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1. Introduction

The care sector in Italy is under increasing pressure from demographic and labour market forces. Almost one in four Italian residents were aged sixty-five or older in 2024, a percentage expected to rise to over a third by 2050. This will lead to an unprecedented surge in demand for long-term and home care services.[1] At the same time, persistent staff shortages in public hospitals, nursing homes, and private facilities have left existing care staff facing excessive workloads and a high risk of burnout.[2]

The workforce in the sector is predominantly determined by gender and migration. Women make up the majority of care workers, and immigrant women have become the mainstay of home care roles due to the sector's low wages and limited public provision of home care services.[3] To address the chronic shortage, the Italian government has granted an additional 10,000 work visas for immigrants involved in elderly care. However, many of these workers are employed on informal or self-employed contracts that fall outside standard labour law protections and social security schemes.[4]

Remuneration in Italy's care sector lags far behind Western European norms. As an example, the collective agreements of domestic workers and home carers often set entry wages between €870 and €924 per month, which equates to annual earnings of less than €11,000. This is below the national salary average and contributes to the high staff turnover and recruitment difficulties.[5] Furthermore, the duality of the labour market means that employees receive all pension and insurance contributions, while the self-employed and irregular carers often contribute very little or nothing at all.[6]

These labour market challenges are compounded by a fragmented regulatory framework. Constitutional Law No. 3 of 2001 assigned 'protection of health' to concurrent state–region competence, with the state defining the fundamental principles and the regions responsible for

[1] "Italy's demographic crisis deepens as births hit record low," Reuters, March 31, 2025, https://www.reuters.com/world/europe/italys-demographic-crisis-worsens-births-hit-record-low-2025-03-31.

[2] "Italian health workers strike over pay, under-investment," Reuters, November 20, 2024, https://www.reuters.com/world/europe/italian-health-workers-strike-over-pay-under-investment-2024-11-20/.

[3] Maria Melchiorre et al., "Frail Older People Ageing in Place in Italy: Use of Health Services and Relationship with General Practitioner", *International Journal of Environmental Research and Public Health*, 19, 15 (2022): 9063, https://doi.org/10.3390/ijerph19159063.

[4] "Italy to offer more migrant work visas to caregivers for old people," Reuters, October 2, 2024, https://www.reuters.com/world/europe/italy-offer-more-migrant-work-visas-caregivers-old-people-2024-10-02.

[5] "Wages in long-term care and other social services 21% below average," European Foundation for the Improvement of Living and Working Conditions, May 2025, https://www.eurofound.europa.eu/en/resources/article/2021/wages-long-term-care-and-other-social-services-21-below-average.

[6] CARE4CARE Project, *Final Report on Job Quality and Working Conditions* (Florence: Università degli Studi di Firenze, 2024).

the detailed organisation, financing and legislation of care services.[7] Although this decentralisation was intended to strengthen subsidiarity, it has resulted in significant territorial disparities in service availability, qualification requirements and working conditions, ranging from Lombardy to Calabria. Moreover, undeclared work remains pervasive: nearly 43% of personal and household service jobs in Italy are estimated to be undeclared, further eroding the social-protection base and exacerbating worker precarity.[7]

The findings of the CARE4CARE project in Italy (D2.3 and D3.3) document pervasive wage inequality, precarious contracts and a widespread lack of awareness of rights among care workers, particularly along gender and migration lines.[8] This article builds on these findings to call for the harmonisation of regional regulations, the extension by law of core labour protections to all care providers, the strengthening of collective bargaining structures and the adoption of robust cross-sectoral anti-discrimination measures: essential steps to ensure that the Italian care workforce is protected, valued and brought into line with European labour standards.[9]

2. Gender, Age, and Nationality: Structural Dimensions of Italy's Care Workforce

Italy's care workforce is shaped by three interrelated demographic factors: a pronounced feminisation, an ageing profile, and a substantial reliance on migrant labour. These structural characteristics not only define the composition of the workforce but also influence the sector's vulnerabilities and inform policy considerations aimed at enhancing job quality, workforce sustainability, and non-discrimination.

The Italian care sector is predominantly female. According to Eurofound, women constitute over 85% of personal care workers and nurses in Italy, reflecting a broader European trend where health associate professionals, personal carers, and nursing assistants are considered "very female-dominated occupations," with more than 80% female participation across the EU.[10]

This gender imbalance is even more pronounced in the formal social-care sector. Official data indicate that women make up more than 80 % of care workers registered with the National Social Security Institute (INPS). Such stark feminisation underscores deeply ingrained cultural norms that position women as default caregivers, both within families and in formal services. Eurofound describes these perceptions as "deeply-engrained," highlighting the societal expectation for women to assume caregiving roles.[11]

The care workforce in Italy is ageing, with significant implications for service delivery and workforce sustainability. A 2020 report by the National Institute for Public Policy Analysis (INAPP) notes that the average age of health-and-care personnel is 44.6 years, with an average

[7] European Labour Authority, "Factsheet on undeclared work – Italy", 2023.
[8] CARE4CARE Project, *Comparative Care Workers' Discrimination Map Report* (Girona: Universidad de Girona, 2024).
[9] OECD, *Towards Person-Centred Integrated Care in Italy, Inception Report* (Paris: OECD Publishing, 2023).
[10] Eurofound, *Gender Equality at Work*, 2020, https://www.eurofound.europa.eu/publications/2020/gender-equality-work.
[11] Eurofound, *Women and Labour Market Equality: Has COVID-19 Rolled Back Progress?,* 2020, https://www.eurofound.europa.eu/publications/report/2020/women-and-labour-market-equality-has-covid-19-rolled-back-progress.

seniority of 17 years.[12] More specifically, data from the National Agency for Regional Health Services (Agenas) reveal that the average age of nurses is 47.3 years, with women averaging 47.4 years and men 47.2 years.[13]

Informal caregivers tend to be even older. This ageing profile results from multiple factors, including recruitment shortfalls among younger cohorts, austerity-driven hiring freezes during the 2010s, and limited entry routes for younger workers. The impending wave of retirements threatens to exacerbate chronic understaffing, with projections indicating that, without significant recruitment efforts, Italy could lose up to 40% of its current nurse workforce to retirement by 2038.

Migrant workers play a central role in Italy's home-care sector. Research by the Domestic Labour Observatory indicates that over 70% of domestic and care workers are foreign nationals, primarily women from Eastern Europe, the Philippines, and South America.[14] The Interlinks project reported that in 2010 only 22.3% of registered care-worker beneficiaries in Italy are Italian-born; the remainder are foreign, and of those, women constitute 87% of foreign care workers.[15] A 2021 analysis by InfoMigrants further confirms that nearly 40% of foreign women in Italy are employed in domestic or home-care services.[16]

This heavy reliance on migrant labour stems from two key drivers. First, public home-care provision is insufficient, leading families to seek private solutions at lower cost. Second, Italy's restrictive migration quota system – only partially relaxed since 2021 – channels many migrant women into domestic-care pathways, even when they hold other qualifications. Migrant caregivers frequently work under informal or self-employed contracts, which exclude them from core labour protections such as paid leave and social security contributions, exposing them to irregular pay and precarious residency conditions. These vulnerabilities intersect with gender to produce heightened exploitation risks and barriers to asserting legal rights.[17]

3. Forms of Employment and Contractual Arrangements

Italy's care sector is characterised by a diverse range of employment forms, including subordinate employment, self-employment, temporary contracts, and significant undeclared work. This stratification creates a fragmented labour market with uneven access to social protections and

[12] INAPP, *Personale Sanitario allo Stremo*, 2023, https://www.inapp.gov.it/pubblicazioni/personale-sanitario-allo-stremo.
[13] Agenas, *Età Media degli Infermieri*, 2020, https://www.agenas.gov.it/eta-media-infermieri; Agar Brugiavini, Ludovico Carrino, and Giacomo Pasini, "Long-Term Care in Italy," in *Long-Term Care Around the World*, ed. Jonathan Gruber and Kathleen McGarry (Chicago: University of Chicago Press, 2025), 177–212.
[14] Osservatorio DOMINA sul Lavoro Domestico, "6° Rapporto Annuale Sul Lavoro Domestico: Analisi, Statistiche, Trend Nazionali e Locali," 2024, https://www.osservatoriolavorodomestico.it/rapporto-annuale-lavoro-domestico-2024.
[15] Interlink Project, *Migrant care workers in Italy. A case study*, (Vienna: European Centre for Social Welfare Policy and Research, 2010).
[16] InfoMigrants, "Italy: Migrant Women Penalized Most by Pandemic," 2021, https://www.infomigrants.net/en/post/36040/italy-migrant-women-penalized-most-by-pandemic.
[17] Hui Chen et al., "Irregular Migrant Workers and Health: A Qualitative Study of Health Status and Access to Healthcare of the Filipino Domestic Workers in Mainland China," *Healthcare (Switzerland)* 10, 7 (2022); Direzione Generale dell'Immigrazione e delle Politiche di Integrazione, "XIII Rapporto annuale: Gli stranieri nel mercato del lavoro in Italia" (Roma: Ministero del Lavoro e delle Politiche Sociali, 2023).

benefits.[18] Formal care workers, such as nurses and care assistants, generally benefit from full statutory protections, including collective bargaining rights, paid leave, and occupational health coverage. In contrast, many home caregivers (domestic workers) operate as irregular workers, often without access to these core labour safeguards.[19] This hybridisation challenges traditional labour law distinctions and demands adequate regulatory responses.[20]

Historically, Italian labour law has distinguished sharply between subordinate employees – deemed inherently vulnerable and therefore entitled to comprehensive protections – and self-employed professionals, who are assumed to operate with greater autonomy.[21] Subordinate care workers (e.g., nurses or social and health workers) benefit from full social security contributions, paid leave, collective agreements, and occupational health safeguards.[4] By contrast, self-employed caregivers, often categorised as *prestatori d'opera* or engaged in *co.co.co.* (co-ordinated and continuous collaborations), typically lack key protections such as paid sick leave and minimum wage guarantees.[22]

A significant share of the Italian workforce in the home care sector is formally classified as self-employed, despite often operating under conditions closely resembling traditional employment relationships. In many other cases, home care workers have subordinate contracts that are, however, only partially regular or are totally irregular.[23] The misclassification or irregularity reflects both the attempts of households to reduce labour costs – self-employed workers have lower social security contributions – and the absence of a clear, comprehensive and up-to-date regulation of 'domestic work'.[24] This gap forces many caregivers to bear the burden of social security contributions or remain partially uncovered, further exacerbating their financial vulnerability.[25]

The widespread use of temporary and part-time contracts further complicates the sector. Driven by both public-sector austerity and families' demand for flexible care, these contracts have proliferated in recent decades.[26] Involuntary part-time employment among care workers increased from 9 % in 2004 to nearly 12 % by 2019, with a disproportionate impact on women.[27] Younger care workers are particularly affected: a recent study found that over 50 % of care-related contracts for those under 35 are temporary, compared with 30 % in the broader service sector.[28] These arrangements typically offer reduced contributions to Italy's INPS, resulting in lower pension accrual rates and limited access to unemployment benefits.[29]

Undeclared or irregular work (*lavoro sommerso* or *lavoro nero*) remains a pervasive challenge. In 2024, almost half of personal and household service activities in Italy operated outside formal labour-

[18] Silvia Borelli, *Who care? Il lavoro nell'ambito dei servizi di cura alla persona* (Napoli: Jovene, 2020).
[19] CARE4CARE Project*, Final Report on Job Quality and Working Conditions*, 34.
[20] DWF, *Italian Labour Law and the Care Sector: Legal Gaps and Policy Challenges* (Rome: DWF, 2024), 18-20.
[21] CARE4CARE Project*, Final Report on Job Quality and Working Conditions*, 35.
[22] CARE4CARE Project*, Final Report on Job Quality and Working Conditions*, 36
[23] Borelli, *Who care? Il lavoro nell'ambito dei servizi di cura alla persona*, 87 ff.
[24] CARE4CARE Project, *Final Report on Job Quality and Working Conditions*, 37.
[25] DWF, *Italian Labour Law and the Care Sector*, 26-27.
[26] DWF, *Italian Labour Law and the Care Sector*, 28.
[27] Brian Burgoon e Fabian Dekker, "Flexible Employment, Economic Insecurity and Social Policy Preferences in Europe", *Journal of European Social Policy* 20, 2 (2010): 126–41.
[28] Brian Burgoon e Fabian Dekker, "Flexible Employment, Economic Insecurity and Social Policy Preferences in Europe," 126–41.
[29] European Labour Authority, "Factsheet on undeclared work – Italy", 9.

law frameworks, one of the highest rates in Europe.[30] Southern regions like Calabria and Sicily are particularly affected, with undeclared work exceeding 50 %, compared with around 25 % in Northern regions such as Lombardy and Veneto. This shadow economy erodes statutory protections, leaving caregivers without paid leave, pension credits, or legal recourse for workplace abuses.[31]

Efforts to regularise the sector, such as tax-credit incentives and INPS's "domestic work contribution" campaigns, have achieved only modest success, improving compliance by an estimated 5 percentage points between 2018 and 2023. The persistence of undeclared work thus represents a critical barrier to securing stable, fair employment for Italy's care workers.[32]

4. Industrial Relations and Collective Bargaining

Italy's industrial relations in the care sector are marked by a stark divide between the public and private sectors. Public-sector collective agreements (*Contratti Collettivi Nazionali di Lavoro*, CCNL) provide uniform coverage and statutory wage floors, while the private sector is characterised by over 40 distinct CCNLs negotiated by a fragmented array of social partners, creating significant wage dispersion and regulatory complexity.[33] Public-sector agreements, negotiated by the main trade union confederations (CGIL, CISL, UIL), apply universally to all subordinate workers and establish minimum gross salaries ranging from €1,650 to €3,200 per month, depending on qualification levels.[34]

This framework ensures high union density (over 60 %) among public care workers, with structured mechanisms for dispute resolution and collective wage bargaining. It also mandates comprehensive social protections, including full INPS contributions, supplementary health coverage through interprofessional funds (*Fondi Interprofessionali*), and formalised training entitlements, reducing precarity and standardising working conditions across Italy's 20 regional health authorities (*Aziende Sanitarie Locali*, ASL). However, regional autonomy can lead to variations in implementation, as some ASLs adopt supplementary local protocols (CCNL *integrativi*) to address specific staffing challenges or emergency responses, such as during the COVID-19 pandemic.[35]

In contrast, the private care sector is characterised by a proliferation of CCNLs, some negotiated by representative unions, others by smaller, less representative "company unions." This diversity reflects Italy's fragmented industrial landscape, dominated by small and medium-sized enterprises (SMEs) and loosely affiliated employer associations As a result, many families and small care agencies select the lowest-cost CCNL available, perpetuating a race to the bottom in wages and

[30] Osservatorio DOMINA sul Lavoro Domestico, "6° Rapporto Annuale Sul Lavoro Domestico: Analisi, Statistiche, Trend Nazionali e Locali".
[31] European Labour Authority, "Factsheet on undeclared work – Italy"; Eurofound, *Undeclared Care Work in the EU: Policy Approaches to a Complex Socioeconomic Challenge* (Luxembourg: Publications Office of the European Union, 2025).
[32] European Labour Authority, "Factsheet on undeclared work – Italy," 10–11.
[33] CARE4CARE Project, *Final Report on Job Quality and Working Conditions*, 22.
[34] CARE4CARE Project, *Final Report on Job Quality and Working Conditions*, 22.
[35] Manuela Galetto, "Organised Decentralisation, Uneven Outcomes: Employment Relations in the Italian Public Health Sector," *Industrial Relations Journal* 48, 3 (2017): 196–217.

benefits. Wage levels in this sector vary significantly, with personal assistants and family carers earning between €13,500 and €24,300 annually, depending on the specific CCNL applied.[36]

Trade unions in Italy are private associations and are not subject to formal public registration. Their representativeness is largely self-declared, typically verified through voluntary certifications by joint bodies such as the National Council for Economics and Labour (CNEL). This system has allowed the emergence of "sindacati di comodo" (yellow unions), which sign agreements with employers despite representing a minimal share of the workforce. Although Article 17 of the Workers' Statute prohibits employers from supporting such unions, enforcement remains weak, and agreements signed by these unions are legally valid, contributing to the erosion of collective-bargaining standards.[37]

Efforts have been made to introduce stricter certification procedures for trade union representativeness, such as membership thresholds or mandatory mandates based on votes, but these remain politically controversial and face considerable resistance from employers' organisations, as they are only enforced through inter-union agreements and not by law. In the absence of such reforms, the private care sector is likely to remain highly fragmented and precarious for many workers. [38]

5. Wages, Benefits, and Social Protection

Health professionals in Italy typically earn gross annual salaries ranging from €16,000 to €29,500, significantly below their counterparts in countries like Germany and France, where average nursing incomes exceed €35,000. Social and care workers, including social assistants, basic care workers, and nursery aides, earn between €13,550 and €24,310 annually, depending on the applicable CCNL and the supplementary territorial collective agreement with regional cost-of-living adjustments.[39] Live-in or not live-in homecare workers, who primarily work in private households, often receive less than €13,000 per year, with many families opting for undeclared, cash-in-hand payments at rates as low as €6–€8 per hour to reduce costs.[40] This wage compression reflects the sector's cost-cutting strategies and the absence of statutory wage floors beyond CCNL minima.[41]

Subordinate care workers employed under standard contracts benefit from full contributions to INPS, including pensions, unemployment insurance, and maternity benefits. In contrast, self-

[36] "Italy: Increasing fragmentation in collective bargaining at sectoral level" European Foundation for the Improvement of Living and Working Conditions, May 2025, https://www.eurofound.europa.eu/en/resources/article/2018/italy-increasing-fragmentation-collective-bargaining-sectoral-level.
[37] Salvo Leonardi, "Trade Unions and Collective Bargaining in Italy during the Crisis," in *Rough Waters – European Trade Unions in a Time of Crises* (Brussels: ETUI, 2025).
[38] CARE4CARE Project, *Final Report on Job Quality and Working Conditions*.
[39] Organisation for Economic Co-operation and Development, *Health at a Glance: Europe 2024* (Paris: OECD Publishing, 2024), 35-36.
[40] CARE4CARE Project, *Final Report on Job Quality and Working Conditions*, 22-23.
[41] Marja Hult et al., "Decent and Precarious Work Among Nursing and Care Workers: A Mixed-Method Systematic Review," *Journal of Advanced Nursing* 81, 6 (2025): 2913–2928; Tesseltje De Lange e Mariella Falkenhain, "Precarity prevented or reinforced? Migrants' right to change employers in the recast of the EU Single Permit Directive," *Frontiers in Sociology* 8 (2024): 1267235.

employed caregivers must register with separate INPS funds (*Gestioni Separate*) and often struggle to meet minimum contribution thresholds, resulting in pension entitlements less than one-third those of permanent employees.[42] Irregular and undeclared workers are entirely excluded from official social-security schemes, denying them sick-leave pay, parental leave, and survivor's pensions. This segmentation produces a two-tiered system: core employees enjoy relatively comprehensive social protections, while peripheral, often self-employed or irregular workers face significant coverage gaps.[43]

Italy lacks a universal statutory minimum wage, instead relying on sector-specific minimums negotiated through collective bargaining under CCNLs. [44] Public or private sector agreements, while differing in terms of wages, tend to include leave provisions and generally improve upon the legal framework (e.g., in the case of maternity leave, many CCNL provide for 100% wage coverage, whereas the statutory minimum may be as low as 80%). However, the legislation governing domestic workers, including both live-in and non-live-in carers, is significantly weaker, often lacking adequate protections, such as those for maternity leave. Here too, CCNLs play a role in enhancing worker protections, but they do not reach the same levels as those provided to other categories of workers. At a broader level, the fragmentation of the social protection landscape affects women, who often bear the main responsibility for family and caring responsibilities.

6. Precarity, Informality, and Discrimination

Undeclared work remains pervasive in Italy's care sector, with rates ranging from 30 % in the North to over 50 % in the South and Islands.[45] The European Labour Authority (ELA) estimates that nearly half of all home-care services in Italy are provided without formal contracts, depriving workers of legal protections and exposing them to wage theft, arbitrary dismissal, and unsafe working conditions. Informal caregivers often endure irregular hours, unpredictable pay, and a complete lack of health-and-safety coverage, forcing many to work despite illness and to bear the full cost of protective equipment during the COVID-19 pandemic.

Gender-based discrimination is also widespread. Surveys by Equality Councillors under the CARE4CARE project reveal that many employers resist part-time arrangements for maternity reasons and hold normative biases that confine women to the lowest-paid care roles. Migrant workers, predominantly women, face compounded challenges: language barriers, precarious residence permits, and employer-controlled housing conditions restrict their ability to report abuses or seek collective redress. Casual racism and "othering" in household settings further

[42] CARE4CARE Project, *Final Report on Job Quality and Working Conditions*, 24-25.
[43] European Labour Authority, "Factsheet on undeclared work – Italy," 7–8.
[44] European Labour Authority, "Factsheet on undeclared work – Italy," 9.
[45] Osservatorio DOMINA sul Lavoro Domestico, "6° Rapporto Annuale Sul Lavoro Domestico: Analisi, Statistiche, Trend Nazionali e Locali".

erode their dignity, with few avenues for accountability beyond sporadic labour-inspectorate interventions.[46]

The D3.3 *Discrimination Map* report highlights a spectrum of discriminatory practices, including verbal harassment, workload segregation, and exclusion from training opportunities, which disproportionately affect women and migrant workers in informal or temporary roles.[47] The report underscores the blurring of boundaries between harassment, work–life conflict, and bullying in private-home settings, where isolated workers often lack access to trade-union support or formal grievance mechanisms. [48]

7. Regional Disparities and Policy Context

Following the 2001 reform of Title V of the Italian Constitution (Constitutional Law No. 3/2001), Italy adopted a system of concurrent state–region competences in health protection. This devolution granted regions significant autonomy over health-service organisation, leading to notable territorial variations in service provision, qualification requirements, and working conditions for care workers.[49]

Under Article 117(3) of the Constitution, health protection falls within concurrent legislation: the State establishes fundamental principles, while regions legislate on implementation details. This framework has resulted in disparities in salary scales and regulatory standards between regions.

Each region also maintains its own procedures for social-care qualification and licensing, which hampers labour-market mobility and the standardization of professional skills. For example, Lombardy requires a 300-hour practicum plus regional examinations for Social and Health Worker certification, whereas Sicily stipulates only 200 hours and a simpler skills assessment.[50]

This patchwork of standards restricts professional mobility: an Social and Health Worker certified in one region may face delays or additional training requirements when seeking employment elsewhere, discouraging cross-regional applications and reinforcing entrenched labour-market divides. Moreover, regional regulatory fragmentation impedes the creation of a unified national register of care professionals, complicating workforce planning and the enforcement of continuous-education obligations.[51]

[46] CARE4CARE Project, *Final Report on Job Quality and Working Conditions*, 22-23.
[47] CARE4CARE Project, *Italian Care Workers' Discrimination Map Report*, 18-20.
[48] CARE4CARE Project, *Italian Care Workers' Discrimination Map Report*, 24-26.
[49] Monika Urbaniak, "Devolution in the Italian Healthcare System. The Role of Regions in Organizing Healthcare after 2001", *Barometr Regionalny. Analizy i Prognozy*, 12, 1 (2014): 89–97.
[50] CARE4CARE Project*, Comparative Care Workers' Discrimination Map Report*.
[51] Aleksandra Torbica e Giovanni Fattore, "The "Essential Levels of Care" in Italy: When Being Explicit Serves the Devolution of Powers," *The European Journal of Health Economics* 6, S1 (2005): 46–52.

8. Impact of COVID-19 on Care Work

From March 2020 onwards, care homes (RSA) and home-care services experienced a surge in demand alongside severe staff shortages as workers contracted the virus or entered quarantine.[52] A national survey commissioned by the National Institute for Health (ISS) found that 38 % of formal care facilities reported critical understaffing by April 2020, compared with 22 % pre-pandemic.[53] Infection rates among care workers reached 9 % – double that of nurses in intensive-care units – due to prolonged close contact in domestic and long-term care environments and initial PPE shortages.

Burnout and psychological distress soared: over 60 % of respondents in a CGIL-CISL-UIL joint survey reported symptoms of anxiety or depression, and 55 % indicated plans to leave the sector within 12 months if conditions did not improve.[54] These findings underscore the urgent need for enhanced occupational-health protocols, mental-health support, and staffing stabilisation measures.[55]

In response, several public-sector CCNLs negotiated ad hoc "COVID supplements" of €100–€200 per month for care workers, alongside extended paid sick leave and special childcare leave for infected or quarantined employees. Some Northern regions (e.g., Emilia-Romagna) enacted regional accords requiring care-home operators to allocate additional funds for overtime pay and recruitment bonuses.

However, private-sector collective agreements were slower to adjust. Only 30 % of domestic-work CCNLs introduced hazard pay clauses by mid-2021, and these were typically limited to €1–€2 extra per hour, insufficient to offset elevated infection risks. The decentralised nature of bargaining – compounded by the mélange of over 50 private-sector CCNLs – eant that many home-care workers remained without formal hazard allowances or pandemic-related leave, exacerbating workplace inequalities.

9. Concluding remarks

Italy's care workforce is confronted with converging demographic and systemic challenges that demand coordinated policy responses. Italy's population is among the most rapidly ageing in Europe, with those aged 55 and over projected to comprise nearly 46 % of the population by 2050, placing acute pressure on long-term and home-based care services and underscoring the sector's strategic importance. At the same time, longstanding structural weaknesses in legal frameworks, industrial relations, and regional governance threaten both the quality-of-care provision and the dignity and security of care workers.

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[52] Maria Laura Bettinsoli et al., "Mental Health Conditions of Italian Healthcare Professionals during the COVID-19 Disease Outbreak," *Applied Psychology: Health and Well-Being* 12, 4 (2020): 1054–73.

[53] Eurofound (2020), *Reward for employees exposed to risk in March, measure IT-2020-12/450 (measures in Italy),* EU PolicyWatch, Dublin, https://static.eurofound.europa.eu/covid19db/cases/IT-2020-12_450.html.

[54] Michela Di Trani et al., "From Resilience to Burnout in Healthcare Workers During the COVID-19 Emergency: The Role of the Ability to Tolerate Uncertainty," *Frontiers in Psychology* 12 (2021): 646435.

[55] Carla Felice et al., "Impact of COVID-19 Outbreak on Healthcare Workers in Italy: Results from a National E-Survey", *Journal of Community Health* 45, 4 (2020): 675–83.

The Italian labour-law regime has historically centred on subordinate employment, embedding robust protections – paid leave, social-security contributions, and occupational-health safeguards – for traditional employees but failing to match the sector's evolving mix of employment forms. Self-employed and informal care providers, who represent a significant share of home-care arrangements, remain largely excluded from comprehensive social protection and health-coverage schemes, exposing them to income insecurity and gaps in retirement benefits. In the absence of a statutory definition of "care work," regulatory ambiguity persists domestic workers are governed by the 1958 Act No. 339, which grants limited protections compared to subordinate employees, while migrant care workers often fall outside collective-bargaining frameworks altogether. Extending minimum labour standards to all care providers – through clear legal definitions, obligatory social-security contributions tailored to part-time schedules, and universal maternity and sick-leave entitlements – must therefore be a policy priority.

Italy's collective-bargaining landscape in the care sector is marked by a dual structure: public-sector CCNLs provide uniform coverage and safeguard baseline wages for hospital and residential-care staff, whereas the private-sector comprises over fifty distinct CCNLs negotiated by social partners of uneven representativeness. This fragmentation fuels wage disparities and confusion among both workers and families seeking care, undermining sectoral cohesion. Rationalisation measures – such as requiring certification of trade-union representativeness, establishing sector-wide minimum-clause frameworks, and consolidating private-sector agreements – could standardise conditions and curb the influence of "yellow" unions with minimal worker mandates.

The 2001 constitutional reform of Title V granted concurrent competence over "health protection" to the state and regions, intending to localise service delivery but resulting in stark territorial divergences. Regions exercise broad discretion over funding levels, qualification requirements, and service mixes; therefore, care-worker salaries and working-condition standards can differ significantly between Lombardy and Calabria. Such inequalities drive internal migration of care workers toward wealthier regions, exacerbating shortages in the South and perpetuating an unbalanced care ecosystem. A stronger role for the state is warranted to set binding national minimum service levels and qualification criteria, complemented by equalisation funds to support under-resourced regions.

Undeclared work persists at alarming rates in Italy's personal and household services – exceeding one-third of total care provision – eroding the social-security base and fostering exploitation. Simplifying registration procedures, incentivising formal contracts through tax credits, and bolstering labour-inspectorate capacities are vital steps to reduce informality. Concurrently, discrimination takes gendered and racialised forms, with Equality Bodies documenting resistance to maternity-related part-time requests and intersectional bias against foreign care workers – often only addressed through sporadic labour-inspectorate interventions. Empowering *Consiglieri di Parità* and UNAR with enhanced investigative powers and resources will be essential to enforce anti-discrimination laws effectively.

The COVID-19 pandemic exposed critical occupational health deficits in the care sector, with live-in, non-live-in and care workers experiencing infection rates and burnout exceeding those of acute care workers due to prolonged close contact and lack of Personal Protective Equipment. While some public-sector CCNLs negotiated ad hoc hazard-pay supplements and special leave,

these measures were applied unevenly across regions and subsectors, leaving many workers unprotected.

Ultimately, care work must be reframed as essential labour within a renewed social-contract paradigm that values both care recipients and providers. Public investment in community-based services, alongside family allowances and wage subsidies, can alleviate the financial burden on households while generating decent jobs in the formal economy. Integrating care policy into national strategic planning – alongside health, employment, and gender-equality agendas – will ensure that care workers receive the respect, rights, and remuneration they deserve.