this paper. What is peculiar in the care arrangement negotiation is that the choices being made also depend on the family's resources and context (Da Roit, 2007). This gives way for social stratification, especially when the social services are limited so that more weight is put on the family and they cannot pay for private market additional care (Saraceno, 2008). In the Italian case specifically, the variations in benefits and resources inflicts on the family and individuals' division of formal and informal care, as we will see in the in the next chapters. Although the intergenerational solidarity in Italy is being revised and changing in these days due to influences both externally (from other western countries and the EU) and internally (national policies), the solidarity between the generations is still highly existent and important (Da Roit, 2007). What is interesting confronted with Norwegian findings (OASIS project) is that the Italian norm of helping your older parents economically is more widespread and even relied on due mainly to a perceived

less secure financial status among the elders (Da Roit, Le Bihan and Osterle, 2007).

## 2. Background on elderly care in Italy and Norway

Before analyzing the individual countries' development and present care situation we must add that both Italy and Norway, at least theoretically, have followed a general path similar to the other European countries. For a long time the care for elderly in Europe was considered a family obligation and responsibility. In modern post-war times the state intervened by institutionalizing the most weak and care-needed in hospitals or recovery houses. During the 1980s there was a paradigm shift in the theory of elderly care and the redefinition of care, concentrating on getting the elderly back in their home environment. The general impression was that even the elderly themselves preferred being cared for at home. This led to developments in home-based care in the years to come following a *community care* strategy and the closing down of the former institutions. The occurring focus on care in the habitat of the elders increased the availability of public services, but still revealing huge differences between countries in the balance between home care and institutional care and in the level chosen for care support intervention. Dependent on the amount of persons in the oldest ages (over 80), the variation of public and private funding and the division of labor between paid and unpaid care giving in the specific country will form the social service package. The Nordic countries have the highest social expenditures because they also have the highest number of nursing homes in Europe and their emphasis on high quality care in these institutions results in higher spending confronted with home care services. Again, we see an example of the short coming of expenditure as a way to understanding the works of the welfare state, as we need to look beyond the simple numbers to understand the workings of social services.

### 2.1 Elderly care in Italy

The elderly care has for some time been a topic in Italy due to the rapid ageing of the population in addition to the shrinking fertility rates, meaning children who are able to take care of these same elders. The low number of Italians entering the workforce, the health service finds itself in lack of personnel. This in combination with being one of the most *familiaristic* Welfare States, in the sense that family is seen as the main resource when it comes to care, the future screams for change.

Today's situation with more than 2 million elderly, almost 20% of the population (ISTAT 2006), in need for care and one of the lowest availability of care institutions and services, heavy weight is on the families to arrange their everyday as best as possible. The decentralization of health care results in main responsibility falling on the regions where health care has the largest part of their budget with its 10%. Moreover the health system is further divided into Local Health Corporations (ASL, USL and so on) and Hospital Corporations. Altogether they amount around 660,000 workers (OECD). The subject care is still in some ways un-debated in Italy since it is seen as a family, or more exactly, a female affair and therefore the right to get paid for care or other social rights are still far from satisfactory. Most of the care weight is put on women, meaning the daughters and daughter-in-laws, but because the modern Italian woman also seeks education and a career this results in very low birth rates around 132 child pr women (EUROSTAT 2005). This is of great concern for the prospects of elderly care in the country already and will become even more a problem in the future. It is important to keep in mind the element of cultural resistance in the way the Italians look at care in terms of norms and values. They still withhold as optimal care situation to keep the elderly at home for as long as possible. Though, as we shall see in the next paragraphs and in the analysis, keeping the elderly at home does not mean cohabiting with other members of the family.

During the last 20 years there has been developed several public health services for elderly in Italy, but with different elements and huge variation in the distribution. In the early 90s the Italian government initiated the project *Progetto obiettivo anziani* to control and secure the quality of elderly care. This project led to a law on health services for elderly that instructed all hospitals to have an emergency geriatric unit and that it should be organized a new kind of intermediary unit for elderly outside the hospitals, called *Residenze Sanitarie Assistenziali*(RSA). In these units, chronically ill elderly or older patients discharged from hospitals could get a prolonged medical treatment and care. At the same time, the home care was to be organized from the geriatric units and a detailed set of rules was in charge of the activity in each unit. Besides, the enthusiasm expressed with the presentation of this law is seen as implemented in very diverse degrees over the country with more development in the north and almost none in the south. In the north, some hospitals have a geriatric unit where the RSA reform has been prosecuted and has created a nursing home where medical treatment, rehabilitation and care are important elements.

In home care there are mainly two services: Integrated domiciliary care (*Assistenza Domiciliare Integrata*, ADI) and domiciliary health care (physiotherapy and home nursing). Municipalities provide the home care, while local authorities provide the health care. The social care is normally with a fee while the health care is free of charge. Like with the Italian social services in general, the

regional variations are huge and the offers are scattered (Gori, 2000). The numbers of institutionalized elders has never reached more than 2 percent of the population over 65 years of age (ISTAT 2006) and since not even home care is substantially developed and restricted to few hours per user, the family is stuck with most of the care work. In this area of care need there has sprung out a new class of care workers who also has changed the former Italian family- model; a female migrant workforce called *badante*.

Until the 1990s the Italian care for elders where mostly informal done by the closest family, but since then more and more elders are living apart from their children and thus receiving less heavy care work from that end on a daily basis. The solution making this possible was found in the market through immigrant women hired directly from the families to care for the dependant elder on everyday basis (Da Roit, 2007). Most of these women, called *badanti*, are paid to care for, supervise and perform all the domestic work in the older persons home 24 hours a day, 6-7 days per week. Some do live by themselves and work shifts at different families, but most live with the older person and in that way receiving room and board in addition to their salary, which normally amounts from 700 to 900 euro per month. Recent estimates show that the number of immigrant care workers in Italy is between 650,000 and 800,000, which mostly consist of Eastern-European women with long-term permanence (Da Roit, Le Bihan, Osterle, 2007). In 2006 the Italian government decided on a quota system for domestic workers and personal care assistants from abroad enabling them to have contract in hand at the arrival in Italy. The first year more than half a million persons applied for the 140,000 contracts available, showing the evidently inadequate number of contracts. Besides the problem of the lack of sufficient contracts it is to presume that most of the contract appliers are already in Italy from the beginning of the process as illegal immigrants. This is probably because Italian families have difficulties in hiring an unknown foreign person and they normally need a person right away and cannot wait for the time consuming paper work to come through (OECD). Arriving from countries in crisis' or poverty these often un-authorized female immigrants demand very low wages so as to give the possibility of private care to all classes of the Italian society. Also since the national coverage of care services is so low, these women has no problem with finding work and get little competition from the Italian workforce since the pay is so poor. The presence of a *badante* does not mean though, that the informal care isn't still present. Instead, the new care model in Italy has gone from strictly informal to a mix of informal and paid care. As we shall see in the analysis, the families are continuously engaged in the organizing, supervising and complementing the care work performed by the *badante*.

There do exist problems with the immigrant care model since the cared for has no guarantee that the

care she or he gets is proper or that appointments will be held. On the *badante's* side, normally a she, will not have any social security or guarantee for the income, no sick-leave retributions, no pension points or vacation guarantees. The recruitment of a private carer normally goes via relatives or neighbors and there are no reports found concerning problems of finding unregulated care assistants in Italy. A friend or relative may have one care assistant, and this carer has a friend or relative, normally from the same country of origin, in her network to be employed through her contacts and so it continues. The immigrant domestic care workers increasingly organize their own private care in their countries of origin by the same type of paid care as they themselves perform in another country (Da Roit, Donani and Naldini, 2008). There are, though, regional differences in Italy as to the use of migrant undocumented care workers. Up until the 1980s, domestic work in Italy was an upper and upper middle class phenomenon and the workers were less educated younger women from more rural areas of the country. In 1992-1994 numbers show that only 12.1% of the registered domestic workers were of foreign origin, while in 2002 the same percentage lay at 60%. Almost all were women (87%). (Caritas *Immigrazione-Dossier statistico*, 98:288). Most part of these workers is employed in northern Italy, in Rome and Naples. An almost invisible amount is employed in Southern Italy, Sicily and Sardinia (Eurispes 2002). There were and has until today been issued legal regulations and legislation waves, which makes it easier for immigrants to enter the country and stay as long as they could prove they were working (Legge Martelli 1990, Decreto Dini 1995, Legge Turco-Napolitano 1998, Legge Bossi.Fini 2002). Still it is not sufficient or convenient enough so as to motivate workers or the general Italian family to 'go legal', especially since the cost for an immigrant worker with a contract is moderately higher. From the carer's perspective there are obvious drawbacks with the situation since she is living 24 hours a day with the older person and has no right to any leave-permits or vacations. As we can imagine, the situation is very unstable for both parts. Some local authorities have tried to integrate these immigrant women in the local care system. By giving courses in medical care, increasing the quality of the care and on the other hand creating a support network for the *badante* who spends most of her time in the house of the elderly person. These attempts have not been satisfactory and have received criticism both for its content quality, but also by that fact that it only works for legal immigrants and therefore excluding the major part of the group (OECD).

From a more macro perspective, the other reason for which illegal work still is increasing is that in addition to the mentioned ageing of the population, low fertility numbers and a more active female work force; the incompetence or unwillingness from the welfare state to provide services to its needing population. The last issue is visible and felt by the Italian families, since the few state run care centers and institutions have high waiting lists and are very expensive. The migrant worker is

for all these reasons an important resource and alternative. Looking further at the externalization of care work in Italy, Da Roit (2007) separates the reasons for this development in three closely connected elements: lack of informal resources, the presence of monetary resources (cash for care) and the low cost of services. I would like to add to the list the family and culture values reflected in the culture. Seeing that by use of a *badante*, the Italian families can keep the care needing parent in her or his home and thus goes in line with the traditional Italian norm of taking care of your own family. By hiring a *badante*, the family is still personally in charge of the organizing and surveillance of the care and so do not diverge significantly from the family care.

The Italian care-policies works as an incentive for this immigrant work-model since the one type of support they *do* give to the families is a monetary allowances called attendance allowance (*indennita di accompagnamento*) or care allowance (*assegno di cura*). The attendance allowance, now amounting around 460€, was from the beginning intended as a resource for disabled persons, but during the 80s it also involved elderly care and is given to all ages independent of their economical status, but to those medically proven unable to work and in need of daily care or aid. In 2006 it is shown that 9% of the senior population benefits from this allowance (INPS). Although the attendance allowance has resulted in the provision of a grey immigrant care market, this was not the intention when expanded to elderly care. It was instead seen as a financial help to aid users of institutional care since the costs are high, but since the numbers of beds are so scarcely spread in the country (especially in the south) this was not how it went. Also the home care arrangements have a very low coverage in Italy, so the attendance allowance cannot serve as means to be spent there either. The result from this digression from the original intention and real use of the attendance allowance has further implications for the whole health sector where employment, qualifications and work condition suffers. As the immigrant care is so available and affordable in comparison to the public or private care services it gives the false impression that increased employment in this section is not needed (OECD). The hiring of an immigrant care worker is easier and less costly for the family on the one hand, but more troublesome on the other. Since money is paid 'under the table' there is no taxation or social contribution involved in the work relation. For example, the hours spent by the immigrant women in the house with the cared for, would not have been possible due to work regulations. This means that there would probably be at least 3 persons doing shifts to cover for the same hours now made by one. On a regular market this 24 hour care would cost the family around 200€ a day while the same hours made by a *badante* cost around 26€ (OECD). By the allowance ending up in privately paid hands show how external variables can make internal shifts in family organization and obligations. This does not mean that the family is no longer the primary carer, since the hiring of a paid carer depends widely on the family's resources and the knowledge

and confidence they have to the hired immigrant help. In addition to this, the attendance allowance does not cover the expenses of a hired *badante*. Therefore, in many cases the family has to supply with money from their pensions, savings or income. On a general basis the family or better put, the female daughters or daughter in laws, are now the care organizers and adds or replaces the work done by the hired helper. This extra help offered by the women in the family is however seldom given any monetary compensation. The alternative care allowance is given by state or local community but is differently from the attendance allowance, where as it is based on high criteria's both in health and economical situation which makes it less universalistic and more unreachable to the general public. In fact, only 1.5% of the target population receives the care allowance (ISTAT 2006). This cash benefits given by the state to the families or the elderly him or herself instead of opening up for more care services, leaves the families no option but to stay home themselves or employ a migrant woman to give private care to their close ones. Further, there is the employment law 104 that provides family or cohabitants to take 3 paid days per month to take care of a person with a severe handicap. After applying for the leave by admitting confirmations to the degree of invalidity, the family can use this law for doctor appointments, pharmacy visits and other care-related tasks approved by the law. The variations in the use of days off to handle the care for an elderly, differ from one workplace to another and depends highly on the employer-employee relation where decisions whether more time is given or not (Da Roit, Le Bihan, Osterle 2007). In regards to the gender equality, one may see benefits from the immigrant care-workforce, which could boost Italian female work participation. But at the same time, since the care work they perform is so poorly paid it can keep up the stereotype of house and care-work for elders as something to be down-prioritized wage wise or the social stratification of the immigrant female care workers (Dawn, 2006). Another consequence of the *badante* arrangement is that because of the strong cultural values describing females as 'carers', Italian women may be placed with bad consciousness for not keeping up with their ideal of being a 'good daughter' when applying the caring to a stranger. In Italy there is both implicit and explicitly pronounced that you are selfish and career-minded if you follow a work path and at least if this means to not be involved enough with the care for your parent or children (Naldini and Saraceno, 2007). In Italy the internal solidarity between family members is still taking very seriously. Even though recent changes in the organizing of the care work through externalization has changed the traditional forms of care work, the norms of taking care of your parents still stands as one of the most important notions in addition to the extended legal responsibilities the family members do have in Italy (Da Roit 2007).

## 2.2. Elderly care in Norway

The goal for the Norwegian elderly care in general is equal offers made to all citizens independent of income, place of residence or social status. At the same time, it is important that the care-needed to a highest possible degree can live self-supporting and has an active and meaningful environment with others (Ministry of health and care services).<sup>3</sup> The municipal elderly care involves institutionalized care, residence measures home-based services, well-being efforts and a variation of economical system of subsidies normally to be organized in a care-department. From 1988 to 1998 as part of the national 'de-institutionalization' politics there was a decrease in bedpost at institutions and they were replaced by bedposts at care homes (*omsorgsboliger*) where the elderly can own or rent their own apartment with certain home care arrangements or close to a main building where all medical and care-services is available. In this way they are not institutionalized, but neither left to themselves. Seldom are care homes suited to the nursing of elderly with dementia,-a group that consists of around 75-80 % of patients in institutions. Since the residents themselves pay most of the finances, the state and municipal can concentrate on the bettering of institutions and home care. The numbers of patients at institutions are 7, 2 % over 67 years of age (Norway Statistics 5). The number of elderly and care needing persons in institutions has decreased by 10 % from 1992 to 2004. At the same time, the numbers in home care receivers have increased with 11% in the same period (Norway Statistics 5). There are also offered day-centres for those elders who cannot stay at home the whole day for medical reasons, but the availability depends on the municipal and volunteer prioritizing. Nursery and care-services is the biggest budget post for most municipals but they are at the same time always under hard criticism and regularly there are uncovered flaws and problems in the elderly care- section. The weaknesses is described best when elderly homes are subscribing patients earlier than they should or at least earlier then what was seen as appropriate 10 years ago. There has developed a polarization between the institutions on one side and the home-based care on the other, while there could be much to gain from a solution in between the two, but unfortunately the municipalities is gaining on increasing the numbers of bedposts in elderly homes instead of the serviced housings. At the same time there is a political aim at the ideal of 'remaining at home' care as it has been in the whole of Europe the last decades. There has ever since the birth of care homes been debates around it's use and meaning and different municipals have different opinions whether it should be used as a step from the senior citizen's own home and before they move in to an institutions or if it is intended as the last stop. The financial aspect and what is

---

<sup>3</sup> These offers are met with criticism by staff in institutions, residents and the media, as we will further investigate in the analysis.

cheaper for the state is also regularly under discussion. As the development towards more 'open care', meaning the possibility of keeping the elderly in their home with help of day-care centres and home care assistance, it is logic that the ones who does live in institutions are to a higher degree struggling with illness and has greater need for medical care.

Internationally, Norway's care service is not considered especially extended geographically or in numbers, but is known for its low cost confronting it with other countries, with the residents paying 80% of their income. Even though it may seem a lot to a resident, they pay in total 10% of the operating budget (Hatland, Kuhnle and Romøren, 2001:162). During the last 20 years the institutional sector has had a standard lift and many new projects has been built. This has not necessarily created more bedposts for elderly, because of a concentration on letting patients have single-rooms. Therefore, there are not a higher number of places, but a higher level of quality and space for the patients. As mentioned, the patients also stay for a less period of time in institution, so the criteria of admission are high and the exchange rate as well. Earlier years, the elders would stay in institution because there were no alternatives or they were there for a long period of time until their deaths, but now they are admitted at a much later stadium being first looked after by the home-based care or in a care home. Home-based services include help for the elders but also young chronically or temporarily disabled persons. The earlier mentioned focus on open care brings further development for the home-based care since it maintains the object of letting the elder remain as long as possible in his or her own home and at the same time there is an increasing need for these services since the patients are subscribed out at an earlier stage from the institutions. In 2005 26% over 67 years of age were users of the home services and 1/3 of them are getting only practical help (Statistics Norway 5). The increase of the older population has not increased the numbers of service-users, but instead a harsher prioritizing of the appliers and reduction of hours spent at each user where people living alone and the oldest are first in line. Inspection and contact are general central elements in the home-based services, but through the years it has been less time to keep the social part of the service alive because of the lack of resources to do so. On the other hand, the field of home-based services is less gender based than it used to (Statistics Norway 5). Beside the all-year-services there also exist relief-measures for the relatives of dependent elders, for example vacation substitute or short-term residence in institution. In addition to institutions and home-based services, there are other centres for older dependant persons like standby janitors, food-distribution and cleaning patrol. Larger cities also have the TT-service, which makes sure the older, or taxi transports help-dependant for a smaller amount of money. The safety alarm works as a direct connection between the care needing elder and an emergency central that directs an ambulance to the residence in short time. Pursuing the idea of decentralized social politics and self-governed

communes, the responsibility for important health and care-services has become each single commune's responsibility. Therefore, the economy of each commune decides whether or not the local inhabitant gets their needs covered or not and the quality of the care-services also depends strongly on the availability of staff and the organization of the sector in that particular commune. The capacity of the family as caregiver is shrinking due to demographic changes such as childbirth-ratio decreasing and the daughters moving out of their homes at an earlier age. It is presumed that the differences just mentioned plus marriage- and gender-role-changes has reduced the family's care-capacity markedly the last 70 years. The challenge obviously does not get less evident looking at the numbers of people living alone where the demands for care-services are higher. Culturally, many signs show that the Norwegian elders prefer to pay for the care given by family or neighbors and a way for the state to promote this informal care could be through economic benefits and support. If there was to be an increase in the private pension of the individual elder,-he or she would raise the demand for private care. The *care-wage*, a part of the home based care and obligatory for all municipalities in the country and given to the close family or partner active in high demanding care for example persons with physical handicaps or elders. Availability of the care-wage depends largely on the municipality's resources and which other offers they can give the family, but is rarely used in practice. Welfare employment leave is a maximum 12-day leave with full pay given by the employer based on subjectively chosen criteria, but in connection with illness or organization of children, parents, funerals or own wedding. The government initiated a plan of action for elderly care in 1997, which focused on improvement in the elderly care-section particularly because of the increasing numbers of elders. In this plan there was subsidies for recruitment, especially home-based, so as to give each individual dependant elder the choice to remain in their home and have an active and meaningful environment in contact with others (Social and Health department 2001). To be able to realize this plan of action for elderly care, the government gives annual contributions to municipals that have plans of increasing or strengthening their elderly care. Critics after the execution of the government's plan of action for elderly care have been many both in the media and from research. It seems there are still many concerns about the elderly with dementia not getting proper or respectful treatment and less human contact between users of the service and staff because of lack of resources and time to spend on contact. It seems though as there are seldom recklessness in medication or physical treatment, but rather the human contact and well being of the residents.

### 3. Research presentation and objectives

The research presented in this paper is based on the WOUPS project (Workers Under Pressure) that wishes to require knowledge about labour market and welfare restructuring tensions and the care needs and responsibilities of households in Europe. The project is collaboration intended to compare seven European countries, chosen for its characteristics as welfare regime, caring regimes and working-time regulations. The countries are: France, Germany, the Netherlands, Sweden, Portugal and the UK. By analysing the policy response in each country concerning the challenges mentioned at a national and institutional level and at the same time performing interviews on households in each country, the WOUPS project wishes to elaborate a description of the status quo in each country when it comes to workers under pressure due to care obligations at home. The pressure is defined as the combination of the different constraints families have and stress is defined as the result of these constraints. Seeing that the countries are belonging to different welfare state regimes, the project wishes to see in what way the national policies vary when it comes to employment and care regulations. Further, there is placed emphasis on the micro perspective, seeing how the households are making use of coping strategies to the situation of working under pressure. This implies the ways of managing the work/life-balance when one also have the strong demand of care from children or older relative. One asks how the various national policies influence quality of life for the individual, what level of stress this brings and who or how they get support from other family members, colleagues or others. In this part there is a substantial gender element since caring has mainly been a female obligation. The project wishes to see how the gender roles work in the different countries and how to facilitate a more gender equal organization of domestic tasks in the household. Lastly, one wishes to find the good solutions, meaning the best practices performed by individuals in the different counties and thus to better distribute time between men and women and to make it possible for families to both work and have children. The method being used is qualitative comparison by use of matched cases analysis. This implies selecting an equal number of cases from each country with similar characteristics so as to match them to one another. This is the point of separation between families with children studied by one part of the research group and those with a care needing older relative studied by another group. My research presented in this paper falls under the latter. By analyzing the data, one will have an insight in the changes in

household care arrangements in various national situations and to define recommendations for decision makers with that aim of facing the challenges in our time.

### 3.1 The sample and the performed collection of data

In line with the WOUPS project, I used semi-structural interviews in my research. In other words, the interview grid was meant to be a guideline with questions that are open so that the respondent can explain in his or her own words. The questions were divided into sections according to the main subjects and supported with detailed sub-questions to put forth if the respondent did not give sufficient information. The main goal was to keep a conversational- like interview where questions were only asked by me if or when the respondent reached a stop or when he or she did not complete with important information or were giving short answers. In general, in this type of in-depth interviews one wishes to let the respondent answer in her or his logical sequence after what occurs as important for her or him concerning the subject. In this way the researcher may get new ideas or new perspectives on the subject without posing perspectives on the respondents. By letting the respondent speak freely after issuing a question, his or her silence and vocabulary may reveal attitudes and perspectives and to dwell on past behaviours or experiences that might be interesting for the topic (Randall and Koppenhaver, 2004). The selection of the sample, I have extracted through the snowball-effect following the following criteria's: the respondent must be working at least part-time (20-25 hours per week), he or she should have a relative that is care needing where the respondent is the one or one of the persons responsible for the main care-giving and lastly he or she must have a cohabiting partner that also works part time or full time. My analysis here is based on the 10 interviews performed by myself: 5 in Turin, Italy and 5 in Oslo, Norway during the spring of 2008. On one occasion, concerning the subject institutionalization, I have made use of two Italian interviews performed by researchers in the WOUPS project to be able to compare the topic in both countries. As we can see in Table 3, most of the respondents (exception of two in suburban area outside Oslo) live in urban areas. I feel it important to underline that Turin is placed in the north of Italy and therefore the sample is reflecting that area's standards and alternatives. This is crucial since there are great regional variations in the care services in Italy. The Norwegian interviews are performed in Oslo, which also implies a diverse picture from that of another city or region. In Italy there is to higher degree female respondents, while in Norway there is actually one more male than female respondent. Because of the small numbers of interviews it will be difficult to say whether or not the unequal gender percentage is accidental or if there are reasons to believe that

Norwegian men are more often caregivers for their dependant parents than the Italian men. Age-wise the respondents are spread from 43 to 66 and in Italy I found more in the upper part of the age scale, while in Norway they were more spread all over the scale. The caregivers in both countries has the responsibility for their mother in most cases (6), while some for their fathers (2) and one Italian respondent for her mother in law. Seeing that one pre defined sampling criteria was that the respondent co-habit with another working partner, all of my respondents does so. Another criteria was to work at least 20 hours a week, and most part of the respondents do, with exception of one part-time (20-25hours per week) male in Italy and one female in Norway that worked longer part-time hours (30-36 hours per week). When it comes to education, there are mainly highly educated respondents in my sample, with only one Italian female being of low education (elementary school) and one Italian female and one Norwegian having medium education (high school diploma). As we analyse the caregivers' situation it is important to keep in mind that the respondents come from very different socio-economical situations which may shape their background for choices made or their practical possibilities.

Table 3. Sample

<b>Characteristics:</b>	<b>NR.ITALY</b>	<b>NR.NORWAY</b>
<b>Gender:</b>		
Male	1	3
Female	4	2
<b>Age</b>		
<50	2	2
50-54		2
55-66	3	1
<b>Educational level</b>		
Low (elementary school)	1	
Mid (High school)	1	1
High (university)	3	4
<b>Working schedule</b>		
High (<36)	4	4
Mid (30-36)		1
Low (20-25)	1	
<b>Sector of employment(main carer)</b>		
Private	1	1
Public	1	3
Self-employed	3	1
<b>Person cared for</b>		
Mother	3	3
Father	1	2
Mother in law	1	
Mother and father		
<b>Person cared for receives cash retributions for care giving</b>		
Yes/ Applied for	4	1
No		5
<b>Territorial area</b>		
Urban	5	3
Suburban		2

## 3.2 The analysis

### 3.2.1 Types of Italian care arrangements

Even though there are some clear common elements in the Italian respondents' situation, there seem to be various paths chosen by the main carers depending on degree of the care needs of the older relative and their work and family situation. This could imply that the care arrangements are elaborated in stages from when the dependency started to the more developed weakness of the elder where the situation is expected to end as the care needed dies, is no longer cognitively capable of communicating or needs constant professional surveillance. The various paths are not seen as stable or as a conscious choice made by the carers, but instead constantly changing alongside the health of the cared for or the family situation. Some carers go through all the paths so as in stages, while others end up with only one solution for the entire duration of the care situation.

The initial phase is recognized by trying to improvise each day in an unorganized situation in a period of unknown length and with the resources available until the situation becomes impossible to uphold or if an acute worsening of health of the cared for. The main carers must cope in their routines often with a fulltime job, a full time household to take care of and their parent or mother in law suddenly becomes in need of care. *Patchworking* could be used as a term for this period of making the ends meet. Lucia, who has a mother still living at home with no paid care assistance, gives us an insight on her everyday where she has to juggle the situation of having a full time job, a son still in school and a mother with increasing need for care:

Here at work (a tobacco store) there isn't even time to have a seat when you eat! I like my work since I get to talk to many different persons during the day, but it also tires me (...) I come home around eight thirty and we cook something simple since we are both so tired. Then I have to go to my mother's house to see if she needs anything if my sister hasn't already done it. Then I have to check upon my sons homework and how his day in school was...I try to follow up on him as best I can... We don't have a lot of time together at home...but I make him come to the store after school if he doesn't go to his father's store...

With the tobacco store open 6 days a week she will have to settle for one day off:

Sunday is my favorite day. Normally I want to do a million things that day but on the other side I would prefer to just lay down on the couch and relax for the whole week to come. And the week that just ended. But normally I at least have to do some housecleaning...and see my mother...I always have and always have had too much to do.

The patchworking period works as a transition phase that seems stressing since there are not yet organized ways to handle the situation and one takes every day as it comes. Depending on whether the care need is initiated by a sudden incident like a stroke or a fall or if instead it is a slow progressing dementia, the initial phase is based on telephone or direct contact between care needed and caregiver while they try to figure out how the future prospects look. The going back and forth

to doctors, hospitals and pharmacies is a common feature in this period. Lucia explains how she and her two siblings organize the care:

Eh, we plan over the phone every day. We take one week at a time..For example this week my husband goes to their house at lunchtime. Just to see if they need anything. Next week my sister takes her turn for lunches. And obviously I call my mother every day to hear how she is. And almost every night I go by her house on my way home or after dinner just to say hi and do the dishes (...)My brother is the one who takes care of the economical part. My sister and I, we occupy ourselves with the more practical stuff in the house. Then there are grandchildren and my husband...we all do one piece and in the end we manage. But we need to talk to each other several times a day to make it..and it cannot last very long..

The duration and stressfulness of the period depends mostly on the cared for's health condition, but also on the family's resources to be able to pay for privately hired care assistance and on the normative negotiations with the care needed and other carers.

The next path or stage is the normalization of the situation where the carer(s) find a solution to the care organization. It must be said that normalization does not necessarily mean stability and tranquillity for the persons involved, but more a selection of the way of caring. We can call this stage externalization: the family plus one. The family wishes by hiring a paid assistance to let the cared for live in his or her house for as long as possible or for the remains of his or her life. As discussed previously, the Italian welfare state facilitates the private home care paid by the family through their cash for care policies. Most of the respondents say they have not experienced great conflict during the decision-making process of private home care, seeing that it is the most available or the best solution for their relative. For their own sake they fell as in this way they at least has someone there who can constantly keep an eye on their parent in case something should happen and in addition perform the everyday tasks such as feeding, dressing, housecleaning and personal hygiene, depending on the health of the cared for. Two out of five of the cared for live in their own house with a paid hired assistant in the house, one live with her son and daughter in law, one with her husband only and the last with her whole family (meaning husband, daughter, son in law and granddaughter). Despite the small number of externalization paths in my sample, this arrangement is the most prevalent in Italy. Although the paid care generally consists of assistance 24 hours a week and all week, the situation for the main carer is filled with smaller or bigger tasks in everyday routine. All of the caregivers not cohabiting with the care needed depend on the phone both at work and at home, to arrange for the care situation. They check up on the relative directly by phone or/and they also talk to the paid assistant, the doctors and the other siblings to organize their week or day. In addition, the main carer or family involved has to step in when the paid *badante* is not present for various reasons. Paolo has paid care for his mother 24 hours a day, 7 hours a week, but still he is very much involved:

My mother had a leg operation, then she broke her thigh-leg and then she has an ischemic heart disease. It has all happened these last two years. It's been filled up...I have to go there every day to see how she is or to let the badante off for some hours.

Chiara, whose mother has developed Alzheimer, has along with her 5 siblings, chosen to hire a *badante*, but takes the role as care assistant when the hired carer has her days off:

We kids, or us daughters to tell you the truth, intervene during the weekends to substitute the *badante*. Saturday and Sunday depending on our other tasks. But at least Sunday we let her have the day completely off. Also since my mother is a quiet person who doesn't create a lot of problems we can manage to care for her.

With the hiring of a paid carer, the family can continue with other duties and wishes concerning work and social life to a various degree and be there more as a cognitive carer for their parent and only help out with practical tasks when needed or when the *badante* is away. As discussed earlier, economy is an issue in this arrangement and so is the trust e reliability on the work performed by the *badante*. As shown in Table 3, the cash allowance is only present in the Italian sample, following the national social policies as a cash-for-care welfare state where the families receive an amount of cash to apply to whatever care arrangement chosen. The attendance allowance is only given to the care for a person who is categorized as totally disabled, which is why one of the respondents did not receive the cash benefit then due. The allowance is crucial for the families to be able to handle the economic side of the care arrangement, but since the amount is too small to maintain a 24-hour care by a *badante*, or a place in institution, the family has to fill in with the rest. Chiara responds to how she and her siblings make the ends meet economically to be able to care for their mother with Alzheimer:

That's a good question...my mother has the minimum pension (ca 500 euro a month) integrated with the surviving pension. She has never worked in her life. First of all because we were 6 children...Anyway, during the first period of the care she had some money saved up...so we used that. But now, after many years...Successively we (the children) gave a contribution because the pension amount received by my mother wasn't enough. One year ago they (the Italian Pension Fund) have accepted to recognize the attendance allowance. It's 460 euro more or less. Now she has these two different benefits. However, if we sum it up, you realize that it's not enough and we need to contribute. The total cost is around 2000 euro (per month).

(Re) cohabitation, resolving it within the family, I have called the next period. The two respondents in my sample who have chosen to live with the cared for, have done so for other reasons and before the onset of the caring itself. They see it more as a family strategy of helping each other or just being together and sharing their lives together. Claudia lives with her husband, her two parents and a daughter of 25. Her father has had two strokes and the last one in 1992 made him greatly care needing. Her mother is still physically able to help out with the everyday care tasks, but she suffers from a recently developed depression, which makes the situation seem critical for the future. Claudia tells us how the cohabitation choice was made before there were any care issues:

The choice of living like this (in extended family) is because from when we married..when we had children we thought of it as a good thing to make them grow up in a real family climate..like an extended nuclear family. Of course there are problems with this choice, and there are many, but I think we give a lot to our parents this way. And they have given a lot to us (...) We have never thought about arranging it otherwise. We have always found ways to manage what we can with our possibilities..and our availability(...) As long as we have the health and availability to do it,

we would like to organize everything ourselves..and to face this load personally.

In Claudia's case, the whole family is active in the care for her father and they have different tasks in the house and with driving and picking up at doctor's appointments and go the pharmacy. Also in Angela's case the cohabiting was initiated before there was any need for care. She and her husband decided to let her mother in law come live with them when she became a widow. Angela works at night as a private nurse and takes care of her now very ill mother-in-law, but she has hired help only during the hours of the day when she sleeps. For the summer vacation they inscribe the mother in law to a nursing home to get time for themselves to rest. Angela, her husband and their son changed house to get more space when the mother in law moved in and hoped, in addition to not letting her mother in law live and die alone, that she would be a resource for her and her family in domestic tasks, but instead she got sick:

Earlier she never had any health problems. She was fine on her own. But I told her to come live with us. But when she came here she got depressed. But no one had to her to do it (to move in with them). On the contrary, we moved into a bigger house, we had to make efforts. At that time she was still walking. She was still doing fine and was quite independent in her movements(...) You can imagine; I have a house, a husband and a son to look after. To be honest when she came to live with us I thought: I work nights, so maybe she could help out around the house, prepare meals for my husband etc. But I kept on doing it myself. She just literally let herself go..

The situation for Claudia and her family seems joyful despite her mother and fathers illnesses:

When I come home from work I check how everything is going with everyone. Or we all discuss everything together. The usual chatting..we like to talk with each other.

Instead Angela is barely holding on:

When she was still at her house, just before she moved, she still did everything, but suddenly here she did nothing. I tried to make her do small things like clean the vegetables, also just to keep her active, but she refused to do it (...)I was wrong bringing her here and I made errors from the beginning being too good with her. Because I knew she was depressed about leaving her house and everything. I was wrong. I should insist that she did continue to do small chores. But I was tired...and this is the result. We have arrived at the day when she can no longer eat by herself(...) There is no motive to continue this. I don't have to feel guilt or remorse, because I have done more than expected of any person. God forgive me, but if one day I open the door; tomorrow, or even today, and she is no longer with us...

It is obvious that there are differences between the two respondents' situation in many ways. Claudia still has her mother and the other family-members to help her with the caring for her father. Angela on her part seems alone with the responsibility. The condition may also be crucial since Angela's mother in law now is tied to the bed and needs constant help with everything, even oxygen and more complex nursing tasks. In addition comes the relation between the carer and cared for prior to the onset of the care need. The feelings surrounding the care arrangement where you care for a parent in your own house varies from the mostly joyful and loving extended family version expressed by Claudia, to the daughter in law, Angela, that only waits for it all to be over:

But I have to say that I almost cannot wait for it all to end. Because I worry about everything. God forgive me, but I hope that one day I come back home and she is no longer. Either way it's going in that direction. It will happen that way and sincerely I hope it happens soon. I advise enemy,

friend, whoever, against ever taking a person into your house. It's hard. You renounce your life. I have had to renounce my freedom. We never have an evening off.

The last period or phase found is institutionalization and could be recognized by the immediate response: "If we absolutely must". As we have seen and will discuss further, institutionalization is not a realistic alternative in Italy and none of my respondents expresses it as an alternative, not even at the end. The impression and attitude towards institutions are in general negative, mainly based on stories heard through friends or short visits in the past. Angela fills in the words:

Why do I have to bring her to an institution? Why should I do it? My husband had it checked out in the beginning. He had some contacts and managed to find a place for her, but I didn't feel like it. I would send her there to die..Now we have a place for her in a nursing home during summer vacation because I am so tired and need to rest, but having her there all year? No, it would never happen(...I myself working in the hospital field, I knew very well how the situation is(...)) Ok, now it is a little bit different, There are good and bad places, but where I have brought her for the summer; there they are really fine. But it depends..There is one here close to our house, I have entered one time to see how it was, it gave me an impression of an old fashioned institution like they go there to...so sad. If my mother in law went there she would be no more. It would have ended a long time ago. Because 6 years ago they told her she had 3months to live. So, she is still here; I don't want it to sound wrong, but because I am here. Because I follow her up. The right diet, medicines at the right time, the hygiene, I have always taken care of all this, the dinners..everything. I don't know if she is still her until this summer to come, but if she does and I take her to a nursing home I am not sure if I will go pick her up and bring her home again. But where I take her will be a place where she will be watched over.

Chiara explains further how the institutionalization is the last resort:

We are many siblings so somehow we manage to organize everything, but if I was all alone I would do everything possible to live with her. In one way or another. To avoid...I have seen persons in need of long term care, with illnesses like my mothers, who only get sedated..No. There are probably different places, but..She has had Alzheimer and other physical problems for 8 years now! I am not sure how long she would have lasted away from her family and from persons that care for her in an honorable way, no.

Since none of my respondents are making use of the institutionalization fulltime we have to go elsewhere to answer the question: is institutionalization it as bad as the rumors? By applying two Italian interviews also performed for the WOUPS project, we can investigate their experiences. In Adriano's his situation, the reasons as to why his mother had to be institutionalized is explained by her heavy dependence physically where she had to be in a wheelchair, and her degrading Alzheimer which made it tough for his father to be with her in the house. They tried with a paid *badante* for a year, but in the end it got too heavy for everyone involved. Could it be that the only justification for having a parent placed in an institution in Italy is in fact the level of dependency and especially that of the mental illness? Luca, who has had his mother in an institution for about two years after a degrading of her health both mentally with Alzheimer and physically after an ictus, can give us some positive and negative perspectives on the care arrangement:

Surely from the nursing and sanitary point of view it is definitely something good being here instead of at her house. From the humane perspective in a scale from one to a hundred, it's zero. It's like this both from the point of view of those living here (in the institution residence) and from us seeing it from outside the walls. The actual organization provides for the physical demands, but not for the psychological ones. And of course there is the feeling of guilt; it's not yet accepted.

Adriano, tried along with his brother and a *badante*, to keep his mother in her home, but in the end it got too heavy and complex the care tasks, so they had to apply for a place for her in a nursing home. In 2007 his mother had an ischemic attacks while she was still living at home and the two brothers were less and less capable of knowing what to do and read the symptoms. Still they were there at nights, and working during the day. They couldn't stay with her 24 hours a day and did not trust the *badanti* enough to be reassured leaving her with one of them. So they applied for a place in an RSA and this is how he felt:

Sorry if I speak in fragments, but this choice created two months of considerable psychological problems because it's not easy. Not only having to put my mother in an RSA and then see that she gets better and so you relax, but also it's about dismantling forty years of memories because the inscription of my mother in the RSA foresaw the closure of the house where she lived, so it was the dismantling of our childhood memories...

When his mother eventually was transferred to the RSA, she thought she was in a hospital and this seems to be another justification to keep her there. This way at least she does not know where she is. When asked if the total impression of institutionalization is in the end positive, Adriano responds:

Mine, yes(...)I have never noticed episodes of mistreatment or screaming to the patients. From 0 to 10 I would globally give it a 7 ½. There is a lot of recreational activity, the afternoons are filled with games and music. They show films, have manicure, gymnastics...the more 'awake' do crosswords together...Sometimes I ask my mother why she hasn't written in her diary /which Adriano has told her to do every day to keep her cognitively active), she replies: I haven't had the time.

When Adriano was asked about the social reactions after the choice to place his mother in an institution was made, he says:

More familial than social I would say. Because now with the use of the *badanti* one tries to withhold it until the end, until there are no other choice or the medical condition demands having assistance for many hours a day. I acknowledge sincerely that when we told about it to our uncles, the aunts didn't accept our decision, but after a few months they changed their minds. Some of them got reminded of the experiences with my grandmother, who in the 70s ended up in a nursing home, she had Alzheimer...but since then the nursing homes have improved a lot. I have seen several before choosing the one for my mother. Maybe they are different in the beauty of the structure and surroundings, but it's the mentality of the employee that has changed, I have never seen persons left to themselves in a small room.

By looking into some Norwegian respondents we may find some answers to whether or not it is social policies, culture or economy only or in a mix that decides whether or not care in an institution is an option.

### 3.2.2 The Norwegian care arrangements

Firstly, there must be stated the obvious differences between the two countries' respondents background in general terms. As we have learned earlier, the statistics tell us that in Norway there is high institutionalization numbers and smaller numbers in home care. Even though home care is increasing, the core difference is though that Italy's cash-for care system is almost not present in Norway and so the private 24-hour unprofessional *badante* does not exist. The same goes for (re) cohabitation since Norway's family legal obligation and culture norms bases on the fact that an elderly and care needing person is helped through universalistic and individual services from the state. The family has a normative duty of course, but not a legal one. We are then left with institutionalization and home care and the arrangements exist in various ways in the Norwegian samples' responses. There seem to be similar elements in the Italian and Norwegian samples at the initial stage called *Patchworking*, although the Norwegian families have a more organized public help system in the social services. Normally when the care need appears; a process is immediately initiated by the doctor to find solutions for the family and the care needed. In the sample 4 out of 5 of the respondents did get immediate transfer-papers or home care appliance from the doctor when the level of dependence occurred. The one respondent, Paul, not receiving transfer or home care benefit applications, says the doctor claimed his mother could still do fine on her own with help from the family. All of the cared for in the sample, with exceptions of those having serious strokes or injuries making them too ill, did spend an initial amount of time in their home with social service assistance in some form. Some only got help with cleaning, others with both cleaning and food delivery and others with the two mentioned plus medical assistance from a trained nurse once a day. Among the respondents two have the cared for still living at the cared for's own home or who has moved back after a period of institutionalization. The remaining two is in some kind of nursing home: one is in a temporary institution where the situation is more acute and going back and forth from the hospital, while other two are in more stable and organized long term care homes. The practical differences between the types of residences are sometimes difficult to see.

The home care arrangement for the two respondents in the sample is described an insecure situation similar to the *patchworking* in Italy. The respondents know it's a temporary arrangement, until further notice, since their parents' illnesses probably will get worse and they both say the next step will be institutionalization. The cared for are their mothers and the main carers are both males in fulltime jobs. They both check upon their mothers 2-3 times a week and do the grocery shopping for them. Paid professional assistants are performing the rest of the care tasks. Stian, a university dean, has had his mother in a nursing home for 5 weeks with tests and controls by doctors and nurses to

see how bad her dementia was and whether or not she was capable of living at home on her own. This happened after she suddenly lost her understanding and memory in the house and put the electrical boiler on the oven. In addition to the dementia, she has problems with her legs after a broken thighbone. Stian describes the situation:

Now she has home care assistance 3 times a day because she forgets everything. She forgets to eat..she weighs now 37kg, so you can imagine that she needs it. She doesn't know which day it is or nothing. So the home care nurses comes and gives her medicines and food and sits beside her to make sure that she eats. There is no one there during the night...for now.. but she has the security-alarm that helps a lot for me... (...)She manages to go to the bathroom herself and has adapted toilet and bathtub but I think she get's help to the personal hygiene (...) She manages to boil water to make tea, but the phone she doesn't understand anymore. She manages to pick it up but not to dial out, so I call every day. And she can use the security-alarm and with that you just have to push the button...

The biggest difference between the two respondents in this situation is that in the case of Stian, his mother gets everything paid for, while in Pauls' case his mother has to pay from her pension. Paul's mother of 83 has trouble walking due to a bad hip, but besides from that she had been in good shape until one month ago when she had to have a stomach operation. She was in the hospital for some days and in rehabilitation for weeks before she recently was placed back in her own home with home care assistance twice a day. Paul is not so concerned about the situation at the moment since she is still cognitively well and for him and his family it is not a problem to help her out with the grocery shopping.

We (the couple) visit her twice a week and so does the others. She lives on a hill and it's impossible to go anywhere without a car. Since she has trouble walking, she depends on us to do the grocery shopping. She gets a card to take the taxi every 6 months, but she has never used them..now she doesn't go out at all, but she has only been back home for a week, so we will see how it goes...

The second care arrangement found in the sample is recognized as the Norwegian stereotype, namely elderly care in institutions. The highest numbers nationally in elderly care arrangement is without question the use of the various nursing homes. As we have seen, the Norwegian welfare state has prioritized in the health care budget, huge amounts in the building and development of nursing homes. Even though there must be said that the ongoing building is concentrated on more loosely arranged care homes, meaning private apartments connected with some kind of assistance from nurses and doctors and in that way in line with the home based care trend all over Europe. The seniors in Norway stay healthy for longer, so the need for institutional care is applied mainly for those with dementia or high levels of physical dependence, where as we have seen, the numbers are high for institutionalization. As a main carer in general the respondents have minor practical tasks or routines, but are more concerned with the cognitive and emotional care of their relative. Jon is caring for his mother of 93 in a nursing home. She has angina, a reduced kidney function with a constant infected wound and hearing disabilities. She has been in a long time care institution for 6 months after living 2 years in her own home with home care in addition to the care from his son.

Jon is working fulltime in an international help organization and has a brother, but who is less present in the care arrangement. Jon describes his involvement to us:

In the weekends I normally take her for a walk...and in the even during the week we have supper together. (...)I feel a lot better now that she is here, so I don't have to worry so much. I feel assured.

The respondents are engaged in the local differences in care institutions and how they vary in quality depending on the resources of the specific centre, the resources of the municipality or the time available for each care-needing resident. One respondent, Helga, works fulltime as a psychologist and has two children still living at home with her. The health of her father degraded suddenly in 2002 when he ended up in a coma and after having performed a huge amount of tests, the doctors discovered a rare muscle disease that now has made him completely paralyzed except from his index finger. He is currently in a nursing home in a smaller town outside Oslo, far from her, but still she feels assured about him being taken good care of:

It is really perfect for him there. They are so benevolent, you just won't believe it. It must be Norway's best nursing home. So I've been so lucky (...)They have older experienced women there and gives of themselves to the patients(...). So my stress related to the organization is not to speak about. Like yesterday, one of the nurses I spoke to on the phone was supposed to quit at 3, but was still there at 5. I asked her: "what are you still doing there?" She just answered: "Yes, I am about to leave". I called back at 6 and she was still there. 6.30 she left. Because she felt like it was a good thing to finish what she was doing. And with a smile! Amazing. Hope she get's paid overtime for this or gets to leave earlier other days, but...

As we will discuss further, the various institutions in Norway has been under debate and criticism due to its lack of humanity in its daily routines. For the respondents in my sample we have two versions that both contradict and confirm this criticism. This could mean, once again, that there are local differences in both the attitude of the employees and the municipal resources, which gives diverse results in the care giving. The reasons as to why they chose to place their parent in a nursing home is for Helga that there were no other options seeing that her fathers physical condition was depending on constant medical care beyond her capability. Jon decided to find a nursing home for his mother after being constantly worried that his mother would have a heart attack during the night and it would take too long to get the medical care she needed if she remained at home. These reflections is similar to the ones expressed by the Italian respondents and can imply that an important element in the choice of care arrangement in both countries is based on the degree of care need present. The subjective evaluation both on the issue of institutionalization and of the level of dependence is also important factors in care arrangement choices, but if the closest family are not able to take care of their parent because it's too complex or heavy, they normally have to look at the alternatives. There is a huge difference in the normative view on the use of institutionalization, which in Norway is never questioned by anyone, and the respondents where to some degree surprised when asked during the interview. As we will hear from respondents, there is also the

subject of the cared for accepting or wishing to be taken care of in an institution to not feel like a burden to the family and to maintain the relationship as it were prior to the illness.

### 3.2.3 How do they become the main care giver?

When investigating care giving to a parent it seems reasonable to re-view the mentioned obligation and responsibility felt by the family in the care arrangement. Finch (1989) and later Finch and Mason (1993) wrote about the subject and found that the relations within families are changing and negotiated constantly. They are not following a set of rules about who should do what for whom. Finch and Mason found more ground for choices being made concurring to the relation they felt they had to the person involved and not to some set of abstract rules or pre-assumed family obligation. This does not mean that the care is based completely on emotions, but instead that the choices and the feeling of obligation and the negotiations within the family are more unconscious than explicit and strategic. It is of my opinion that within these implicit norms there are influences from the present and past culture norms. This meaning the welfare norms since the welfare state is giving the alternatives and therefore directing and moulding the responsibility of the family. I am here in line with, Pfau Effinger and Geissler's (2005) way of including the family and welfare values in the care organization as presented earlier. The family values interferes in deciding who and in what way the care arrangement should be performed and the welfare values influence on the choices made for the care arrangement via distribution of benefits and the availability of institutions and practices. There is also the issue of felt obligation which in many occasions can be seen where there is no seemingly passionate emotional relation between the carer and the cared for, but a normative pressure that is in some way internalized. The felt obligation can be defined as expectations on how to behave towards specific persons over time and is seen as the duty to provide assistance or contact to that person (Stein, Wemmerus, Ward, Gaines, Freeberg and Jewell 1998). In my sample when asked how they became the main care giver, this has happened most of the time without explicit conflict, but it depends in addition to the kin obligation on several elements similar for the two countries, such as: proximity, having siblings or the personal relation to the care needing parent or relative. In addition and seemingly tightly linked to all the mentioned elements is: gender. We will now investigate these variables further to see how the families negotiate and which characteristic or roles exist in the two countries when it comes to taking the care responsibility for a parent.

Describing gender as an indicator and influencing on who becomes the main carer, it is consistent with the Pfau-Effinger and Geissler's view of family values. They are present here as values that

shape the ideals for how the care should be arranged and who should be in charge. As we have seen the family values include the culture values and this varies between the two countries even though there is not one clear culture value in each country. There normally are many types of families within each culture and the sample used here is a small example, but we know the diversity in culture values in the two countries concerning gender equality seeing that the Mediterranean welfare state has a history of viewing women as carers and the Social democratic welfare state viewing both sexes as workers. Through the respondents' replies we will see in what way they incorporate these cultural values. In Italy all but one respondent are female. They all have siblings (except from the one male), but express implicitly that it is natural that they take care of the relative and not the brothers. Some express negative values to this, but in a way that says there is nothing to do about it. The normative perspective is crucial for this understanding. Through history, the caring of both children and dependant elderly has been a female task in Italy. Although times have changed and as we have discussed, there has been transformations in both work market and family organizations, in the Italian responses it seems, as the traditional gender roles in elderly care are still valid today. The males involved in the care situation, either sons or sons in law of the cared for, are normally participating in the more non-physical parts of the care, such as filling out documents or paying bills. Moreover they participate in driving the cared for back and forth to the doctor or hospital. The women perform the rest. Some of the respondents give us an impression that it would not make a difference whether or not the husband was there. Angela takes care of her mother in law and even though she feels her everyday tough, she felt like she had no choice in keeping her mother in law in her house:

It was almost like a duty. I didn't feel like having her in an institution. I work in the health sector so I know perfectly how they are(...) Of course it varies from one place to another. Like the place we normally leave her during our summer vacation is a beautiful and secure place, but we could never afford it all year round. And the others..I had a look at one here, close to our house and it felt like this terrible chronic care institution where you just go to...you know. It's so sad. If we sent my mother in law there maybe she wouldn't still be alive..maybe she would have died a long time ago .

Still she takes all the responsibility for the sickening mother. When asked whether her husband helped out, she answered:

My husband is an only child, so everything is on our...,on my shoulders. Because my husband works(...). He can't stand his mother. He has love in his heart for her probably, but he has absolutely no patience with her.

Chiara has two brothers, but they do not participate on a regular basis in the care arrangement:

I go there and stay with her at least two whole weekends each month. And if I cannot go, one of my sisters do it. Let's not talk about my brothers...One of us sisters see her every day.

The only male respondent in the sample has no siblings and therefore sees it as the only possibility that he engages in the care for his mother and has even gone from full time to part time work to be

more available. His wife participates, but maybe for him and the family it does not seem right to demand of the daughter in law to be main carer? His wife is also a full time worker as a managerial engineer and is younger than him, which means that she still has career possibilities ahead of her. In Norway the gender variable still is a subject, but seeing that three out of five in the sample are men it is more difficult to find any gender specific conflict that lead to elaborations. There must be underlined though that all male respondents are either lonely child or with male siblings only. One woman, Leah, who is taking care of her father, lives further from her father than her brother, but still she is the one in charge of the care arrangement. Her reasons when asked are:

He (the brother) is there as someone I can talk to and discuss important choices with.. But he has 4 kids that are younger than mine and a job that makes it impossible for him to take days off. He runs his own business and doesn't receive any sick leave, so...But now and then he has to go check up on dad since he lives so close. But then he normally does just that: check. And then tells me about it if something is missing or needs to be changed.

The variation in the practical care work performed in the two countries could be a reason for why men are more engaged. The dependant elderly are quickly arranged either in their homes with assistants or in care homes, so the physical care tasks such as cleaning, feeding and changing of clothes et cetera, are not necessary for the caregiver to carry out. Only one of the respondents says that he has no problems changing his mothers' bandages, but his brother refuses. Jon explains further:

I tried...I have changed bandages with the whole family present, my brother included, and they all backed away. I spent some time letting the nurses here know how to change them even though in the beginning they were not so found of listening to me...they were too experts, but now they manage to do it right(...) But rinsing inside the wound with saltwater I don't do because it hurts her. So I've said that I'm not doing it...

The factor that is most relevant for the care organization is having brothers or/and sisters who are able to help in one way or another. The amount of engagement from each of the sibling depends both on the geographical distance, but also the relational level between both the siblings and the care needing elderly and the son or daughter. As mentioned, in Italy the gender factor is clearly important in the sample, deciding who does what in the arrangement, but possibilities arises and the worry can sometimes be less of a burden when the care is divided, although unequally, between siblings. Chiara has this kind of situations with her siblings:

Of course there has been some problems. Some has taken on more responsibility than others based on our individual economical possibilities. We older female siblings have felt it the most. Both economically and from the assistential viewpoint.

Chiara explains implicitly how the pressure on who does what comes from several sides and not just the other siblings:

I like to be with her (mother) now. We have no problems now that she is ill. It didn't use to be like that. We had a conflicting relationship. Maybe because I am the oldest daughter she has.. in some way I have to do more and feel obligated to do certain things. It more than anything feels like a duty. I have never forgiven her for making me feel that way...

In Norway the presence of siblings are relevant for the respondents in the sample, but it does not seem to be of relief except from when work related travels or vacations occur. Four out of five respondents have the main responsibility and only have additional help from their siblings when needed. As reasons for this when asked, two of the respondents answer that they are more fit to take the responsibility and a third respondent, Lea, that her brother has a big family outside the caring situation to take care of. Closeness geographically makes up an important factor in the choice of the family or siblings to who becomes the main carer, but it does not seem to be the crucial one except when the siblings live on the other side of the country (for example in the south of Italy or in the north of Norway). In the Norwegian cases, the 'safety-alarm' has been or is being used by all the respondents and is emphasized as an important factor as to why they feel assured by living away from their care needing parent. Most of the respondents live close to their relatives and is therefore more prone to engage in the care organization, but the importance of a former or actual personal relation to the relative seems like an influencing factor. The former relation seems crucial in both samples where it is often used as explanation as to why one is the main carer or why another sibling does not participate. In Italy there is the personal characteristic of being 'caring', 'good in the house' or the older sister elicits the natural labelling of main carer when there are several siblings in a family. Again we see the cultural values shaping the attitudes and behaviours of the carers. Also in the Norwegian sample we find this feeling of being the one who should take responsibility, and as mentioned there are several respondents that mentions why they are more fit or why the other sibling is not. Helga gives us her reason:

Before my father ended up in a nursing home she was really not good at all. She was never there. She probably realized to some extent that the situation got serious when he was emitted, so she started to get engaged. But still I am the one in charge and the one who visits him the most (...). I have reflected upon going there to live close to him, but I have my children in school here, so I cannot. But for my sister to take care of him. Over their on her own? No. No, no, that's completely impossible. She's a researcher and it's not a life for her.

The feeling of care as ones obligation may stem both from personal needs or wishes, the parents wishes or the reflection of the other siblings view on her as the most appropriate one. The normative perspective of having to care for ones relatives does not seem particularly for the Italians in the sample, but also felt by the Norwegians as we will see from citations later

### 3.2.4 What kind of care do the main carers perform?

Seeing that I have described the main carers and their everyday it is interesting to look more in detail on what kind of tasks they perform in the care arrangement. We have already seen examples of the fact that the tasks performed vary according to gender, but does it vary in the sample between the two countries? There are visibly huge differences in the way the main carers involve themselves

in the caring situation. The more engaged example is an Italian, Angela, who is taking full care of her mother in law, both physically and mentally. In Norway we may use the example of Jon which never leaves his mothers' side to have a vacation and that changes her bandages. But it depends on the need of the parent and the relation between them on the one side and, the family values and welfare values on the other. The informal care seen as cognitive stimulation or just being there as a son or daughter for a social visit does seem important to the respondents from both countries especially when they enter an institution. These informal visits in the may act as a compensatory element for the cared for since the surroundings in the institution for most of the respondents' lack of humanity. There are some, although not huge differences between the respondents in the two countries when it comes to which tasks they perform in the care organization. The one thing they all do is grocery shopping. 7 out of 10 name it as their primary task. With equal intensity expressed in the Norwegian sample is the emotional or social presence. They describe it as just being there through talking, reading, listening to music and so on. The second most mentioned task in Italy is cooking. It seems that cooking is down prioritized in Norway compared to Italy. This could be because of the emphasis placed on food in the Italian culture or the convenience of the food to the door-service in Norway. When the Norwegian respondents cook for their cared for, this is normally done as part of the social and emotional togetherness and not because they need to. Transportation, whether it is back and forth to the doctor, to the pharmacy or to the grocery store, house maintenance like changing light bulbs and housecleaning seem to appear equally in the two countries' samples. Personal care or physical hygiene and feeding appear some more in the Italian than the Norwegian sample and could be linked with the earlier mentioned 'Norwegian wall' between being a child and being a nurse that make the Norwegians draw clearer lines between what is caring emotionally and what is taking care of physically. The Norwegians seldom give care in form of personal hygiene to their parents and their numbers are higher on practical tasks such as transportation or house maintenance. As mentioned, financial support given by children of frail elders is not common in Norway, but more widespread in Italy. This could be because of the legal obligation incorporated in the Italians or the lack of coverage by the minimum pension, so that the children have to add a sum to secure the quality of the care. There seem to be elements of family-specialization in Norway, meaning that the areas less developed within the services provided by the state, become the ones the families perform. From the respondents we find that almost none do any kind of cleaning, except from small operations like dusting when they accidentally are passing through or cooking for the elders to make something special for them Friday night. But the services provided by the local government are prioritized as much as possible and then the family add and fill in where the services are poor. Paul tells us his view:

That's how life goes. If it happens it happens now with my mother. From here on (...) Of course in

a way it's a problem, but you just got to resolve it. No one else does it for you. I would rather do the grocery shopping for her, than to pay 350 crones (40 euro) for an assistant to do it.

### 3.2.5 Combining care with work: work attachment and leaves

Since my purpose with this thesis was to explore how work and care are combined in the two countries it seems crucial to look into their relation to their job specifically and to work as a part of life in general. The work leaves and flexibilities in the work place are important in the way that they give us an input on which kind of alternatives the carers have when they need to bring their parent to the doctor or an emergency happens. The presence and information of sufficient leaves and flexibilities should be one way of making their everyday a little bit easier. We will now see how the respondents make use of leaves and which importance their paid work is given. On the contrary to what one may have expected seeing the traditional gender roles and employment patterns, the only Italian respondent that had changed extensively his work situation was the one male, Paolo, and even he said it was a personal wish to diminish his work hours and not for the sake of his mothers illness. All the female respondents had no intension of decreasing their work hours and spoke of their work as an important part of their being and quality of life. Most of the respondents come from middle class economies and could therefore have chosen to not work full time, but still they feel work as a stimulating and not an issue to quit unless the health of anyone in the family gets so degraded that she would have to stay at home. The exception was the extended family where Claudia, expressed some concerns about work progress and said she probably could have had other and more prosperous titles if she wanted, but that she had chosen to have more time with her family and her dependant father at home. She has to work, not just because of her own development and wish, but because the economical situation demands it. When asked if she had ever down prioritized work for the care situation, she replies:

Of course it is true that it conflicts with other necessities, also those occupational. So it depends on what type of job you do among other things..If my husband and I had a lot of work-responsibility and –activity it wouldn't have been possible. You cannot do everything. You cannot just get up and leave..

As mentioned, though, most part of the Italian respondents sees their employment as something important for themselves and not just from an economic aspect. By this we could see a change from the former Italian traditional gender roles and culture values. The Italian women seem to get self-fulfilment from their jobs and to quit would mean to give up on their own lives. Chiara who takes care of her dement mother describes this to us:

I really like my work. I worry and take care of my mother in any way possible, but without destroying me. If there were no alternatives I would stay with her and take care of her myself on day to day basis. But I would have been angry with myself, with her and with the world...No, I couldn't not work. I couldn't not take care of my interests and my own family, like my son. Any way you see it is always difficult because you feel like this and like that. You feel selfish or..But

we are not made to be martyrs and she is not left to herself. We feel better like that the both of us. Obviously there are sacrifices..like the economic ones even though in the end they are the least worry. Of course if you don't have enough money..it would be different and you would try to contribute in other ways, I don't know..

Angela who lives with her mother in law at home, tells us her feelings about her job as a nurse. She never says she is voluntarily thinking about quitting, because she really likes it, but her situation is too tiring even though she can more or less choose her own work schedule:

I am a private nurse and I like it a lot! I have never done it for the money, but because I like it. I am very enthusiastic about my job. Working gives me a lot and not from the financial viewpoint. Now, in this period I am tired, really tired and I am afraid that I have to stop working....because of her.

In the Norwegian sample 4 out of 5 respondents underline that work is important for their personal wellbeing. Work is seen as something not up for discussion and therefore a natural part of life. The one respondent that didn't emphasize work this way was Paul and he expressed only economic reasons as to why his job was still needed. His view could be tainted by the fact that he is the oldest person in the Norwegian sample with his 66 years and that he therefore is closer to retirement age himself. Explicitly making sacrifices to be able to care is the case for only one of the Norwegian respondents, Jon. Vacations or work related travels are planned ahead and he hasn't been for more than a few days in years because of the health of his mother. He is very satisfied with his work in a volunteer organization, but has said no to career possibilities, especially those abroad because of his mother:

She is lucky having someone visiting her so often obviously (...) I know it varies a lot from person to person. But she has been kind and good to me always so I can be the same for her now (...) Of course I could probably work more and make more money..having a job that demanded more of me, but this gives more. I have enough. What do I need to triple my money for if I have food and drink on the table (...)

The possibilities the respondents have for combining work and care depends on their flexibility, work hours and conditions. In Italy it seems as though the respondents are aware of the have the possibility of using the Law 104 if an emergency happens, but since three of the female respondents are fully or partly self-employed, they have to search other ways if an emergency happen or just hope that it does not. The last option is describing for Lucia's situation. She and her husband owns a in a tobacco store and she works there fulltime by herself. This way she has the problem of leaving if anything happens. As mentioned, Lucia depends highly on phone contact with the other siblings and her husband to be able to manage the situation with her mother who is constantly getting worse. She cannot leave work, not even for a minute during the day, so the week has to be planned and they have to hope that nothing unforeseen happens that will disturb their plans:

Earlier I always worked part-time, so I could fix small stuff like grocery shopping, paying bills, cleaning the house...now I am trapped here. I cannot go anywhere and I cannot be sick..It's a bit heavy I have to say...but I have chosen this work myself so I just have to do what I can.

Some of the women seem to have a very intense work and care situation, but still they try to cope until they reach a complete stop mentally or physically. Their responsibilities and fulfillment as worker is prioritized highly. For example, Angela works as a private nurse during the night and takes care of her mother in law living with her and her family during the day. She is self employed, but takes her job very seriously:

I organize the work myself, so I can choose to go or not go, but it wouldn't be serious from my part if I started to not go. I wouldn't be right to my patients. If I start something, I finish it. Of course if I have an incredible stomachache I stay at home, but besides that....

Chiara is partly also self employed and partly employed on project basis and seem to be able to define her workday more or less herself:

It happened one time that my mother was hospitalized. I try to manage. I mean, in my job it's not like I cannot go anywhere. If I want to go see her one day, no one tells me not to. It's a personal choice, but I always try to do everything I can. But if there are emergencies that need to be taken care of, I am the one who does it.

Since only one of the respondents, Claudia, work in private sector, I cannot see if there are any variations in the conciliation strategies between private and public. Claudia herself makes use of the Law 104 if she needs to stay at home for an emergency, and the same goes for Paolo who works as an engineer in a public office. Claudia underestimates the relationship with co-workers:

In theory, thank God, if we need to ask for permission for leaves, we have had the same positions for years and our bosses knows about our family related problems, so it wouldn't be a problem to ask(...) Maybe also because we have never taken advantage of the situation. I say this because looking at my colleges...who maybe does this. Maybe with the 104 Law..for example in our case specifically there are moments when we need to go to the doctor or if he (her father) is not feeling well..then I stay at home. But the rest of the time I always work.

In the Norwegian sample, all the respondents work full time except one female, Lea, that decided to work a longer part time, but not because of her fathers' care needs. During the interview, though, she acknowledges that she actually does use this 'extra time' for the caring of her father:

The flexibility I have chosen to have for my self, or at least the point of reducing my hours to 75% position was to get more time for myself...I like to have time to do other stuff. But this hasn't happened. It has only been dad.

Beside this statement from Lea, generally the question of shortening their work hours does not appear as an alternative for the Norwegian respondents since the norm is to work and as long as it is easy to get a day or hour off to take care of one's parent in emergency, there should be no discussion to it. None of the respondents expressed worry about leaving work for emergencies and say they are met with understanding by their employers and are normally given welfare-leave or the day off if it's needed. They feel obligation for their work and co-workers, but it seems like the communication with employers are good enough to keep them relatively calm. Lea, the women working long part time, says though, that she is always ready to leave her job for an emergency with her father:

I have a new employer, so it doesn't feel so good having to say so early that I have to leave for

some time because of my father(...)But all my colleagues understands how it is to have a parent in need of care(...)With my former employee we played on the same team as I call it. She really understood and told me to just use sick-leave whenever I needed it for my mother at the time, so that I always had the welfare leave for the emergencies that were the most acute(...) I feel like my employees have always been easy to talk to about these issues. But with my mother as now, I keep two weeks of work ready on my desk, so if I over night have to leave, they can come and pick it up.

There does not seem to be differences in private or public workplaces although Stian, the one Norwegian respondent, which is, partly self employed (and partly taking a university dean), has greater liberty in choosing his work schedule.

### 3.2.6. Implications of care on main carers private and social life

The care arrangements I explore in my thesis have a great impact on the life for all the involved respondents. Their everyday is changed from when their parent got care needing. The impact may vary depending on the degree of the illness, the type of illness, the relation the carer had to the cared for prior to health problems. Further crucial elements to the impact of the care for the main carers are the cultural norms, the personal or family norms on who and how one should be involved with care, the resources available for handling the care arrangement in different ways and the alternatives available to substitute family based home care. Leah, having her father in a temporary institution tells us about her constant worries:

It's always in the back of my head(...)In the weekends I just try to get some rest. If anything happens obviously I go see my dad, but I try to rest. I don't have a lot of social activities...I don't even have time to go to the gym. You get so tired that when the weekend finally comes you just want to go to bed... have peace and quiet around you. It's a little bit over the top right now.

Although the respondents have different care arrangements the same mental preoccupation is pronounced by Chiara, having her mother taken care of by a *badante*: "I really worry for my mother. Every day". It is obvious that for the main carer this unsecure situation gives them more worry and demands more organization of them personally. We have several times heard Angela, the Italian lady co-habiting and caring for her mother in law, being under high levels of preoccupation and tiredness. Their relation prior to the illness has impact on with the present frustration:

My mother in law...Also when she was doing fine she never went to the park with us, with her grandson to play or nothing. We asked many times, but she never came. Never. I never remember her babysitting so that me and my husband could go out for dinner. She is that type my mother in law. So I have been a fool for letting her come live in my house(...)She has a bad character(...) I never had a relation to her. The one we had was false at most(...)It depresses me because she has never given me anything. I have never even got a thank you. My God, I am ruining my life for her...

Seemingly for some, the change of care arrangement from *badante* to institution seems relieving, but still there are family concerns like lack of social support. Adriano with his mother now in an institution after ischemic attacks and dementia fills us in:

I am not so stressed now in this moment. Before I felt it a lot. Now I am fine. I am relaxed. The tranquility even for my mother happened immediately after she came here (to the RSA) so my stress has fallen. It only remains my worry about still having to explain to other family members about our choice, the ones that was against it from the beginning and after a few visits they don't go to see her a lot(...)

The stressors are many, but the most part of the respondents from both countries express feelings of mutual duty. To re-give what has been given to them in their upbringing. Important questions are to what can be done to improve the caring for an elder and which part of society should have what responsibility?

### 3.2.7. Norms and values: how can elderly care improve and with what measures?

As I have explored, Italian welfare state focuses on the family in care giving by more or less only distributing cash-for care for them to organize the care themselves. In the interviews made for the WOUPS project used for this paper, the respondents were explicitly asked who should be responsible for the care of an elderly parent. Their answers could give us an impression about the family and state culture currently flowing in Italy. Adriano, with his mother in an institution responds:

I would say the children (should care for a care needing elderly). I like the job they do the *badanti*. But its contradicting voices here, since there are those you cannot manage without and there are those you would gladly manage without(..) I have always thought that our parents have always cared for us during our upbringing and we give to them when they are care needing now...

The norms and values surrounding what is the optimal the care arrangement is well thought of by Luca:

I have thought about that. Surely from the theoretic point of view it should be the family, but I think in either way that the society is changed, it has changed per se, I don't know if it's for better or worse. I'm thinking that years ago a lot of the services didn't exist, the social services, the structures and so on, so the only real care providing alternative was directly in the family, there were the so-called extended families. Everyone was more solidarism and so on. Now, society has changed for sure, it's the emphasis on female occupation who used to have, if you ask me, a considerable weight on her shoulders(...) So you ask yourself, also because substantially almost always it seems like a choice, I won't say obligation, but if you work you cannot..even though from a moral point of view I believe it to be unjust. If I think about it, I am completely in line with this and it makes me a little angry. So, if I see a paradox it is: where there are social services that work the families are less present. I talked to a Finnish friend where the social services are at the top, they told me this, and from the family point of view, when it works well, you lose a bit of the contact and the overview and everything.

Living close to your parent and in that way always be available is not anything necessarily taken for granted in Norway. This could be because the presence of a functioning doctor-awareness and home care system, but may easily be because Norwegians more often apply for a place in a care or

nursing home. This alternative seems like something negative for the Italians and they therefore see it as crucial to be there for their parents unless something important like job or spouse makes them live in another part of the country. The presence of other siblings also inflict on the choices of geographic proximity. But the general notion of giving back to your parents after what they have done to you, seem to be acknowledged by respondents from both countries. Jon, actively taking care of his mother in an institution tells us:

It seems like there are few visitors here...Almost like they think: "now you are 'placed' and I don't care anymore" That doesn't suit me. First and foremost we always had a good contact my mother and me. And beside she has been so good to my growing up so why shouldn't I care for her? There are obviously differences between people, but not taking care of her is not for me...

By asking who should have what responsibility in the care arrangement, we can see clearer the diverse welfare state traditions and orientations as well as the family values mentioned by Pfau Effinger and Geissler (2005) In other words, the role of the state and the family and how it affects the choices made in the care arrangement. As we have seen examples of, the respondents' answers can give us an impression on the weight of *de-familization* and the cultures welfare and family values. In Norway it is well known to be more state involvement, but this does not seem to mean less family involvement. The differences in access to services are much bigger than the access to family help. In countries like Italy where the service provided is poor, the family is on it's own and need to cope with what they have to manage the situation. The resources (except some cash provided by the state) are what the family has at hand and they alone have to find a way to make it work. In the Norwegian situation the families can enjoy the services given by the state even though they may need to wait in line for them, and in addition use what resources they personally have to fill in where the services are lacking or not satisfying. This way of *patchworking* is seen in all the Norwegian respondents having home care, which is not completely enough. But it is also seen in those caring for a parent in an institution. The tending and cognitive 'being there' for their parent is the main focus when all the physical help is already given by the social services. Helga, the respondent with her father living in an institution far away has put this dilemma of being a caring daughter in words:

I think that I would have wanted more time with him. Meaning talk to him, be there as a daughter, not a nurse. He wouldn't want it and I wouldn't want it. That is how it is. Even when we are there...obviously I could and I would manage to feed him but I prefer if the nurses does it. And I will guess that my father would prefer it as well. Because then we have a different relation. A father-daughter relation. We can discuss books, or...be something else. Since he is cognitively well, our relation has not changed much from when he got sick.

It does seem more expected for the Italians to take care of an elderly, but this could again reflect the lacking alternatives given by the state. Adriano, with his mother in an institution describes some similar way of thinking that they do not want to be a burden.

My mother says: I am fine here (in the institution). And she doesn't say it just to make us happy, its also true. Her panic attacks have passed, that terrible headache that was probably linked with

the anxiety of being in the house and having to depend on us

After hearing pro's and con's from the respondents about state interference in care arrangements,- how can we improve the situation both for carers and cared for? The respondents shared some of their views that can be presented as policy suggestions for elderly care in the two countries. In the Italian case the first expressed subject of improvement is the information about what, where and how to apply to the various benefits, work leaves, private carers and institutions. The words of Luca, having his mother in an institution, are:

Let's say that what could be most needed immediately was an organ that could illustrate a complete how to address certain things. For example, going around from place to place to ask for a care benefit; you don't know where to go. You have to activate yourself on your own. And if you are lucky enough to have contacts in the right places it helps to know the various documents and rights, but if not.

Another issue that seems important for the Italian respondents is the possibility of having more developed work-leaves that make them capable of being more involved in the care arrangement.

Adriano explains:

The state should give more possibilities of work-leaves...almost like the ones for maternity, because in that way one can follow up on situation and for example the *badanti*. Even now I am fortunate enough to be in a comfortable situation; I have my mother only few steps from my work place. But if it were further away? What would I have done? Two hours drive every day to go see her? I also have four out of five afternoons I can have free, so I am particularly fortunate. I can also choose when I want to see her.

Referring to the problem with *the badanti*, it seems obvious that employment regulation of private care workers is in place. This task seems huge and maybe impossible seeing that huge parts of the *badanti*'s are undocumented immigrants and thus the immigration regulation must as well develop even more and become more efficient. Further, looking at the situations of the main carers in the initial period of the care giving, there should be suggested an organ for assistance also to the ones not categorized medically as invalid. The need for help to perform even the smallest tasks, like grocery shopping and picking up medications, would be of great relief to main carer in this period. Issuing carer-centres or a place to communicate and cooperate internally between carers could also be an interesting way of coping. Through the interviews I felt the respondents need to tell their story to someone interested in listening and by interacting with others in similar situations or specialists in-group meetings; one could at least fulfil that need. In the Norwegian cases I find that emphasis is put on the mental stimulation of the elders when they are first in an institution, which normally happens at one point. Jon gives us an impression of his mothers' care centre:

Sometimes when I enter the door here, they just sit there. Someone is sleeping and there is no activity. Maybe 5-6 persons in silence just looking at the TV screen. Then I know she is annoyed. She needs more than that, or else(...) Now it's always just the question about stimulating her, about pushing her to be active physically and mentally. (...)when I leave she wants to go to bed. And that's not normal for her. She never wants to go to bed early...normally. But now. Here. It has something to do with the people here (referring to the other patients). They are in such a state of illness. And the nurses, the probably have more than enough to do, but I feel like they don't

integrate with the patients when they could, -like watch TV or chitchat. They don't have to separate themselves from the patients to do that. But I often see them sitting by themselves in the kitchen, only the nurses chatting. It has to do with the brain. The stimulation. She needs stimulation. (...)

We can see by the diverse stories told about the institutions; that there is a lacking of congruency in the Norwegian health care system. The different municipality prioritizes various kinds of care following their own norms that gives huge differences in the services given even though the costs are the same.

## 4. Conclusion

In this study the care arrangement for workers in Italy and Norway has been described to shed light on complexities and state measures of help, or not, in making their everyday life possible. By taking into consideration the history of the welfare state, gender equality and employment situations in the two countries, I have tried to discover the welfare and family values in the two countries and how they differ or resemble each other. By analyzing the interviews, I have found some elements that characterize the care arrangements in Italy and Norway.

In Italy, the main responsibility for elderly care remains in the hands of the family. They are the ones who from the beginning organize the care for their parents by attaining the right documents for cash benefits, private home care assistance or a place in an institution. At the initial stages of a care-situation the family negotiates and co-operates on a daily basis to manage to care for and supervise their parent. This period is stressful and highly demanding for the family. The most common care arrangement, though, is found by the family through the market, where migrant workers, *badanti*, are employed for a low cost making the situation more manageable for the family. The *badante* normally lives 24 hours in the house of the cared for and performs a huge variety of tasks depending on the illness of the cared for and the resources financially and time-wise of the family. Irrelevant of the arrangement being based on family care or the 'family-plus-one' care arrangement, the care giving remains gendered. Within the family women are the main caregivers, namely daughters or daughter-in-laws. The sons of care needing elderly in my sample generally apply some additional help in form of transportation, financial organization or as moral support. Since also the hired paid *badanti* are women, the care work continues in gendered hands. Considering that *badanti* are immigrants, and often with no documentation when they arrive in Italy, the possibility of social stratification is high and can give consequences for the care role and work itself as unprofessional and not valued. The care arrangement with a *badante* can be uncertain for both sides of the employment since there is normally no work contract. Other care arrangements that appear in Italy are (re)-cohabitation and institutionalization, but they are less favoured. In fact, the former implies too much involvement by the family or too unavailable or in humane as in the latter. Irrelevant of what arrangement they choose or end up with, the families carry the role as task-managers supervising and controlling the situation from all angles depending on the context, for example by

regularly communicating with the paid carer, the doctors, the social services, other informal caregivers and so on. The family has to put the pieces of the puzzle together to apply the best care available or wished for to their parent. The work leaves are seldom used, -only in emergencies, and in general the care-giving has a limited influence on the carers work. This seems to be because work is of high importance to the respondents and is therefore the last sphere they let the care arrangement disturb. Instead the social and private spheres are the ones suffering and the care giving interfere with everything from dinners with friend to vacations depending on the care arrangement, the illness of the cared for and family resources. Despite of their stressing environment, the families still uphold their cultural values implying that the family should have prime responsibility for the care giving. Moreover they wish for better cash benefits that would cover the entire cost of the care and for guidance and assistance in the jungle of documents and bureaucracy.

In the Norwegian cases the picture is somewhat opposite: the respondents are happy with the public care alternatives, which are highly represented by institutions. The home care is publicly provided or both publicly and privately financed and work as drop-by visits for the elderly still capable of living at home. This differentiates much from the Italian cases where care assistance is found in the market and paid for in part by the state and in part by the family itself. The Norwegian families in the sample have a supplementing role in the care arrangement where the main care given is social stimulation and emotional care giving. Instead of the family being in charge of the document handling, there is the doctor who in most cases attains the correct documents or guides the family to the right organ for further care organization. This doctoral help seems like taken for granted and the main stressors are concentrated around emergencies or cognitive stimulation to the elderly. Not even in the Norwegian case does the care giving interfere much with work, where only one respondent makes sacrifices in his career to care for his mother. The respondents see working as something natural and one 'does without questioning', but they are able to make use of welfare leaves or sickness leaves when needed, if an emergency occurs. Institutionalization has been and still is debated in the public sphere in Norway and some of the respondents do express worry for the lacking physical and mental stimulation given, since the staff is too busy and/or the other patients too cognitively ill. An important dissimilarity between the two countries in addition to the ones mentioned concerns gender. There seems to be more male involvement in Norway, but the reasons for this are not clear. One possibility could be that in the Norwegian care giving the more practical care tasks such as personal cleaning, feeding and house cleaning are not present almost at all in the tasks mentioned by the respondents. These tasks are immediately provided by public home care from the onset of any illness or incapability by the parent, so the family do not have to engage in

such tasks. This non-practical care giving may therefore stimulate the male's involvement in the care arrangement. In the Italian responses the male tasks like transportation and bank visits, are distinct from the female tasks like cleaning and feeding and since all tasks have to be performed by the family itself or a hired private carer, we see a greater distinction in involvement between men and women. As an additional reason to the gender division in elderly care, one cannot ignore the diverse development in female employment and gender equality in the two countries: the Nordic countries have a longer tradition for a gender equalizing culture and employment rates similar to the dual breadwinner, while Italy still is a male breadwinner culture.

## References

Anttonen Anneli and Sipila Jorma, “European Social Care Services: Is it possible to identify models”, in: *Journal of European Social Policy*, nr.6, 1996, pp.87-100.

Anttonen Anneli and Sipila Jorma “Comparative approaches to social care: diversity in care production modes”, in *Care and social integration in European societies*, edited by Pfau Effinger Birgit and Geissler Birgit, The Polity Press, Bristol, 2002

Bambra Clare, “Cash Versus Services: ‘Worlds of Welfare’ and the Decommodification of Cash Benefits and Health Care Service” in: *Journal of European Social Policy*, nr. 34 2005, pp. 195–213.

Caritas *Immigrazione-Dossier statistico* 98. pp.288 Anterem editors, Roma, 1998.

Da Roit Barbara “Changing Intergenerational Solidarities within Families in a Mediterranean Welfare State” in: *Current Sociology* nr.55, 2007, pp. 251-269.

Da Roit Barbara., Le Bihan Blanche and Osterle August. “Long term Care Policies in Italy, Austria and France: Variations in Cash-for-Care Schemes”, in *Social Policy & Administration*, nr. 2007, pp.653-671

Da Roit Barbara., Naldini Manuela and Donati Elisabetta, *Working and caring for an older parent in Italy* Report for the WOUPS (workers under pressure) project 2008.

Daatland Svein Olav, “Ageing, families and welfare systems: comparative perspectives”, in: *Zeitschrift fur Gerontologie und Geriatrie*, vol 34, no.1, 2001, pp.16-20.

Daatland Svein Olav and Herlofson Katharina, *Ageing, intergenerational relations, care*

*systems and quality of life*. Oslo: NOVA Report 14/01-2001

Daatland Svein Olav and Herlofson Katharina, *Family, welfare state and ageing. Family solidarity in a European perspective. (Familie, velferdsstat og aldring. Familiesolidaritet i et europeisk perspektiv)*. NOVA Report nr.7,2004.

Daly Mary and Rake Katherine. *Gender and the welfare state*. Polity Press, Cambridge 2003

Eurispes *Ricerca eurises sul lavoro domestico in Italia. La colf del 2002 e straniera, giovane, istruita*. Rome: Istituto du Studi Politici, economici e sociali

Evers Adalbert and Wintersberger Helmut, *Shifts in the welfare mix: Their impact on work, social services and welfare policies*. Campus Verlag/Westview Press, Frankfurt/Boulder, 1990

Esping-Andersen Gösta, *The Three Worlds of Welfare Capitalism* Polity Press & Princeton: Princeton University Press, Cambridge, 1990.

Esping-Andersen Gösta, *Why We Need a New Welfare State*. Oxford University Press, London, 2003.

Ferrera Maurizio, "The "Southern Model" of Welfare in Social Europe, in: *Journal of European Social Policy*, vol. 6, nr.1, 1996, pp.17-37.

Finch Janet, *Family Obligations and Social Change*, Polity Press, Cambridge, 1989

Finch Janet. and Mason Jennifer, *Negotiating Family Responsibilities*, Routledge, London, 1993

Gordon Linda and Fraser Nancy "Dependency" demystified: inscriptions of power in a keyword of the welfare state", in: *Social Politics*, nr.1, 1994, pp.14–31

Halvorsen Knut, *Grunnbok i helse- og sosialpolitikk*, Universitetsforlaget, 2005, Oslo

Hatland Aksel, Kuhnle Stein og Romøren Tor Inge, *Den Norske Velferdsstaten*, Gyldendal Akademisk, 2001, Oslo.

Knijn Trudie, "Fish without bikes: revision of the Dutch welfare state and its consequences for the(in)dependence of single mothers, in: *Social Politics*, nr.1, 1994, pp.83–105

Knijn Trudie and Kremer Monique, "Gender and the caring dimension of welfare states: towards inclusive citizenship", in: *Social Politics*, nr.3, 1997, pp. 328-361

Kohn Melvin L., "Cross-national research as an analytical strategy" in M. L. Kohn (ed.) *Cross national research in sociology*. Newbury park, 1989, Sage.

Leitner Sigrid, "Varieties of familialism. The caring function of the family in comparative perspective", in: *European Societies*, vol.5, nr.4, 2003, pp. 353-375.

Lewis Jane, "Gender and the development of welfare regimes", in: *Journal of European social policies*, vol.2, nr.3, 1992, pp. 159-173

Lewis Jane and Ostner Ilona, "Gender and the Evolution of European Social Policies", *ZE-S, Arbeitspapier* nr. 4, 1994.

Lewis Jane, "Men, women, work, care and policies", in: *Journal of European Social Policy* vol.16, nr.4, 2006, pp 387-392.

Lingsom Susan, "The substitution issue. Care policies and their consequences for family care" Oslo: *NOVA Report*, nr.6, 1997

Lister Ruth, "Women, economic dependency and citizenship", in: *Journal of Social Policy*, 1990, nr. 19, pp. 445–67.

Lister Ruth, "She has other duties: women, citizenship and social security", in: *Social Security and Social Change: new challenges to the Beveridge Model*, edited by Baldwin Sally and Falkingham Jane, Harvest Wheatsheaf, New York, 1994.

Lyon Dawn, "The Organization of Care Work in Italy: Gender and Migrant Labor in the New Economy", in: *Indiana Journal of Global Legal Studies* , Vol.13, nr. 1, 2006, pp. 207-224.

Mangen Steen, “Qualitative research methods in cross-national settings”, in: *International Journal of Social Research Methodology*, Vol. 2, Nr 2,1999 pp.109-124.

Naldini Manuela, *Le Politiche Sociali in Europa. Trasformazioni dei bisogni e risposte di policy*, Carocci, Roma, 2006

Naldini Manuela and Saraceno Chiara. Draft paper: *Italy: Old and New Debates and Immobile Policies?* London, 2007

Naldini Manuela *The Family in the Mediterranean Welfare States*, Frank Cass, London, 2003.

Millar Jane and Warman Andrea, *Family Obligations in Europe*, Family Policy Studies Centre, London, 1996.

O’Connor Julia, “Gender, class and citizenship in the comparative analysis of welfare regimes: theoretical and methodological issues” in: *The British Journal of Sociology*, nr.43, 1993, pp. 501-518.

Orloff Ann “Gender and the social rights of citizenship. The comparative analysis of gender relations and welfare states” in: *American sociological review*, nr.58,1993, pp.308-328.

Orloff Ann “Gender in the Welfare State” in *Annual Review of Sociology*, nr.22, 1996 pp.51-78 .

Pateman Carole, “The patriarchal welfare state”, in: *Democracy and the State*, edited by Gutmann Amy, pp. 231–78, NJ: Princeton Univ. Press, Princeton, 1988.

Pfau-Effinger Birgit and Geissler Birgit *Care and Social Integration in European Societies*. The policy Press, Bristol, 2005.

Randall Sara and Koppenhaver Todd, “Qualitative data in demography: The sound of silence and other problems”, in: *Demographic Research*, nr.11, 2003, pp.57-94.

Rossi Alice S. and Rossi Peter H. *Of human bonding: Parent child-relationships across*

*The life course*, Aldine de Gruyter, New York, 1990.

Saraceno Chiara, “The ambivalent familism of the Italian welfare state”. *Soc. Polit.*, no.1,1994, pp.60–82.

Saraceno Chiara, “Gendered Policies: family obligations and social policies in Europe”, in: *Gender, Welfare State and the Market* edited by Boje Thomas P. and Leira Arnlaug, Routledge, London, 2000.

Saraceno Chiara and Keck Wolfgang *The institutional framework of intergenerational family obligations in Europe: A conceptual and methodological overview*. Wissenschaftszentrum für Sozialforschung, Berlin, 2008.

Siim Birte, *Gender and Citizenship. Politics and Agency in France, Britain and Denmark*, , Cambridge University Press, Cambridge, 2000.

Stein Catherine H., Wemmerus Virginia A., Ward Marcia, Gaines Michelle E., Freeberg Andre L. and Jewell Thomas C., “Because They're My Parents: An Intergenerational Study of Felt Obligation and Parental Caregiving”, in: *Journal of Marriage and the Family*, nr. 60, 1998, pp. 611-622.

Thomas Carol, “De-Constructing Concepts of care” in *Sociology*, Vol. 27, Nr.4,1993,pp.649-669

Ungerson Clare, “Gender, labour markets and care work in five European funding regimes” in *Care and Social Integration in European Societies* edited by Pfau-Effinger, Birgit and Geissler, Birgit, The policy Press. Bristol, 2005.

#### **Websites:**

<http://www.multilinks-project.eu>

<http://www.demographic-research.org>

<http://journals.cambridge.org> Downloaded: 30 Mar 2009 IP address: 129.240.182.16

[http://dictionary.reference.com/browse/ideal type\)](http://dictionary.reference.com/browse/ideal%20type)

<http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&plugin=1&language=en&p=tps00099> (EUROSTAT)

<http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&plugin=1&language=en&pc>

ode=tsdde530 (EUROSTAT)

[http://epp.eurostat.ec.europa.eu/portal/page?\\_pageid=1996,39140985&\\_dad=portal&\\_scheme=PORTAL&screen=detailref&language=en&product=REF\\_TB\\_population&root=REF\\_TB\\_population/t\\_popula/t\\_pop/t\\_demo\\_fer/tsdde220](http://epp.eurostat.ec.europa.eu/portal/page?_pageid=1996,39140985&_dad=portal&_scheme=PORTAL&screen=detailref&language=en&product=REF_TB_population&root=REF_TB_population/t_popula/t_pop/t_demo_fer/tsdde220) (EUROSTAT)

<http://www.oecd.org/dataoecd/34/10/41431698.pdf> (OECD)

<http://www.oecd.org/els/social/family> (OECD: Babies and Bosses – Policies towards reconciling work and family life 2007)

<http://data.un.org/DocumentData.aspx?id=118> 2008 (UN)

[http://www.ssb.no/emner/03/02/nos\\_d370/tab/tab-05.html](http://www.ssb.no/emner/03/02/nos_d370/tab/tab-05.html) (Statistics Norway, SSB: 1)

<http://www.ssb.no/pleie/tab-2008-08-29-06.html> (SSB 2)

<http://www.ssb.no/english/magazine/art-2003-12-04-01-en.html> (SSB 3)

<http://www.ssb.no/samfunnsspeilet/utg/200504/05/index.html> (SSB 4)

<http://www.ssb.no/helseforhold/> (SSB Levekårsundersøkelsen 1998)

<http://www.sintef.no/Helse/Aktuelt-om-SINTEF-Helse/Eldreboom-gir-sengejakt/> (SINTEF)

[http://www.snl.no/.sml\\_artikkel/eldreomsorg](http://www.snl.no/.sml_artikkel/eldreomsorg)

[http://www.tidsskriftet.no/?seks\\_id=1202047](http://www.tidsskriftet.no/?seks_id=1202047) (The Norwegian doctoral society)

<http://www.arbeidstilsynet.no/c26964/nyheter/vis.html?tid=49276> (The Norwegian Labour Inspection Authority)

<http://www.Istat.it> (2003, 2006)

[http://www.helsedirektoratet.no/vp/multimedia/archive/00013/Seniorpolitiske\\_utfo\\_13515a.pdf](http://www.helsedirektoratet.no/vp/multimedia/archive/00013/Seniorpolitiske_utfo_13515a.pdf) (Norwegian Social and Health department 2001)

## Abstract

The greying population has for some time been an important issue in European countries since it implies change and development for national and international social policies to be able to care for its increasing elderly population. In my thesis I discuss and analyze the variation and similarities between two diverse welfare states, namely Italy and Norway, and how the issue of care is proposed or resolved by social policies and the families themselves. Italy is little developed in formal social care and instead seeks to help its inhabitants through cash allowances, while Norway has a more comprehensive family policy in addition to extended long term care provided by the state. Since Italy is known to be a familiaristic welfare state where informal and especially female engagement is crucial for elderly care and Norway is considered a more gender equal state and structuring the care more formally, I analyze if these pre-assumptions exist in real life situations and how the families arrange and cope in their everyday life of working and caring for an elderly parent. Through a qualitative analysis in the two countries, I explore the respondents' cultural and personal attitudes and norms concerning who and how the care should be performed and how it is to be organized side by side with work and family life. My results imply that families in the two countries spend almost the same amount of time to care for their parents and they show similar attitudes and feelings connected to the care situation. However, my analysis shows also that issues surrounding whom and how tasks are performed vary according to traditions, culture and welfare strategies in the two countries and create two diverse paths of care arrangements. In both countries there has been a decline in informal (unpaid) care, but due to the lack of formal services in Italy combined with their cash for care scheme, there has been an increased growth of market services provided by migrant women hired by families in the grey market. Norwegian respondents on the other side rely heavily on formal care services, but need to supplement these services informally and express concern for the in-humane or standardized way of formal care institutions. On the other hand, the Norwegian respondents receive more direct guidance and help from the social system, while the Italian respondents often struggle to find a secure and adequate care arrangement for their parents and themselves.

Keywords: Welfare state, gender, family, formal and informal care, employment, Italy, Norway