Sabrina Marchetti and Francesca Scrinzi

Bureaucratized management of paid care-work

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The number of Italian households relying on home-based care provided through social cooperatives is growing since, after a reform of the sector in 1991, social cooperatives can be active also in the provision of home-based and residential care. They are entitled to provide these services on behalf of the municipalities – thus at no cost for low-income care-recipients – after a tender selection, and on the condition of certifying that they meet certain standards in terms of quality and availability of the service.

Through the example of the management practices in place a small-size social cooperative in Milan, and a large-size cooperative in Reggio Emilia we examine the impact of cost-effective and business-like approaches to home-care provision, albeit organized by public and not-for-profit actors. In each of the two cities, ten interviews with both workers and managers were conducted in collaboration with the administration of the cooperative under study. Lombardy and Emilia Romagna share similarities which are significant from the point of view of the development of the not-for-profit social and health care sectors.

Both are characterized by a high degree of implementation of the model of local multi-stakeholder administration promoted by the new Italian laws on public services mentioned above (Iori, 2011; Mosconi, 2011). Emilia Romagna is the historical cradle of social cooperatives (Fabbri, 2011) and Lombardy has been an area of intense development for them

(Unioncamere, 2009). Almost 40% of all cooperatives' caregivers in Italy are employed in these two regions (Andreaus et al., 2012).

Cooperatives like the ones we studied are adopting all kinds of tools in order to adjust to the requests of marketized home-care (partially) funded by public authorities. We have noted that they had to adjust to the requests of local authorities in order to keep up with the demands of not-for-profit marketized elderly care. From the interviews conducted, the following examples emerge as some of their strategies to accomplish this goal.

1. Ill and disabled people are approached as if they were the objects of a '**project'**, in which their individual cases are seen within the logic of economic cost-benefit calculations. Not for nothing, personal care provision is called, in these organisations, 'care plan.' This 'plan' consists of a list of goals drawn up on the basis of an analytical assessment of the situation of each care-receiver and relative objectives for the future. The care plan is jointly prepared by a manager of the cooperative, a social worker (on behalf of the local authority) and the care-receiver with his/her family. In practice, a care plan sets out the treatment that is needed for each elder person, together with its duration and frequency. From the point of view of the local authority, it is important to minimize costs and identify the kinds of task which are 'really necessary' in each case. From the point of view of the managers, it is important to consider whether the social cooperative is in a situation to be able to provide the treatments requested, especially in terms of organizing their resources and workforce availability.

2. Local authorities demanded social cooperatives to **schedule** the provision of their services on the basis of 30-minute care-interventions, meaning that the provision of care treatment ideally should last 30 minutes or multiples of 30 minutes. This means that each task accomplished by the worker is quantified on the basis of its duration: so many minutes for

giving medicines, so many minutes for a body-wash, so many minutes for serving food, so many for lifting the person out of bed and taking her to the bathroom, etc. A full bath for a person, for example, has to last exactly 30 minutes. Giving medicines needs to last 8 minutes. Basically, in this system, the care provision entails a series of carefully planned 'interventions' consisting in several tasks which, all together, should result in a job with a minimum of 30-minutes' duration.

3. Local authorities also set the **pricing** of these interventions, which is fixed at 18 euros for each 30-minute intervention. This price is subdivided on a 13-point scale which is used to calculate how much is to be paid by the care-receiver and how much by the local authority, depending on the local authority's assessment of the care-receiver's finances and health conditions. In the case of care-receivers with lower incomes, the service is paid for in full by the local authority. The opposite can also happen: local authorities can assess that persons are not in need of financial support from public funds and so they have to fully pay for the services themselves. This assessment is not only based on the income level of the care-receivers but also on their physical and health conditions as verified by social workers during a preliminary meeting, which is described below.

3. Local authorities also determine the **quality of the service** by specifying that the sponsored cooperatives need to meet a certain standard in terms of the professional qualifications of their personnel. All the caregivers have to possess a Socio-Sanitary Operator (OSS) diploma, and, as the cooperative managers related, in order to participate in the selection for the sponsorship, the cooperative had to undertake a process of professionalization of their employees. This often means that cooperatives provide free

training programmes for their employees who are at lower professional levels, supporting them in upgrading their professional (and employment) status.

5. In order to facilitate the (quite complex) process of payment for the care-interventions described above, the caregiver uses an electronic **tablet** with a catalogue of all the tasks that can possibly be performed in care-intervention. After their accomplishment, tasks are systematically ticked off on a tablet-screen, thus caregivers can automatically produce a complete calculation of the time they have worked and therefore a receipt for the payments. When in the care-receiver's house, caregivers also have to sign a traditional paper-register, writing down their times of arrival and departure. At the end of the month, this can be used by the care-receivers to check that the working-times accounted for in the receipts are correct.

6. Caregivers use a special type of **electric car** to move between their destinations and which is equipped to transport disabled or elderly people if necessary. One can see this car in some ways as the actual 'workplace' of the caregivers. In fact, caregivers' working-time is calculated not on the basis of the duration of the care-interventions that they provide, but starting from the moment they pick up the car in the morning. Their working-time ends when they bring the car back to the parking lot at the end of the day. This car is also the place where they carry the tools for their job: care-equipments, their patients' house keys, the documentation regarding each patient and, most importantly, the tablet. It therefore goes without saying that all the workers in the cooperative need to be able to drive these vehicles safely, and this is an additional working skill attached to their profile.

Conclusions

All these elements together lead us to a portrait of a bureaucratized management of home-care that, as it is sponsored by public authorities, involves the limitations, requests and obligations set by them since they will pay for the service, *at the condition of* keeping public expenditure low. In this example, we see how it is the public authority that encourages the cooperative towards more business-like behaviour in the management of their workforce.

The article has shed light on the role of state and public authorities in the expanding market for home care and other welfare services. The Italian case, with the gradual replacement of the state with regional and municipal authorities in the realm of social services invites us to draw attention to the role that public actors maintain not simply in regulating and (partially) sponsoring the activities of care providers but even more in promoting the spread of a business logic which they justify from the perspective of reducing costs to public budgets. The article has also described how cost-effective and business-like approaches have impacted on the bureaucratized organization of paid care-work in the not-for-profit sector.

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