-Safer Social Professionals At Home-

NEEDS OF HEALTHCARE PROFESSIONALS IN GREECE, ITALY, SPAIN

COMPARATIVE STUDY

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Executive Summary

This comparative report examines home care services in **Greece, Spain, and Italy**, highlighting each country's legislative framework, service delivery models, and the experiences of home care professionals and users (people with disabilities receiving care). The study was conducted in late 2024 under the *Safer Path* project, involving focus groups with home care workers and interviews with service users in all three countries. Key findings indicate that **all three countries face common challenges** in home care: **increased workload and stress due to the COVID-19 pandemic**, insufficient support and training for caregivers, and rigid service structures that sometimes hinder effective care. Professionals across Greece, Spain, and Italy reported **high job strain**, whether from inflexible regulations (Italy), confrontations with family members (Spain), or job insecurity (Greece). Users in all countries generally have **positive relationships with their caregivers** and value the emotional support they receive, but they also observe that caregivers are **overworked and under-supported**, leading to fatigue and occasional lapses in service quality.

Despite differences in context – e.g., Italy's well-defined legal framework, Spain's regional regulation, and Greece's nascent municipal program – **common trends** emerge. The **COVID-19 pandemic** placed heavy burdens on home care systems everywhere, increasing tasks and anxiety for caregivers and users alike. **Organizational support** structures exist (such as training programs or supervision protocols), but gaps are evident: Italian and Greek workers lack formal psychological support and consistent supervision, while in Spain support is available but often not via specialized professionals. **Major barriers** affecting care quality include **work overload**, **time constraints**, **insufficient resources** (e.g. lack of transport reimbursement in Italy), and **tensions with families** (notably in Spain).

The report identifies a comprehensive set of **recommendations**. Country-specific proposals converge on the need to **increase investment in home care** (more funding for longer care hours and additional staff), **improve job conditions** for home care workers (higher wages, stable contracts, and benefits), and **expand training and supervision** (including disability-specific education and mental health support). Better **service coordination and flexibility** is recommended: for example, allowing caregivers more autonomy in scheduling to meet user needs and reducing travel burdens by assigning workers to clients in the same area. **Family engagement** is also highlighted – educating family members about the home care program's scope and the importance of respecting the autonomy of people with disabilities.

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In conclusion, while Greece, Spain, and Italy operate under different home care systems, they share **common challenges in delivering quality home care**. Addressing these through **policy reforms and resource allocation** is crucial. By implementing the report's recommendations – from **strengthening legal frameworks** and **funding** to **supporting the frontline workforce** – each country can improve home care services, ultimately enhancing the well-being of both caregivers and users across Europe.

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Introduction

Home care services are a vital component of the social and health care continuum, enabling **older adults and people with disabilities** to receive assistance in their own homes rather than in institutional settings. This report provides a comparative analysis of home care services in **Greece, Spain, and Italy**, based on research conducted as part of the *Safer Path* project in late 2024. The objective is to understand how home care is structured and operates in each country, and to examine the experiences of those directly involved – **home care professionals** (care workers, nurses, coordinators) and **service users** (persons with disabilities receiving home care). By comparing three different Southern European contexts, the study aims to identify both **common challenges and best practices**, and to formulate recommendations for improving home care delivery.

The scope of this study encompasses multiple dimensions of home care. First, it reviews the **legislative and policy frameworks** governing home care in each country, recognizing that laws and regulations set the foundation for how services are funded, organized, and accessed. Second, it describes "how home care services work" in practice, detailing the delivery models and organizational structures in Greece, Spain, and Italy. Third, the report delves into the **findings of qualitative research** carried out in each country: focus group discussions with home care workers and in-depth interviews with home care users. These findings are analyzed at two levels – the **professional level**, exploring the working conditions, challenges, and support systems for caregivers, and the **user level**, exploring the impact of home care on users' well-being and the quality of care from the recipients' perspective.

A particular emphasis is placed on the **impact of the COVID-19 pandemic** and the lessons learned from that period. Given that the pandemic (2020–2022) significantly affected health and social services worldwide, understanding its effects on home care in each country provides important context for current challenges. Throughout the report, a formal academic tone is maintained and references are provided to the original national reports and the comparative presentation from the *Safer Path* project. The analysis follows a structured format to ensure clarity: after presenting the context and methods (*Executive Summary, Introduction, Aims and Participants*), it covers the **legislative framework** and **service delivery models** in each country, then compares the research results theme-by-theme (COVID-19 effects, support systems, barriers, and improvements) at both professional and user levels. Finally, the report discusses **proposals for improvement**, draws out

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key similarities and differences, and offers **general conclusions and policy recommendations**. Through this comprehensive approach, the report seeks to inform policymakers, service providers, and stakeholders about the state of home care in Greece, Spain, and Italy, and to contribute to the development of safer and more effective home care pathways in the post-pandemic era.

Aims and Participants

Overview of the Research: The comparative study was carried out between October and November 2024 in Greece, Spain, and Italy, following a common methodology developed by the Greek partner of the project.

Each country conducted qualitative research involving home care service providers and users with disabilities, using focus group discussions for professionals and one-on-one interviews for service users. The aim was to capture insights on home care practices, challenges, and improvements from both the supply (worker) and demand (user) sides.

Italy: In Italy, the research took place in October–November 2024 and was guided by the shared methodology guidelines. A single focus group was held with 15 home care operators on 21 November 2024 at the GMC Consortium headquarters in Lanciano. (Initially, two smaller focus groups were suggested, but due to worker scheduling difficulties, one consolidated session was conducted.) The focus group was facilitated by project researchers and included 2 male and 13 female participants, all of whom worked as home care providers. Among them were 2 nurses and 13 social/health care workers, employed by social cooperatives within the Consortium that deliver public home care services. These professionals were recruited voluntarily after being informed about the project's objectives. In addition, five in-depth interviews were conducted in November 2024 with persons with disabilities receiving home care. The interviewees (2 men and 3 women) were recruited via their social workers on a voluntary basis. Four interviews took place at the users' homes and one at a municipal office. The disabilities represented in this user sample were diverse – including visual impairment, physical disabilities, and mental health conditions– to reflect a range of home care needs.

Spain: In Spain, the study was conducted in the Andalusia region (with coordination by COCEMFE Sevilla) during the same period (late 2024). Two focus group discussions were organized on 29 October 2024, targeting different contexts of home care provision. One focus group took place in the small municipality of *El Ronquillo* (population ~1,360) in the City Council's plenary hall, involving

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5 home care workers employed in the local public home help service. All five were women, aged roughly between 30 and 55 years. The second focus group, held the same day in Seville, involved 10 professionals from Clece, a private social services company contracted to provide home care in urban Seville. These 10 participants were chiefly in coordination and administrative roles related to home care (managing and informing on services) and were a heterogeneous group (mostly female, aged ~25 to 45). Thus, Spain's sample of professionals (total 15) included both frontline caregivers and managerial staff, capturing perspectives from public and private service provision. Additionally, five individual interviews were carried out in early November 2024 with home care service users (people with disabilities) in Seville. The interviewees, predominantly women aged between 30 and 60, were all affiliated with COCEMFE Sevilla and had experience receiving home care services over their lifetimes. These interviews were conducted in the NGO's facilities. By including urban and rural, as well as public and private service experiences, the Spanish research aimed for a broad view of home care in Andalusia.

Greece: In Greece, the study focused on professionals working in the municipal "Help at Home" programs. A total of 17 home care professionals (mostly women) from two different municipalities participated in focus group discussions. The exact dates of the Greek workshops were in late 2024 (aligned with the other countries' timeframe). These participants were staff such as social workers, nurses, or home aides employed by local government to provide in-home support. It is noted that the Greek partner led the development of the research methodology, ensuring that similar questions and processes were followed in all countries. The Greek professionals' input is thus based on their experience with elderly and disabled clients in the Help at Home scheme.

Below is a summary of the research participants in each country:

Country	Professional Participants	User (Client) Participants	Research Format & Dates
Italy	15 home care workers (2 men, 13 women; roles: 2 nurses, 13 social/health workers, all from social cooperatives).	5 people with disabilities (2 men, 3 women; various disabilities: visual, physical, mental)	1 focus group on 21 Nov 2024; 5 individual interviews in Nov 2024 (4 at users' homes, 1 in municipal office).

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Country	Professional Participants	User (Client) Participants	Research Format & Dates
Spain	15 professionals in total: 5 home care workers (all women, ages ~30–55) in El Ronquillo's public service; 10 coordinators/ administrative staff (mostly women, ages ~25–45) from Clece (private provider in Seville).	5 people with disabilities (majority women, ages ~30–60, linked to COCEMFE Sevilla).	2 focus groups on 29 Oct 2024 (one in El Ronquillo City Hall, one in Seville with Clece staff); 5 interviews in early Nov 2024 at COCEMFE facilities.
Greece	17 home care professionals (majority women) working in "Help at Home" programs across 2 municipalities.	5 people with disabilities (2 men, 3 women, various types)	Focus group discussions in Oct–Nov 2024, following a common methodology guided by the Greek partner

Each country's research provided qualitative insights that form the basis for the comparative analysis in this report. In the following sections, we first compare the legislative frameworks and operational models of home care in Greece, Spain, and Italy, and then delve into the study findings at the professional and user levels.

Legislative Framework on Home Care

Effective home care services depend on a robust legislative and policy framework that defines eligibility, scope of services, funding, and responsible authorities. The three countries in this study have differing frameworks:

Italy

In Italy, home care for persons with disabilities is underpinned by comprehensive national legislation. The cornerstone is Law No. 104 of 1992, often referred to as the *"Framework law for assistance, social integration and the rights of disabled people."* This law establishes the rights of people with disabilities and the general principles for providing support, including home-based care. Notably, Article 15 of Law 104/1992 guarantees that individuals with severe disabilities or chronic

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disabling conditions are entitled to integrated home care, which involves coordinated medical care and social assistance delivered at home. This care is typically arranged in collaboration with the person's general practitioner and the National Health Service (NHS), ensuring medical oversight.

Beyond Law 104/1992, specific regulations detail the inclusion of home care in the national healthcare system. A Prime Ministerial Decree (DPCM) of 29 November 2001, updated by a DPCM on 12 January 2017, explicitly lists home care among the services that must be provided by the NHS. In Italian health policy, home care is part of the Livelli Essenziali di Assistenza (LEA), or Essential Levels of Care, which are the guaranteed health and social care services for all citizens. This means that every region (which manages healthcare in Italy) is required to offer home care services meeting certain standards and coverage. Typically, the actual delivery is carried out via accredited non-profit organizations (especially social cooperatives) under public contracts, in line with the principle of horizontal subsidiarity.

In recent years, Italy's commitment to strengthening home care has been reinforced by national strategic plans. For instance, Mission 6, Component 1 of Italy's National Recovery and Resilience Plan (PNRR) (post COVID-19 recovery plan) specifically calls for investment in expanding and improving home care services. Overall, the legislative framework in Italy is well-established: it enshrines the right to home care for those in need and integrates it into the national health and social care system, though implementation can vary locally.

Spain

In Spain, the governance of home care can differ by region due to Spain's decentralized structure. The focus here is on Andalusia, where the research was conducted. Andalusia's home care services (Servicio de Ayuda a Domicilio) are regulated by the Order of July 27, 2023, issued by the Andalusian Regional Ministry of Social Inclusion, Youth, Families, and Equality. This Order provides an updated regulatory framework for home help services in the autonomous community.

According to the Andalusian regulation, home care is defined as a preventive and supportive social service delivered primarily at the home of the person in need, through qualified and supervised personnel. It encompasses a range of actions – integrative, social, and care-oriented – aimed at individuals and families who have difficulties in autonomy or in maintaining their normal living environment. The regulation clarifies who can receive these services: any resident in Andalusia who either (a) has an approved Individual Care Programme under Spain's national Law 39/2006 of

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Dependency (which is the Spanish national law on Promotion of Personal Autonomy and Care for persons in a situation of dependency), or (b) is not formally recognized as "dependent" under that law but is assessed by local social services to lack autonomy (temporarily or permanently) for basic activities of daily living or social inclusion. In the latter case, the only requirement is that the person (or their family unit) is registered in the municipality – thus, the service can also support older persons or disabled individuals who fall outside the strict criteria of the dependency law.

The Andalusian Order sets out criteria and limits for service provision. For example, Article 8 outlines technical criteria for determining the intensity and duration of services based on the person's level of dependency, disability, and social support network. Article 11 defines the modalities of service: *personal care* (personal hygiene, mobility support, feeding, etc.) versus *household support* (cleaning, cooking, laundry, etc.). It also enumerates exclusions – tasks that home care workers are not expected to do, such as caring for other family members not in the care plan, performing health care tasks beyond basic first aid (except minor health-related tasks like treating small wounds), or any activities not included in the care plan as per the regulations. The rights and duties of users are spelled out in Chapter III of the Order (Articles 16 and 17), ensuring users have clarity on what to expect and how to cooperate.

Crucially, the Spanish framework (in Andalusia) delegates responsibility to local authorities (municipalities) for organizing and delivering home care. Articles 18-20 of the Order state that municipalities are the owners of the service and can provide it directly or contract it out to private entities. In practice, many Andalusian municipalities contract private companies (like Clece, as mentioned in the study) to supply the caregivers and manage day-to-day operations. For small municipalities (under 20,000 inhabitants), the administration of home care is often handled by the Provincial Councils, which may similarly outsource to third-party providers. This public-private partnership model is a hallmark of Spain's approach to social services. Additionally, Spain's national *Dependency Law (39/2006)* provides a co-funding mechanism from the central government for dependent persons' care, which interacts with regional programs like Andalusia's – those officially assessed as dependent have a right to services (including home care) supported by both national and regional funds. In summary, Spain's legislative framework for home care (as seen in Andalusia) is characterized by detailed regulatory definitions, a rights-based approach for eligible users, and a devolved implementation via local authorities with possible private sector collaboration.

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Greece

Greece's home care framework has been comparatively less formalized, though recent legislation has started to codify services. Traditionally, home care in Greece has largely been provided outside of a strict legal framework, often by privately hired caregivers (many of whom are migrant women living with and caring for elderly or disabled individuals). This long-standing informal sector arose due to limited public home care options in the past. However, the Greek state has implemented a program known as "Help at Home" (*Βοήθεια στο Σπίτι*), which in 2023 was given a renewed legal basis under Law 5027/2023. The Help at Home program is the primary structured home care service offered by municipalities in Greece.

Under the "Help at Home" initiative, municipal social services hire multidisciplinary teams – typically including social workers, nurses or health visitors, and home care aides – to support vulnerable individuals in the community. The beneficiaries are defined as elderly people who are not fully self-sufficient and people with disabilities or mobility impairments who meet certain social criteria. Priority is given to those who *live alone or without adequate family support*, or those with low income who cannot afford to pay for private care. The goal is to improve their quality of life and help them remain living at home for as long as possible.

Greek legislation (via the 2023 law and related ministerial decisions) outlines the scope of services in Help at Home: it typically includes personal care (help with bathing, dressing, etc.), household tasks, running errands (like shopping or paying bills), psychosocial support and companionship, and facilitating access to healthcare (arranging medical visits, etc.). The municipality is responsible for administering the program, and it is funded by a combination of national and municipal budgets, often with the support of EU social funds historically. Notably, unlike Italy or Spain, medical nursing care is not fully integrated into Greek home care services; medical needs may be partially addressed by visiting nurses from health centers, but the Help at Home staff mainly handle non-medical support. Thus, a gap exists in providing comprehensive in-home medical care, which many families fill by hiring private nurses or caregivers if they can.

In summary, Greece's home care legislative framework is evolving. While much care is still delivered informally by the private market (with migrant caregivers playing a big role), the Help at Home program provides a formal structure for basic home support through local authorities. The 2023 law has solidified this program as an ongoing service (whereas previously it operated through successive EU-funded projects). Beneficiaries are clearly targeted (elderly and disabled with greater need), and

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the inclusion of various professionals aims at a holistic approach. However, coverage and consistency can vary by municipality, and the lack of a universal entitlement like Italy's LEA means access may not be equal everywhere. Greece is thus in a phase of strengthening the legislative and funding framework for home care to meet the growing demand from an aging population.

How Home Care Services Work

While legislation provides the blueprint, the actual operation of home care services – how services are organized and delivered – differs in each country. This section describes the service delivery models and practices in Italy, Spain, and Greece.

Italy

In Italy, home care services for people with disabilities (and the elderly) are typically delivered through an **Integrated Home Care system** known as *Assistenza Domiciliare Integrata (ADI)*. The ADI model involves a coordinated network of healthcare and social service providers working together to deliver care in the patient's home. There are generally two main categories of support provided:

- **Healthcare services:** These are medical and rehabilitative interventions delivered at home. They include visits by doctors (for check-ups or specific treatments), nursing care (e.g., wound care, injections), physiotherapy and rehabilitation, administration of medications, and other specialized therapies as needed. For example, an individual with a severe physical disability might receive periodic home visits from a nurse to monitor health status and a physiotherapist for rehabilitation exercises.
- **Socio-health (social care) services:** These involve assistance with activities of daily living and instrumental activities, as well as psychosocial support. Home care aides or support workers help with personal hygiene (bathing, grooming), mobility (transferring from bed to wheelchair, accompanying outside if possible), feeding and meal preparation, housekeeping chores necessary for health (cleaning, laundry), and even providing companionship or emotional support to reduce loneliness. They may also assist family caregivers by training them or giving them respite.

The objectives of home care in Italy are twofold: to improve or maintain the recipient's quality of life and autonomy in a familiar environment, and to reduce unnecessary hospital or institutional

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care. By treating and supporting individuals at home, the system aims to prevent health deteriorations that lead to hospitalizations and to support families in caregiving roles.

Home care services in Italy are integrated into the public health system. A person in need (for instance, a person with a significant disability) is assessed by the local health authority (ASL) and, if eligible, a home care plan is drawn up. The intensity of care is stratified typically as "low", "medium", or "high" intensity ADI, depending on whether the person needs just a few hours of support per week or daily, complex care. For example, *high-intensity ADI* might involve daily nursing plus multiple weekly therapy sessions, while *low-intensity ADI* might be a couple of short visits per week for monitoring and help with bathing.

To deliver these services, local health authorities often contract social cooperatives or NGOs to supply the workforce (especially for socio-health services). The cooperatives, like those in the GMC Consortium in Abruzzo (as per the Italian report), employ the care workers and nurses who then operate under the coordination of public case managers. Care is usually free of charge for the user if it falls under the ADI/LEA provisions, though in some regions, certain social care components might require co-payment depending on income (means-tested). Importantly, the continuity of care is emphasized: the same providers strive to follow the patient over time, adjusting care as conditions change. However, one noted characteristic in Italy is that often the same care worker remains assigned to a given user for years (no rotation), which has pros (trust and familiarity) and cons (risk of burnout or over-attachment).

Coordination between healthcare and social care is a critical feature. Family doctors, social workers, and home care providers communicate to ensure that the person's medical and social needs are both met. Yet, challenges exist; for instance, the Italian report highlighted instances where necessary equipment (like wheelchairs or patient lifts) may not be provided timely by the health system, forcing care workers to improvise. Transportation between clients (especially in rural areas) is another operational aspect – some organizations provide vehicles, others rely on workers to use their own cars.

In summary, Italy's home care services work through an integrated, multi-professional approach anchored in the public health system. The model leverages partnerships with cooperative organizations to deliver day-to-day care and has a structured assessment and planning process for each user. The system's strength lies in its formal integration into healthcare, but it also faces issues of bureaucratic rigidity and resource gaps in practice (as we will see in the results).

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Spain

In Spain (Andalusia), home care services (Servicio de Ayuda a Domicilio) are a social service managed at the local level, often with a blend of public oversight and private execution. The Andalusian model works as follows:

Eligible individuals (elderly or disabled people who cannot fully manage on their own) are assessed by the municipal social services. If approved, they are allocated a certain number of hours of home help per week or month, based on their level of dependency or needs (for example, a moderate-need individual might get a few hours weekly, whereas a severe-need individual might get multiple hours daily). This becomes part of an Individual Care Plan.

Service delivery has two main facets, as defined in the regulations:

- ***Personal Care (Atención personal):*** This includes assisting the person with basic daily activities such as bathing, dressing, grooming, eating (including help with feeding if needed), mobility (moving within the home, exercises to maintain mobility), and attending to personal hygiene needs. It may also involve accompanying the person outside for walks or medical appointments, though typically within the limits set by the care plan.
- ***Domestic or Household Care (Atención a las necesidades del hogar):*** Caregivers help with household tasks that the user cannot do themselves. This covers cleaning the house, doing laundry, ironing, shopping for groceries, preparing meals, and other routine housework. It ensures the living environment remains healthy and safe.

Importantly, Spanish home help workers are not medical personnel, so they do not perform healthcare procedures (as explicitly excluded by regulations, except very basic health-related help like reminding to take medication or minor first aid). If a user requires medical home care, that is handled by the healthcare system (e.g., a visiting nurse from the local health center, separately from the home help service).

The operational structure in Andalusia often involves outsourcing. For instance, in the study, the City Council of El Ronquillo directly employed a small number of home carers for its community (public provision), whereas the City of Seville contracted a large company (Clece) to manage home care for many of its residents. In the outsourced model, a private company is responsible for recruiting and training home care workers, scheduling visits, and ensuring the service meets the

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standards, while the municipality monitors performance and pays the provider per service hour delivered. Clece, mentioned in the Spanish report, is one such provider operating at regional and even international levels.

Home care workers in Spain's system usually have a qualification as "Auxiliar de Ayuda a Domicilio" or similar (home helper certificate) and operate under the guidance of a coordinator or social worker. Supervision and training mechanisms are part of the organizational support (as noted by professionals, they have continuous training and quality protocols).

From the user's perspective, once they are in the program, they receive regular visits according to their care schedule. The relationship often becomes quite personal; as reported, strong emotional bonds are formed between users and caregivers. However, because companies may assign multiple carers or have staff turnover, a user might see different caregivers over time (and high turnover was cited as an issue affecting trust and quality).

Another feature of how services work is coordination with family members. Family involvement in Spain can be intense: families sometimes direct what tasks they want done and when, which can cause friction if their expectations exceed the service scope. The Andalusian regulation encourages that the care plan be followed as prescribed and that family cooperate rather than dictate changes unilaterally. Some professionals suggested working directly with families to educate them on the service's limits and how they can complement it.

In summary, Spain's home care service operates as a locally managed, needs-assessed home help system, heavily oriented toward personal and domestic support. It relies on a workforce that is often employed by private contractors under public supervision. Strengths of this model include clear definitions of services and a broad coverage via municipal networks; challenges include maintaining consistency and managing the expectations and involvement of users' families.

Greece

In Greece, the primary organized mechanism for home care is the "Help at Home" program run by municipalities, but a large part of home care is still provided informally. Here's how home care works in practice:

For those enrolled in Help at Home, the municipality's social service department will assign a team to the eligible individual. This team usually comprises a social worker, one or more home care

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assistants, and sometimes a nurse (if the program includes one, though often health visits are from clinics). They make home visits on a scheduled basis – for example, a home helper might visit an elderly client several times a week for an hour or two each time. The kinds of support provided include: helping the person with personal hygiene, ensuring they take medications (the helper cannot administer injections, but can remind or assist with oral medicines), doing grocery shopping or paying bills on the person's behalf, light house cleaning, and offering companionship. A social worker might visit periodically to assess any changing needs or provide counseling, and to liaise with other services (like arranging a doctor's visit or organizing a disability benefit application).

However, the intensity of service in Help at Home is limited – typically a few hours per week for each client, due to staff capacity. Greek users often express that the time allocated is not enough to cover all their needs. For example, an elderly person might need daily help, but the program might only be able to send someone twice a week, so gaps remain.

Family members play a crucial role in Greece. Many families hire a full-time live-in caregiver (commonly migrants from countries like Georgia, Philippines, or Albania) to take care of an elderly or disabled relative. These live-in carers provide round-the-clock assistance that the municipal program cannot offer. The interaction between these private arrangements and the Help at Home program can vary; sometimes the municipal worker coordinates with the live-in caregiver (e.g., the social worker advising on care), but other times they operate separately. The Greek study noted that *users require services that are more medical and intensive than what the program provides, so family or private carers fill the gap*.

Healthcare at home in Greece (like home nursing, physical therapy) is not systematically provided through Help at Home. Instead, if someone needs medical attention at home, they rely on local health center outreach (which is limited) or must visit a hospital. During crises like the COVID-19 lockdown, some Greek municipalities tried to step up by delivering medicines or arranging telehealth calls, but those were ad hoc measures.

The consistency and quality of Help at Home can vary widely. Larger municipalities (e.g., Athens or Thessaloniki) have more staff and possibly a more developed program (including vehicles for transporting staff, better equipment, etc.), whereas small towns might have only one or two workers covering many villages. As the comparative study noted, the situation increasingly varies from one municipality to another. This leads to inequalities in service availability.

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In practical terms, Greek home care workers often have to travel to multiple clients a day. They may not have much travel time allotted, similar to Italy's issue, meaning workers rush between households. With many Greek clients living in remote or hard-to-reach areas (especially on islands or mountain villages), providing consistent service is challenging.

In summary, Greece's home care service operation is a hybrid of a basic municipal service and a large informal sector. The formal Help at Home program offers essential support to those most in need (basic personal care, errands, social support) with limited hours and staff, focusing on those without family or financial means. For more comprehensive care, families often employ private caregivers. Greek users, therefore, experience home care as a patchwork: some support from the state and significant reliance on family and hired help. This system's strengths lie in its community-based approach and targeting of the most vulnerable, but it is undermined by insufficient coverage (time and scope), lack of medical integration, and variability in service quality across regions.

With this understanding of how home care is structured in each country, we now turn to the empirical findings from the focus groups and interviews, examining the situation from the perspectives of home care professionals and users.

Study Results at the Professional Level

This section presents the comparative findings from the focus group discussions with home care professionals in each country. Despite different contexts, many experiences and challenges overlap. The analysis is structured by key themes that emerged in all three countries: **(1) the effects of the COVID-19 pandemic on home care work, (2) organizational support received by home care workers, (3) barriers that challenge worker performance,** and **(4) professionals' proposals for improvement**. Each theme is discussed in a comparative manner, highlighting similarities and differences across Greece, Spain, and Italy, with direct references to the national reports.

Effects of the COVID-19 Pandemic (Professional Perspective)

Home care workers in all three countries reported that the COVID-19 pandemic (2020–2021) had a profound impact on their work, especially at the height of lockdowns and contagion fears.

Italy: Italian home care providers described the pandemic period as a time when their work "increased exponentially" in both volume and difficulty. With many services shut down, home care workers became a lifeline for their clients, taking on additional tasks that were not previously part of their duties – for example, doing grocery shopping, fetching medications, and extra

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housekeeping for their vulnerable clients who could not go out. This expansion of responsibilities led to a significantly higher emotional load and stress level. Workers felt that *"there was no turning back from Covid"* – in other words, the nature of home care had changed permanently due to the pandemic's demands. They all vividly recalled the early pandemic months when they had to continue visiting clients without adequate protective equipment, as masks and gloves were initially scarce. There was a constant fear of either catching the virus or transmitting it to high-risk clients. Some positive changes were noted: the crisis forced improvements in hygiene protocols and safety training. Italian workers mentioned that strict hygiene practices and the provision of safety gear (once available) became routine and have *"continued to be implemented"* even after the acute phase of the pandemic. These measures include wearing PPE on visits, frequent sanitization, and a general awareness of infection control that wasn't as pronounced before.

Spain: Spanish home care professionals also went through a traumatic period during COVID-19. They acknowledged that the pandemic *"traumatically affected the entire society (and of course also these professionals, who were on the front line)"*. However, by the time of the research (late 2024), Spanish participants felt that the immediate aftermath was no longer very visible in their daily work. In other words, while COVID-19 had been a major shock, two years later the home care service had largely reverted to normal routines, with the exception of some lasting changes. They observed an increased use of teleworking for administrative tasks and coordination – for instance, care coordinators or social workers might do phone assessments or follow-ups remotely more often than before. Also, there was a greater awareness of hygiene: both staff and clients are now more conscious about measures like handwashing, disinfecting surfaces, or not coming to work when feeling ill. The professionals implied that society learned to live with the virus, and home care services adapted accordingly. Importantly, Spanish workers did not emphasize a permanent increase in tasks post-pandemic as much as the Italians did; instead, they indicated that the situation had stabilized and the extra trauma had subsided by 2024, although everyone remembers the fear and mistrust that marked the relationship with users during the worst months. (Users in Spain confirmed they initially felt great fear toward allowing outsiders into their home during COVID, which caregivers had to manage.)

Greece: Greek home care professionals reported facing major challenges regarding safety during the pandemic. Given that many Greek home care clients are elderly, workers were extremely cautious. The number of home visits was often reduced to minimize contact, which put pressure on families to care for daily needs. Many municipalities attempted to maintain support through

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telephonic check-ins or delivering essentials without direct contact (contactless delivery of groceries or medications). Care workers described an environment of heightened fear – fear among workers of carrying the virus into a client's home and fear among clients of any outside contact. This sometimes led to clients refusing entry to caregivers or insisting on very short visits. On the other hand, families became more involved in care out of necessity (since workers could not visit as frequently). Greek workers had to balance protecting themselves with the duty to ensure their isolated clients were not completely abandoned. By 2024, they noted that normal services had resumed, but the pandemic period highlighted the need for better crisis preparedness (e.g., having protective supplies and protocols in place).

In all countries, the pandemic underscored the crucial role of home care workers as frontline responders in a public health emergency. They provided not only practical support but also human contact to those isolated at home. The emotional toll was significant: Italian workers spoke of sustained high stress, and Spanish workers acknowledged the pandemic was traumatic even if its visible effects had faded. A common thread is that COVID-19 led to lasting improvements in hygiene practices in home care across all three countries, and it also brought to light issues like the lack of emergency support for these workers (initially being without PPE, etc.). Each country's system had to adapt: Italy expanded task scope, Spain incorporated remote methods and public health awareness, and Greece leaned on tele-support and family involvement. These experiences informed many of the later proposals for improving support to home care workers.

Organisational Support Received

This theme explores the extent and nature of support that home care professionals receive from their employing organizations or the system at large – including training, supervision, equipment, and emotional support resources. There are notable differences in organizational backing among the three countries, but also some similarities in gaps.

Italy: Italian home care workers indicated that some support measures improved after COVID-19, but certain longstanding support deficits remain. On the positive side, safety equipment is now routinely provided by their employers (usually the cooperatives or agencies they work for). Workers said that following the pandemic, they do get all necessary personal protective equipment for visiting clients (gloves, masks, sanitizer), which helps them feel safer. This suggests a recognition by organizations of occupational health needs. However, when it comes to resources needed to physically assist clients, the public health system doesn't always deliver. They cited

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cases where they arrive to care for a person with severe mobility issues but the person's home lacks a hoist lift or a proper wheelchair due to delays in the National Health Service's provision of these devices. This lack of necessary equipment means the worker must perform strenuous lifting or improvisation, making their work *"physically demanding"* and also emotionally frustrating since without equipment they cannot fully help the user. Another practical support issue in Italy is travel reimbursement. Some cooperatives give their home care staff a car or cover mileage, but others require workers to use their personal cars and do not reimburse fuel or wear-and-tear costs. Participants from inland rural areas were especially affected: they often drive between remote villages on mountainous roads to reach patients, incurring expenses that aren't compensated. This inconsistency in financial/logistical support is "deeply felt" by workers as an unfair burden.

Regarding psychological and supervisory support, Italian workers reported mixed experiences. Generally, if they encounter a difficult situation with a patient, they can informally consult their service manager or support staff in the cooperative for advice. This indicates that an *ad hoc* support network exists internally – for example, a care worker can call their coordinator to discuss how to handle a challenging client behavior. However, there is no formal system of clinical supervision for home care workers in Italy (except for social workers). Unlike some healthcare professions that have regular supervision meetings with a psychologist or senior supervisor, home care aides and nurses in these cooperatives do not automatically get that. Any psychological support depends on whether the employer sees it as important and arranges something. As a result, supervision is "occasional" and not standardized. If an employer is proactive, they might organize a debrief session or bring in a consultant for a troubled case, but many workers go without any formal outlet to process work stress.

Spain: The Spanish home care professionals appeared to have a relatively structured support environment in the organizations studied (particularly the private company context). They mentioned the existence of continuous training programs and quality supervision protocols as part of their job. This implies that their employer(s) (like Clece) provides ongoing in-service training to keep skills up-to-date and has procedures to monitor service quality (perhaps through periodic evaluations or home visits by supervisors). They also noted there are established channels for support: for example, a telephone hotline they can call, and the possibility of face-to-face appointments to discuss issues. These could be for reporting incidents, seeking guidance, or even counseling.

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Specifically, Spanish participants highlighted that if they have mental health or emotional issues due to work, there are resources, though these are typically provided by social workers rather than psychologists. In other words, within the company or service, a social worker might double as a counselor to the staff, offering advice or a friendly ear. However, they lack dedicated psychological professionals for staff support. So while the support exists, it may not be specialized. On a day-to-day basis, Spanish carers seem to have supervisors or coordinators they can turn to (especially since in Clece's model, there were coordinators in the focus group who likely handle staff oversight). The presence of supervision protocols suggests that, unlike Italy, the Spanish system has more formal check-ins and performance monitoring, which can be a form of support if done constructively (ensuring workers aren't overwhelmed or correcting issues before they escalate).

It's worth noting that none of the Spanish professionals complained about lacking equipment or materials – likely because their tasks don't involve heavy medical equipment (they focus on personal and domestic tasks), and perhaps companies ensure basic tools (like uniforms, gloves, etc.) are provided. The main support gap they identified was the mental health support being not fully professionalized (no on-staff psychologist).

Greece: Organizational support in Greece's home care seems more limited. Greek home care workers are often municipal employees on temporary contracts, which itself is a source of stress (every so often their contract must be renewed, depending on government funding). This instability means that the employing organization (the municipality) may not invest heavily in long-term training for them, and workers feel insecure. The Greek participants noted a lack of psychological support as well. There are generally no counseling or supervision services for Help at Home staff; they are expected to manage the emotional toll on their own. Training opportunities are also not mentioned, implying they might be sporadic or minimal.

One challenge is that Greek home care programs differ by municipality – some might offer a bit more (maybe local seminars or a supportive social services director), while others offer almost nothing beyond the work tasks. The comparative findings note that the situation *"varies from a municipality to another"*. So organizational support is inconsistent: a few municipalities could have good practices (like supportive management, regular team meetings), whereas others leave workers entirely to their own devices. Across the board, however, workers mention work overload and insufficient time per client as issues, which is indirectly an organizational support issue – indicating

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not enough staff are hired to cover the needs, and scheduling doesn't allow breathing room. There's no indication that Greek workers have access to things like hotlines or formal debriefings.

On the practical side, Greek municipalities do provide some equipment, like workers usually have home care kits (gloves, antiseptics – especially post-COVID likely improved) and sometimes municipal vehicles for traveling to villages. But these are dependent on local budgets; many workers likely use their own cars or public transport to reach clients and may not be reimbursed either (though this wasn't explicitly stated in the provided info, it can be inferred as a possibility given Italy's similar issue).

In summary, organizational support is uneven across the three countries. Spanish home care workers seem to have the most structured support environment (with training, oversight, and some channels for help), reflecting perhaps a more corporate approach in the private provider context. Italian workers have some support (especially regarding safety equipment post-Covid) but suffer from systemic gaps like lack of formal supervision and inconsistent logistical support. Greek workers, often in a public program with limited resources, have the least formal support – facing job instability, high workloads, and no formal psychological support system. All three groups would welcome stronger backing: better training, reliable resources, and emotional support, which they highlighted in their improvement proposals.

Barriers that Challenge Worker Performance

Home care professionals identified numerous challenges and stressors that hinder their ability to perform their jobs effectively. These **barriers** range from structural issues (like regulations and workload) to interpersonal difficulties (like dealing with families or emotional strain). Below, we compare the barriers reported in each country:

- **Italy:** Italian home care workers pointed to several critical barriers:

The foremost issue was a new municipal regulation on home care services, described as overly rigid and focused narrowly on cost efficiency. This policy change seems to have reduced flexibility in how care can be delivered – for example, it likely prescribes strict time allotments and tasks for each client in the name of standardization and budget control. Workers felt that this rigidity does not account for the reality that *"their working days are never the same"* and are full of unexpected situations when caring for people in their homes. The inability to deviate from the schedule to handle an urgent need or spend a bit more time with a client in crisis caused them anxiety and

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frustration, as it “prevents them from doing their work effectively”. In essence, bureaucratic inflexibility is a barrier to responsive, human-centered care.

High workload and time pressure have become pronounced, especially since the COVID era. Workers noted that the number of users each caregiver visits per day increased, but the hours per user did not increase. Now they often have to hurry from one client to the next in a single morning. Compounding this, each user can have very different needs (one might be physically disabled requiring lifting, another might have dementia requiring supervision, etc.), yet *caseloads are not assigned with a specific matching of skills*. A worker might see a complex mix of cases in one day, making it “impossible to meet all the users’ needs” adequately. The sheer volume and diversity of tasks lead to fatigue and a feeling of doing an incomplete job.

Family surveillance and lack of trust: Italian carers mentioned that in many cases, family members install cameras in the house to monitor the caregiver’s activities. This constant surveillance creates a sense of pressure and indicates that some families do not trust the professional. Workers feel anxiety and frustration under this kind of scrutiny, which can undermine their confidence and comfort in performing tasks. While cameras might be intended for the safety of an elderly person, their use signals a challenging relationship dynamic, potentially making the caregiver feel suspected or micromanaged.

Emotional over-involvement: Because Italy’s system often has the same caregiver with a client for years with no rotation, very deep personal bonds form. The caregivers become almost like “extended family” to the user. While a good relationship is generally positive, the workers acknowledged it can “invade the private and temporal sphere” of their lives. They find it nearly impossible to maintain professional distance; some tried the strategy of keeping a distance but “it is almost impossible to maintain over time”. This emotional entanglement can lead to burnout – for instance, the caregiver might worry about the client even off-duty, or feel guilt when taking time off. It also complicates end-of-life situations (losing a client becomes a personal loss). The *all-inclusive* nature of the work (no shift rotation, always being the primary carer) is thus a barrier to emotional well-being.

The Italian report summarized these issues: **excessive workload, inflexible care plans, inadequate travel time between clients, heterogeneity of patient needs requiring varied skills, and risk of excessive emotional involvement**. Together, these factors significantly impact performance and

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well-being, leading to burnout ("burn-out" explicitly cited as a result of the rigid new regulation and cumulative stress).

- **Spain:** Spanish home care professionals also face heavy workloads and other stressors, with a slightly different emphasis:

Work overload and unmet needs: They reported that it is physically impossible to meet all the needs of users within the time and task limits they have. This is aggravated by factors such as the *complex conditions of users, the level of family support or lack thereof,* and their own experience level. For example, if a user needs assistance with many tasks and the family expects additional help, the caregiver cannot accomplish everything in the allotted time. This leads to a constant feeling of underachievement and pressure.

Confrontations with family members: A major source of stress in Spain is conflict with users' relatives. Family members frequently criticize the service, complaining that the caregiver didn't complete all desired tasks or that the care is insufficient. The professionals attribute this to a *"lack of knowledge of the service in a comprehensive way"* by the family. Many families do not understand that the home help service has predefined tasks and schedules (as per the care plan) and that not everything they might want is included. Instead of recognizing the limits of the program, some relatives accuse the caregivers of laziness or incompetence (e.g., "lack of professionalism"). Additionally, an issue was raised that often *relatives, not the disabled person, hold decision-making power* about the care. This disempowerment of the actual user can lead to tension, especially if the caregiver tries to prioritize the user's preferences but the family overrides them. The Spanish professionals see this as contrary to the goals of fostering autonomy and it causes them moral distress.

Issues with colleagues and substitutions: Another unique point raised in Spain is misunderstandings arising when colleagues substitute for one another. If a regular caregiver is off and a substitute comes, that substitute might sometimes do extra tasks (perhaps out of kindness or to go above and beyond). However, doing more than what is "strictly established in a legal manner" can set a precedent. When the regular caregiver returns, the family might expect that extra work to continue, leading to complaints when it doesn't. Thus, inconsistent performance among staff – especially if some bend the rules – creates conflict and undermines the team's collective standing with the client.

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Coordination with other professionals in the home: Spanish workers also mentioned friction with other professionals who visit the home, for example, a nurse from the health system or a physiotherapist coming separately. Sometimes roles may overlap or clash (for instance, if a nurse tells the family something that contradicts what the home care aide says about care tasks). Also, the presence of multiple caregivers can cause confusion for the user about who is responsible for what. The Spanish report noted that conflicts can arise in these multi-provider situations due to "lack of knowledge about the rights and duties involved in the service" – possibly meaning the user/family not understanding each provider's scope.

Emotional strain from client loss: Like Italy, Spanish carers develop bonds with long-term users. They cited the death of users as a particularly hard-hitting event. Over years of care, they inevitably become attached, and when a user dies, it leaves an emotional impact similar to losing a friend or family member. Unlike some health professionals who might receive training on grief or have coping strategies, home care workers don't receive formal preparation for this. They mentioned that they *learn coping mechanisms from personal experience* but that's after going through such losses multiple times. Supervisors in their organizations seem aware of the toll and sometimes allow "rest days" after a client's death to help workers recover emotionally. Nonetheless, the lack of systematic support for bereavement is a gap.

In summary, Spain's barriers center on **overwhelming workload** and **conflictual interactions with others (families, colleagues, other pros)**, plus the inherent emotional toll of the job. The theme of *depersonalization of users* (families making decisions over the user's head) is a barrier to providing person-centered care and causes ethical stress for workers.

- **Greece:** Greek professionals indicated barriers that somewhat mirror those in Italy and Spain, albeit with a Greek context:

Work overload and insufficient time: Greek home care workers are assigned many clients with very limited time for each, leading to a sense that they cannot give proper care. They specifically lament *"not enough time with each beneficiary"*. This is similar to both Italy and Spain's workload issues. An additional factor is that some clients may need services beyond what the Help at Home program offers (like medical help), so workers feel unable to meet those needs, which is frustrating.

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Job instability: A distinctive barrier in Greece is the precarious nature of employment (many on contracts that need renewal every year or two). This creates stress and possibly affects performance – worrying about one's job continuation is a distraction and may lower morale. It also leads to staff turnover, which breaks continuity of care (something users noticed, as high turnover was an issue in Spain as well).

Variability and lack of standards: Since each municipality runs its program somewhat differently, workers in some areas might face understaffing or lack of support more acutely than others. This uneven landscape is a barrier at the systemic level – there isn't a consistent standard of resources or practices across the country. For example, one town might give a caregiver 10 clients to see in a week, another town might give 20 clients in the same time with no extra pay, etc.

Emotional toll and lack of support: Though not as elaborated as in the other reports, we can infer Greek workers also experience emotional attachment to clients (given they too form personal relations as noted in user perspective) and suffer stress from seeing unmet needs (like knowing a client needs a nurse but one is not available in the program, leaving the family to cope).

Family expectations: Greek users tend to blame the municipality rather than the worker for lack of time, which might reduce direct conflict with workers, but it still places the worker in an awkward position of being the face of an under-resourced service. They have to explain to clients why they can't stay longer or why certain needs can't be met, which is a difficult part of the job.

In all, **common barriers across countries** include **high workload with insufficient time per client**, leading to stress and a feeling of not delivering quality care. **Emotional stressors** (either from bonding too much or losing clients) are acknowledged in Italy and Spain and likely present in Greece. Another common issue is **lack of flexibility**: whether due to rigid regulations (Italy) or rigid care plans and schedules (all countries) that don't adapt to real-life needs. **Relationship with families** emerges strongly in Spain and Italy – Italy highlighted surveillance and trust issues, Spain highlighted conflict and misunderstandings. In Greece, family appears more as filling gaps rather than clashing with workers, but managing expectations is still a barrier since workers cannot provide more than the program allows.

These barriers directly inform why workers in all contexts voiced certain proposals for change, aiming to remove or alleviate these obstacles to improve both their performance and job satisfaction.

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Proposals for Improvement (Professional Suggestions)

During the focus groups, home care professionals in each country were not only critical of the challenges but also constructive in suggesting improvements and solutions. There was a notable optimism and dedication among workers – they strongly believe in the value of their service and want to make it better. Many of the proposals are shared across countries, though some address country-specific issues. Below is a summary of the main proposals from the perspective of professionals:

- **Italy (Workers' Proposals):** The Italian focus group put forward a comprehensive list of improvements:

Improve the National Home Care Contract (NCHC): They urge reforms that would raise wages for home care workers and provide more job stability (e.g., more permanent positions rather than short-term contracts). Better pay would reflect their increased responsibilities (especially post-pandemic) and stability would reduce stress and turnover.

Increase public investment in home care: With more funding from authorities, they envision:

- *More staffing and hours:* being able to allocate more hours of care per client according to each person's needs, instead of the current minimal hours. This would ensure no client is underserved and possibly reduce each worker's caseload.
- *Expanded workforce:* hiring more well-trained home care professionals, which would help eliminate waiting lists for services and distribute the workload more evenly. Essentially, addressing the manpower shortage to match demand.
- *Adequate tools and equipment:** ensuring they have "all the tools" needed so they aren't doing backbreaking work – e.g., lifts, wheelchairs, assistive devices should be readily available. They also suggest compensation for work-related expenses like a fuel allowance or meal vouchers, especially for those traveling long distances in rural zones. This would acknowledge and offset the personal costs workers currently bear.

Introduce more flexibility and autonomy in work schedules: They want the rigid regulations to be loosened, allowing them to organize their working day more autonomously to avoid constant time pressure. For example, if a client needs an extra 15 minutes one day, they could adjust their schedule without penalty. They propose that care plans and schedules be organized in a participatory way – likely involving the workers in planning – to ensure they are realistic and truly

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meet user needs. This would reduce anxiety and let workers use their professional judgment to be more effective.

Implement a job rotation system: To address the "all-inclusive" continuous assignment problem, Italian workers suggest rotating assignments among professionals after some period. This would prevent one worker from being indefinitely tied to the same client, thereby reducing emotional strain and providing variety that can prevent burnout. Rotation also means multiple staff become familiar with each client, which can provide backup and continuity if someone is on leave.

Restore and expand vocational training: All participants noted that prior to Covid, employers provided regular vocational training, which stopped during the pandemic (except mandatory safety training) and was never fully reinstated. The majority view is that ongoing training is *essential*, especially training focused on different types of disabilities and new care techniques, given the diverse and evolving needs of their patients. They argue that continuous learning would improve the quality of care and equip them to handle cases (for instance, a caregiver who mostly knew physical disability support might learn about autism or psychiatric conditions, which a few clients have). A minority felt daily experience is enough training, but most see value in formal education sessions.

Establish mandatory group supervision and peer support: Italian workers believe that although their work is mostly solitary (one worker per client), having regular group meetings for supervision would be extremely beneficial. In such sessions (perhaps led by a psychologist or experienced supervisor), they could share difficulties, get advice, and emotionally support each other. This kind of peer exchange would help in "overcoming difficulties and stress factors" together. It formalizes the support that currently happens only informally (if at all), making sure everyone has a chance to debrief and learn from colleagues' experiences.

- **Spain (Workers' Proposals):** Spanish professionals also had several proposals, with an emphasis on tailoring services and involving families:

Differentiate services based on user needs: They suggest establishing greater differentiation among end users not only by degree of dependency but also by *type of disability and specific needs*. The idea is to assign caregivers in a more specialized way. For example, some workers might handle cases of physical disability requiring mobility assistance, while others handle cognitive impairment cases, etc., matching their training or strengths to those user groups. This

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specialization could improve care quality because the caregiver's skill set would better align with the client's needs.

Increase allotted care hours: Similar to Italy, Spanish workers call for more hours to be allocated per user so they can perform all needed functions and provide a truly comprehensive service. Right now, limited hours mean only essential tasks get done; with more time, caregivers could attend to additional needs (maybe some social interaction, exercise, or thorough household help) that currently are cut due to time.

Improve family involvement and education: A significant proposal in Spain is to work directly with families of users. This has multiple aspects:

Information and awareness: Educate families about their rights and obligations when accessing home care – essentially clarifying what the service covers and what it doesn't, to set realistic expectations.

Training families in caregiving skills and knowledge: Equip family members with some basic skills to complement the professional's work (for times when no caregiver is present) and to "make up for the system's shortcomings". For instance, training a family caregiver on safe transfer techniques, or how to engage a person with dementia in activities, so that the home care worker's efforts are reinforced rather than undermined.

Education on disability rights: Ensure families understand and respect the rights of people with disabilities, particularly the right to autonomy and decision-making. The professionals see some families acting in an overprotective or even authoritarian way (as noted, scheduling without regard to the person's wishes). Training and dialogues could encourage families to give the person more agency and to collaborate with, rather than command, the care process. In fact, some workers in the Spanish group strongly criticized overprotection by families as *"a form of violence"* against the person's dignity. By raising awareness, they hope to shift attitudes.

Address negative family attitudes: Following from the above, Spanish participants suggested that part of the awareness campaign should confront harmful mindsets. For example, when families impose their convenience over the user's, or when they depersonalize the user's needs, these should be called out and changed. The mention in the report that some called it *"violence"* and noted it can cause serious issues like depersonalization underscores the need for cultural change in how families and society view the autonomy of people with disabilities.

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Guidance for substitute caregivers and colleagues: They noted that other caregivers (like live-in caregivers or rotating staff) should be included in the information loop so that they don't inadvertently encourage unrealistic expectations by doing things outside the care plan. So one proposal is to ensure all caregivers (even those not directly in the municipal program, like private hire "live-ins") are aware of the program's limits and standard practices to maintain consistency. Possibly through professional standards or communication, so that when a substitute comes, they stick to the agreed tasks.

Increase workforce and reduce travel strain (coordination): While the Spanish professionals didn't explicitly list this in the "professional" section, the issue of coordination came up in the context of user suggestions which professionals would likely agree with. That is, improving route planning and staffing so that caregivers aren't crisscrossing large distances. A proposal would be to assign workers to clients in the same neighborhood or locality where possible (especially in cities or spread-out rural areas) to reduce travel time and stress. This also implies hiring more staff to cover all regions adequately. Additionally, Spanish stakeholders implicitly endorse increasing funding (like via budget increases mentioned by users) to make all these improvements feasible.

Continued professional development: It was noted that Spanish workers showed "great interest" in further training. So, another proposal is to offer them more opportunities for professional growth – whether formal courses, workshops on specific disabilities, or sharing best practices among municipalities.

- **Greece (Workers' Proposals):** Greek professionals' suggestions can be inferred from the comparative analysis and align with many of the above, focused on resource and stability improvements:

Increase salaries and job security: Greek home care workers would like to see higher wages (their salaries are relatively low in the public sector for such work) and, critically, a move to permanent positions or at least longer-term contracts to end the cycle of uncertainty. Job stability would not only reward their dedication but also ensure continuity of care for clients (reducing turnover).

Expand the workforce and hours: They likely advocate for hiring more staff so that each worker's load is manageable and each client can receive more frequent or longer visits. This ties with increasing the funded hours of service – essentially an injection of funding into the Help at Home program to widen its scope.

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Provide necessary tools and transportation support: While not explicitly mentioned in Greek text, by analogy with Italy, Greek workers in rural areas would benefit from travel reimbursement or municipal vehicles. Ensuring they have supplies (like protective gear, first aid kits, etc.) is expected.

Introduce flexibility and better scheduling: If any rigid local rules exist, they would want more say in organizing their daily rounds to account for real-time needs. Also, implementing some form of rotation or time-off system could help (Greek programs might already rotate staff across cases, but since staff are few, one worker often covers many clients anyway).

Training and specializations: Greek staff, many of whom might not have advanced medical training, would benefit from additional training, especially as the needs of their clients become more medical (e.g., basic nursing skills, dementia care techniques). They might propose partnerships with health services so that some medical support is integrated into home care (since they noted many needed services are medical and not covered).

Psychological support and supervision: Given the lack of it, Greek workers would likely call for establishing regular meetings or support sessions, similar to the Italian proposal. They might also want the presence of a social worker or psychologist dedicated to staff support in addition to client support.

Standardize services across municipalities: While not a worker proposal per se, a recommendation could be to unify the program standards so that no matter which town a caregiver works in, they have similar resources and working conditions. This would require central guidance and equitable funding distribution.

Family expectation management: Greek workers observed that users blame the municipality for shortcomings, which suggests they too would appreciate if the authorities communicated clearly to users what the program can and cannot do. Essentially, an honest dialogue with the public so that the strain isn't put on the worker to explain limitations constantly.

Overall, **across all countries**, professionals' proposals converge on improving working conditions, resources, and training. They want better pay and stability (making home care a more sustainable career), more manpower and time to adequately care for clients, the right tools for the job (from medical devices to vehicles), and support systems like training and supervision to enhance their skills and cope with stress. Additionally, they emphasize systemic changes: flexible policies that trust their professional judgement and educating stakeholders (families, other caregivers) to create a

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more cooperative environment for care. These suggestions by the workers themselves lay the groundwork for the recommendations we will discuss later in the report.

Study Results at the User Level

This section presents the perspectives of home care service users – primarily people with disabilities or dependent older adults – in Greece, Spain, and Italy, based on the individual interviews conducted. The findings are structured around key themes similar to those at the professional level: **(1) the effects of the COVID-19 pandemic on users, (2) the relationship with home care workers and its impact on user well-being, (3) perceptions of workload and support from the user's viewpoint,** and **(4) areas for improvement as suggested by users**. Comparing user experiences across the three countries reveals a great appreciation for home care services, as well as candid observations on how services could better meet their needs.

Effects of the COVID-19 Pandemic (User Perspective)

Home care users in all countries experienced significant challenges during the pandemic, though their emphasis is on the social and care gaps they faced:

Italy (Users): All five Italian interviewees with disabilities reported that COVID-19 affected them severely, primarily through increased isolation. During lockdowns, many were unable to have in-person contact with their home care workers, either because services were paused or limited for safety. They had to rely on telephone check-ins instead of face-to-face support. This abrupt loss of regular visits left them feeling *"isolated and disoriented"* at times. Two of the interviewees, who had physical disabilities, mentioned they did not use any home services during the pandemic. This could be due to service suspension or personal choice to avoid exposure; regardless, it meant they went without assistance they normally depended on. The result was a period where their needs might not have been fully met (possibly family had to step in more, or some needs went unmet). The Italian users' accounts highlight the emotional toll: not only was daily living harder without help, but the lack of human contact from their caregivers, who they often see as friends or confidants, was deeply felt.

Spain (Users): Spanish users also described the pandemic as a time of "great fear and mistrust" between them and the caregivers. Initially, they were afraid to let caregivers into their homes due to risk of infection, and caregivers were also cautious. However, Spanish users understood this was not one-sided – "both parties were in a situation of great vulnerability". This mutual

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awareness means users didn't blame the workers; instead, both users and caregivers sympathized with each other's fears. Over time, as necessary visits continued (with precautions), users likely adjusted, but the psychological impact remained: fear of catching COVID, especially since many users have health conditions that would make COVID severe, and perhaps anxiety whenever a caregiver who visits multiple homes came. The Spanish context also hints that some services might have shifted to tele-assistance; however, Spanish users did not report complete loss of service the way Italians did, possibly because formal support may have continued in some capacity or resumed earlier with protocols.

Greece (Users): Greek users experienced less frequent support and had to rely more on family. They likely felt anxious about the virus because if the few visits they get stopped, they might have no outside support at all. Moreover, in Greece, some users may not have had any visits for a while, pushing more responsibilities to family or leaving some needs unmet. The Greek situation also involved more family involvement during the pandemic, meaning users had to adjust to perhaps having only relatives (if any) taking care of them without the usual help, or going without certain help.

Across all three countries, home care users experienced a diminished sense of security and increased loneliness during the pandemic when their routine care was disrupted. The emotional impact – fear, anxiety, isolation – was significant. One positive note: Spanish users recognized the shared humanity in the crisis (seeing caregivers also vulnerable), which may have strengthened empathy on both sides. Italian and likely Greek users, after the height of the pandemic, were eager to see their caregivers return, underscoring how essential that service is not just for practical help but also for companionship and stability in their lives.

Relationship with Home Care Workers and Impact on Well-Being

Users in all countries generally spoke very positively about their relationship with their home care providers, highlighting it as a cornerstone of their well-being. They also pointed out a few issues such relationships can entail, especially when things don't go well.

Italy: The Italian users unanimously expressed a positive opinion of their home care workers and their experiences with the service. They recognized that caregivers play an *"important role in their daily life"* and appreciated the workers' ability to listen and be empathetic. Italian users identified understanding and meeting patient needs, and offering emotional support as the main skills of a good home care worker. They felt their caregivers do have these skills – being kind, attentive, and

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supportive. All interviewees noted that their caregivers have consistently positive attitudes towards them and contribute greatly to their health and well-being. This indicates strong satisfaction and a personal bond that is beneficial. They feel comfortable confiding in their caregivers, "free to talk…even sharing problems and critical issues" in their lives. This level of trust means the caregiver is not just doing tasks but is a social support, potentially noticing early signs of issues and providing comfort.

Only one Italian user mentioned a negative experience: a person with a psychiatric condition said he *"did not feel understood"* by a previous caregiver who lacked specific training in mental health, and he requested a change of personnel. After getting a caregiver more suited or simply one with whom he had a better rapport, his experience improved. This case underlines that while generally relationships are good, matching caregiver skills to user needs (especially for mental health or specialized needs) can be crucial. It also shows the system's flexibility in Italy to change a caregiver if the match isn't working, which is a positive for user autonomy and satisfaction.

Spain: Spanish users also reported very good relationships with their caregivers, often forming strong emotional bonds. Many Spanish users see their caregivers like *"part of their family"*. This familial feeling illustrates deep trust and affection – a Spanish user might chat with their caregiver about personal matters, celebrate small occasions together, etc. They specifically highlighted the unanimously positive relationships and the empathy they often receive. Such bonds greatly improve their quality of life; having someone dependable who cares for them beyond just chores helps emotionally.

Users noted that caregivers' presence and friendliness contributes to their emotional support system. In fact, some users empathize with their caregivers in return: they see when caregivers are stressed due to systemic issues (like too much work) and they blame "the system" rather than the caregiver for that stress. This indicates a mutual caring relationship – users worry about worker well-being too, and don't fault them personally when, say, a visit is rushed or late, because they realize the worker is doing their best under constraints.

However, Spanish users did raise a couple of concerns in relationships:

- A few mentioned **overprotective attitudes** by some professionals that *"have a very negative effect on their self-esteem"*. This relates to caregivers (or possibly family caregivers too) sometimes doing things for the user that the user could do themselves, or

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not giving them enough space to try tasks. While meant kindly, it can make users feel infantilized. Some Spanish users said the best emotional support is **respect for their will and ending overprotection**. They desire caregivers who encourage independence, not ones who take over unnecessarily.

- **Crossing personal boundaries:** A very negative aspect noted was when certain personal limits are not respected by caregivers. Examples given include **confidentiality breaches** (a caregiver gossiping about a user's private matters, perhaps) or **punctuality issues** (arriving late or not at all without notice). These were sometimes linked to the **high turnover** among professionals – new or temporary caregivers who don't know the user well might inadvertently violate preferences or not maintain the same trust level. Consistency in staff helps build understanding of boundaries; high turnover disrupts that. Though these issues were not the norm, they were pointed out as significant when they occur.
- **Autonomy and respect:** Spanish users want their autonomy respected. They gave feedback that caregivers should wait and allow them the necessary time to do things independently, rather than impatiently doing it for them. It's a subtle aspect of relationship: a kind but rushed caregiver might think they're helping by completing a task quickly, but the user might feel disempowered. Training caregivers to strike the right balance between helping and enabling independence is something users advocated for.

Greece: Greek users, as summarized in the comparative findings, also generally have **personal, close relationships** with their caregivers. In fact, given many caregivers in Greece might be long-term figures in their lives (or even live-in for those who hire privately), the bonds can be strong. Greek users did criticize the lack of adequate time they get with their caregivers but interestingly tend to blame the municipality (the system), not the caregivers, for this shortcoming. This indicates that Greek users value their caregivers and don't fault them for systemic issues like short visits. It implies a trust that "my caregiver would do more if she could, but the program only allows so much."

The Greek report also suggests that users *require services that are more medical in nature which cannot be covered through the program*. This is not a direct comment on the relationship with the caregiver, but it does reflect on it: users may appreciate their caregiver but still feel some needs unmet because the caregiver isn't trained or authorized to provide certain help (e.g., injections or physiotherapy). If anything, this limitation might frustrate both parties: the user knows the caregiver

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can't do more and doesn't blame them, but feels the absence of those services. Users likely express to their caregivers or social workers that they wish a nurse or doctor could come, etc.

Because Greek caregivers often become like family (especially live-in migrant caregivers who literally reside with the user), the relationship can be very personal, with all the positives (companionship, trust) and potential negatives (losing professional boundaries, dependency). However, given the data, Greek users did not highlight negatives in the relationship itself; their focus was lack of time and lack of broader service coverage, again pointing blame at the structure rather than the individuals.

In summary, users in all countries highly value their home care workers, often describing them in terms akin to friendship or family, which significantly benefits their emotional well-being. These caregivers provide psychosocial support beyond just physical assistance. Trust and empathy are recurrent themes – users feel listened to and cared for. On the flip side, when issues arise in the relationship (be it a mismatch of personality or skill, overstepping boundaries, or not respecting the user's autonomy), it has a tangible negative impact on the user's satisfaction and well-being. Consistency and training appear key to nurturing positive relationships: consistency to build trust, and training to ensure caregivers know how to handle different needs and uphold respect for the person's independence and privacy. Users' feedback on relationships effectively calls for person-centered care – they flourish when caregivers are attuned to them as individuals, and any deviation from that (like treating them as incapable or violating trust) is harmful.

Workload and Support (User Perspective)

This theme examines how users perceive the workload of their caregivers and the support (or lack thereof) in the care they receive. Interestingly, users often comment on what they observe about their caregivers' working conditions, as well as how those conditions affect the care they get.

Italy: Italian users observed that their home care operators often appear tired and overstretched. They described their caregivers as always kind and willing to help, but "they often appear tired" which the users attribute to a "rigid work schedule" and having to attend to too many people in a day. Users are aware that each worker has a tight timeline and maybe multiple clients to visit, which sometimes causes the worker to be in a rush or fatigued by the time they arrive.

Italian users also humbly noted that *"they themselves are all demanding patients"* with many different needs. This shows users understand that caring for them is not easy, especially when each

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of them has unique requirements – one might need physical assistance, another needs conversation and psychological support, another perhaps complex medical routines. Because of this diversity, they see that the workload on each worker is very heavy and the allocated hours per user are too few. They gave concrete insight: workers "run out of time with the anxiety of having to do many things in a short time". So from the user side, they feel the pinch of short visit lengths – perhaps some tasks remain incomplete or are done in a hurried manner – and they empathize with the worker's stress.

Additionally, Italian users commented on how care plans are structured: they said care support plans are designed in a fixed way that doesn't account for "human variability". By this, they mean the schedules are too strict – e.g., exactly X minutes for a task – which doesn't reflect real life where some days a person might take longer or have a different need. They feel that home care workers can't develop their own strategies to manage individual behaviors and needs because of this rigidity. This makes the worker's job harder and, by extension, sometimes leaves the user's actual needs not fully met because the worker has to stick to a predefined routine. Essentially, Italian users are calling out the same inflexibility that workers did, noting that it is detrimental to care.

In terms of support, Italian users are primarily concerned with the support given to their caregivers. They suggest that a better home care system must be built by meeting workers' needs (this will be elaborated in areas for improvement). From their perspective, if workers were better supported (more time, training, emotional support), then users would receive better care. They indirectly say that currently, the lack of support for workers (too little time, lack of specialized skills in some cases) means the service they get, while appreciated, is not as good as it could be.

Spain: Spanish users echoed some of these points. They highly value the dedication of their caregivers, but they also see that sometimes caregivers are stressed or exhausted, which can affect the service. In Spain, users explicitly mentioned that when caregivers are stressed, they empathize and feel the system is to blame. So they notice the heavy workload and likely short staffing as well.

Spanish users also indirectly commented on workload through their improvement suggestions: they mention the need for increased workforce, longer service times, and less turnover. This implies they see current workloads leading to quick burnout (hence turnover) and insufficient time per user. One user said coordination should be improved so professionals do not have to make long journeys, as "this has been mentioned as a cause of stress and exhaustion by professionals". This is interesting

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because it's the user report repeating what professionals perceive: it shows a close understanding; perhaps these users, being part of an advocacy group (COCEMFE), are quite informed of worker issues. In any case, Spanish users know that if a caregiver has to travel across town, by the time they arrive they're tired or time is lost, which effectively shortchanges the user's visit length or quality.

Spanish users also talked about emotional support within the service: some feel a close emotional bond with caregivers (which is supportive to them), while a few said they do not receive emotional support or that respect for their autonomy is the best support rather than any paternalism. This relates to workload in that an overworked caregiver might default to doing tasks for efficiency's sake, inadvertently undermining user autonomy – a rushed schedule could cause that. So one could interpret that improving workload (more time per client) might help caregivers be more patient and allow users to do things at their own pace, which users want for dignity reasons.

Regarding support, Spanish users rely on both the formal service and often family or personal assistants. The interviewees from COCEMFE might have had experience advocating for more systematic support, like budgeting increases and policy changes. They explicitly urge for a budget increase to expand service scope and quality, reflecting that they see the current support as insufficient to meet all needs – some needs fall through the cracks of what home care currently provides (for example, maybe more specialized care or simply more hours for leisure support).

Greece: Greek users are in a situation where they often do not get enough hours of service, so they are very cognizant of what is lacking. They criticize the lack of adequate time from caregivers but, as mentioned, put the blame on municipal authorities. They likely feel that the caregivers do what they can in the short visits, but it's not enough. They probably also experience gaps where certain tasks aren't done due to time constraints, or perhaps the caregiver can't come every day, meaning the user has to manage or rely on family on off-days.

The Greek note says they *require services which are more medical and could not be covered through this program*. This means from the user's perspective, the support they receive is incomplete – for example, maybe they need a nurse to change a catheter or do physical therapy exercises, but Help at Home staff can't do that, so the user's health might suffer or they have to travel to a clinic (which is difficult for them). So, Greek users feel the support system has a scope limitation problem, not just a quantity problem. This is a different nuance: beyond wanting more hours (quantity), they want a broader range of services (quality/scope) to truly support them.

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They also likely rely heavily on family or private caregivers to fill these gaps. Users might feel they are a burden on family when the state service doesn't cover enough, which is another aspect of "support" – if the formal support is lacking, it indirectly pressures their informal support networks. In that way, the workload issue boomerangs: not enough formal care hours mean family members have higher workload caring for them, which can strain family relations or the user's emotional well-being.

In essence, **users in all three countries are acutely aware of the constraints their caregivers operate under**, and this in turn affects the support they themselves receive. Italian and Greek users explicitly note the too-short durations of visits and its impact. Spanish users call for more resources, indicating current support is not fully meeting their needs. A common observation by users is empathy toward their caregivers' workload – they do not blame the caregivers for being stretched thin; instead, they advocate for systemic improvements (more staff, more hours, better organization) so that caregivers can perform to the best of their ability and users can get comprehensive support. They also pinpoint that caregivers lacking certain specialized skills or flexibility can hamper support: e.g., an untrained caregiver not understanding a psychiatric condition (Italian example), or a rigid schedule preventing personalized approaches (Italian users on care plans), or high turnover preventing consistency (Spanish users on turnover issues). Users thus indirectly call for better training and consistency as part of support improvements.

Areas for Improvement (User Perspective)

Just as professionals gave suggestions, users in each country highlighted improvements that would enhance their well-being and satisfaction with home care. Notably, many of the users' suggestions align with what professionals themselves want, centering on enabling caregivers to do a better job.

Italy (Users' Suggestions): Italian users believe that improving the home care system requires supporting the workers better. They explicitly state that a "better home care system must be built trying to meet workers' needs". The rationale is that if caregivers are well-supported, they will in turn provide higher quality care. Specific improvements they call for include:

More guaranteed hours for each patient: Users want longer visit times or more frequent visits, as needed, so that their needs are fully addressed without the worker rushing. For example, if a user needs help with both personal care and some household tasks, currently maybe only one can be done thoroughly; more time would ensure comprehensive help.

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Specialist training and education for caregivers: They suggest that caregivers should have training on different kinds of disability to provide individualized service. Users realize that their caregivers sometimes don't know the specifics of their condition (as one user with psychiatric issues experienced). If workers were trained in, say, mental health support, visual impairment assistance, or autism, depending on the user, they could tailor their approach better. This would make users feel more understood and properly helped.

Emotional support (supervision) for caregivers: Italian users recommend that workers receive emotional support to face users' problems – essentially, some form of supervision or counseling for staff. They likely have sensed that caregivers sometimes struggle with stress or complex cases and that if the caregiver had someone to consult or had less stress, they'd be more effective. Also, a well-supported caregiver is less likely to burn out and leave, ensuring continuity for the user.

Italian users commented that currently, some caregivers lack certain skills or knowledge to manage all disability types and are hampered by time pressure and lack of tools. They observe that these deficits cause job stress in the worker which then leads to fatigue and slower responses – in other words, if the caregiver is stressed or improvising due to lack of training or equipment, the care they give might be less effective or attentive. So users are basically advocating for equipping caregivers with knowledge and tools.

They note that workload demands and psychosocial interactions (dealing with them and their families) can affect the worker's health and quality of care. This is a perceptive insight: they see the link between worker well-being and the quality of the service they themselves receive.

In sum, Italian users' improvements focus on **investing in the workforce** (time, training, support) as the key to improving their own experience. This is somewhat unique and very altruistic: they are thinking about what their caregivers need to help them better, rather than just listing what they personally want. It highlights a partnership mentality.

- **Spain (Users' Suggestions):** Spanish users provided a clear list of improvements, many of which align with the professionals' proposals:

Greater training for professionals in specific disabilities: They want carers to be knowledgeable about their particular disability. For example, a user with multiple sclerosis would like their carer to understand that condition's symptoms; a user with a visual impairment would like a carer who knows how to guide the blind, etc. They even suggest categorizing professionals by specific

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knowledge and assigning them to users accordingly, which mirrors the professionals' suggestion for specialization.

Increase funding to expand service quality and quantity: Spanish users urge an **increase in the budget** for home care, which would allow:

- *Broader scope (extension) of services:* perhaps inclusion of more services like minor healthcare tasks, or covering more people who need help.
- *Improved quality:* which they detail as needing **more workforce, greater specialization, longer service times, and less turnover**. This indicates they want more caregivers hired (so each has fewer clients and can specialize), those caregivers to be better trained (specialization), each user to get longer duration of service, and to reduce staff changes so they can build stable relationships with their carers.

Reduce travel strain on professionals through better coordination: They propose improving **coordination** in how services are delivered, specifically so that a caregiver does not have to travel long distances between clients. If the logistics are improved (e.g., assigning nearby clients to each carer), then the worker will not be as tired or pressed, benefiting both parties. Users see this as directly beneficial to them because a less exhausted, more punctual caregiver arriving after a short trip can provide better service. They explicitly note that long journeys are perceived as a cause of stress and exhaustion for workers which presumably they have noticed in their carers.

Implied in their suggestions is also an endorsement of family education as the professionals suggested, since they did mention needing more respect for autonomy – which is part of educating caregivers and families.

- **Greece (Users' Suggestions):** In Greece users called for:

More time per visit / more frequent visits: This would likely top Greek users' list. They want the caregiver to stay longer or come more often so that all necessary tasks and some social interaction can happen. Many likely feel that visits are too short to even have a proper conversation or address anything beyond the most essential tasks.

Broader range of services (especially medical): Greek users explicitly require more medical services at home. They would likely advocate for integrating healthcare into home care – for instance, having a nurse come via the program for certain needs, or better linkage between the

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Help at Home team and medical providers. They might also want physiotherapy or other rehab services to be available at home.

Consistent and stable care provision: If their municipality had interruptions (some programs in Greece have had funding lapses historically), they would ask for guarantees that Help at Home is continuous and not dependent on short-term funding. They would also want that their caregiver remains the same person if possible (since trust builds), which ties to the workers' desire for job stability.

Increased capacity of the program: So that more people can get help (some may be on waiting lists) and those in it can get more hours. Essentially, an expansion in scale. This again comes down to more funding and hiring by municipalities.

Communication and information: Possibly, Greek users would appreciate better communication from the service about what they can and cannot provide (to manage expectations) and about any complementary services (like volunteer groups or NGOs) that could help with needs outside the program's scope. If they know the limits clearly, they might plan differently. But this is more on the agency's part.

Greek users mainly stressed quantity and scope of services. They might not explicitly mention training or worker support (perhaps because they take it for granted or see it as a backend issue), but they likely assume that any expansion includes qualified staff.

To summarize user-driven improvements: more care and better care. "More care" means more hours, more types of services (especially noted in Greece and Spain), and more staff to reduce waiting or gaps. "Better care" means caregivers with the right skills for each client, consistent assignment (less turnover), and an approach that respects the user's autonomy and preferences (addressing issues like overprotection and impersonal treatment). Users are essentially advocating for a strengthened home care system that is well-funded, person-centered, and holistic (covering medical and social needs). They see that as beneficial not just for themselves but also making the job more doable for caregivers, reflecting a holistic understanding that the welfare of caregivers and the quality of care are interconnected.

In the next section, we will consolidate these proposals from both professionals and users, distinguishing country-specific recommendations and general ones, before moving on to discuss overarching similarities and differences observed in the three countries' home care situations.

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Proposals for Improvement

Building on the detailed suggestions from both professionals and users in Greece, Spain, and Italy, this section outlines country-specific recommendations and general improvements that can strengthen home care services. While many recommendations overlap across countries, each context has unique priorities. By addressing these proposals, policymakers and service providers can tackle the challenges identified and enhance the quality and sustainability of home care.

Italy – Country-Specific Recommendations

In Italy, the research highlighted the need to reform structural and labor aspects of home care services. Key recommendations include:

- **Enhance Employment Conditions:** Update the National Home Care Contract (NCHC) to increase salaries for home care workers and provide greater job stability (e.g., more permanent positions). Higher pay would recognize their expanded role (especially post-pandemic) and stability would reduce turnover and burnout. Additionally, introduce benefits such as travel allowances (fuel or vehicle maintenance) and meal vouchers for staff serving in remote or rural areas to offset personal costs.
- **Increase Funding and Staffing:** Invest more public funds into home care so that services can expand. This means hiring additional home care professionals to reduce each worker's caseload and increasing the hours of care allocated to each user based on need. With more workers and more paid hours, each client can receive adequate attention (eliminating waiting lists for service) and workers won't have to rush from client to client.
- **Provide Adequate Tools and Resources:** Ensure that all necessary assistive devices (wheelchairs, patient lifts, shower chairs, etc.) are readily available to users and their caregivers without delay. The national health system and local authorities should streamline the provision of such equipment so that workers are not physically strained and users get the full benefit of care. Also, equip workers with mobile phones or communication devices and ensure they have access to company vehicles or mileage reimbursements so they can travel between clients safely and efficiently.
- **Introduce Flexibility in Care Plans:** Reform rigid regulations that currently govern home care visits. Allow home care workers greater autonomy to adjust schedules and care activities in response to real-time situations. Instead of minute-by-minute task lists,

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implement flexible care plans with input from caregivers. This participatory scheduling would let workers spend a bit more time where needed and manage unforeseen events without penalty, thereby improving effectiveness and reducing stress.

- **Implement Job Rotation:** Develop a system where home care staff rotate assignments periodically (for example, every few months or year). This means a client might have more than one familiar caregiver and no worker remains indefinitely the sole carer for a particular person. Rotation will prevent over-attachment and fatigue, ensure coverage during any absence, and let workers share the emotional load of intensive cases.
- **Reinstate and Expand Training Programs: Resume regular vocational training** for all home care workers. Training should focus on areas like handling different disabilities, new caregiving techniques, use of new medical devices, and person-centered care approaches. Given the diverse needs of clients (physical disabilities, mental health issues, sensory impairments), specialized workshops can equip staff with the knowledge to tailor care. Continuous professional development should be institutionalized, perhaps requiring a certain number of training hours each year.
- **Establish Mandatory Supervision and Peer Support:** Introduce group supervision sessions for home care workers, facilitated by a trained supervisor or psychologist. These could be monthly meetings where caregivers discuss challenges, share experiences, and receive guidance. This provides much-needed emotional support and collective problem-solving, mitigating feelings of isolation in the field. Additionally, foster the creation of peer support groups or networks (possibly moderated via online forums or in-person) where workers can regularly exchange tips and encouragement.

Collectively, these recommendations for Italy focus on making home care jobs more sustainable and professional, which in turn will improve service quality for users. By addressing contract rigidity, resource gaps, and lack of support, Italy can alleviate stress on caregivers and ensure that people with disabilities receive attentive, individualized care at home.

Spain – Country-Specific Recommendations

In Spain (with a focus on Andalusia), the recommendations center on customization of care, better integration of stakeholders (professionals and families), and resource augmentation:

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- **Specialize and Match Services to User Needs:** Develop a system to differentiate users by the type of support needed and assign caregivers accordingly. This could involve training certain staff as specialists in dementia care, physical rehabilitation support, visual impairment assistance, etc. and then **pairing them with users who would benefit most from those skills. By refining assessment and matching, each user gets a caregiver with the optimal skill set, improving care outcomes.
- **Increase Service Intensity:** Through additional funding (from regional or municipal budgets), raise the number of hours of help provided to each user in line with their degree of dependency. If a moderate-dependent currently gets, say, 5 hours a week, consider upping it to 7-10; higher-dependency cases should move from perhaps 2 hours daily to 3 or 4, etc. The goal is to enable comprehensive care, where all necessary tasks (personal, household, even some companionship) can be covered without rushing. This recommendation acknowledges that current time allocations often leave important needs only partially met.
- **Educational Programs for Families:** Launch initiatives to educate and involve family members of home care users. This has multiple components:
    - **Orientation sessions** for new families entering the program, explaining *what the home help service entails, the schedule and task limitations, and the rights and responsibilities of both users and providers*. Well-informed families are less likely to have misunderstandings or conflicts with caregivers.
    - **Workshops or support groups for family caregivers**, teaching skills such as safe mobility assistance, basic first aid, or how to better communicate with and empower their relative with a disability. This training helps families supplement the formal care and understand how to cooperate rather than inadvertently hinder progress.
    - **Disability rights and autonomy awareness campaigns:** Perhaps in partnership with organizations like COCEMFE, educate families (and the public) on respecting the autonomy and wishes of persons with disabilities. Emphasize why involving the user in decisions (like scheduling care tasks) is important and how overprotectiveness can be harmful. This could be done through brochures, community talks, or

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including a social worker's counsel during home visits. The intended outcome is to reduce instances of families unilaterally making decisions that conflict with the user's preferences or the care plan.

- **Expectation management:** Make clear the *scope of the service* to families – for instance, that caregivers are not allowed to do certain medical tasks or care for other family members not in the program. If families understand this, they are less likely to pressure workers inappropriately.

- **Improve Communication and Mediation:** Establish a formal channel for resolving conflicts or misunderstandings between caregivers and families. This could be a mediation service via the municipal social services, where recurring complaints can be discussed and addressed (often through clarifying service terms or adjusting care plans slightly). It ensures small issues don't fester into hostility, benefiting both users and workers.
- **Expand Workforce and Limit Turnover:** Use increased funding to hire more home care staff, which will reduce each worker's load and enable offering more hours per client. With a bigger workforce, also strive to assign the same caregivers consistently to the same users to build trust over time, thus tackling the issue of high turnover and unfamiliar replacements. Municipalities and contracted companies should aim to improve job attractiveness (through slightly better pay or hours, or paths for advancement) to retain staff. Reducing turnover was explicitly linked by users to improved reliability and respect of personal boundaries.
- **Enhance Service Coordination and Logistics:** Implement smarter scheduling systems so that caregivers serve clusters of clients in nearby locations. Municipal planning can leverage mapping software or local knowledge to minimize travel distances for each worker. This might mean reassigning cases between workers to group by neighborhood. The result will be shorter transit times, which means caregivers can use more of their paid time caring rather than commuting, and they arrive less exhausted to each home. Additionally, consider providing travel stipends or company transportation in spread-out rural areas to ease the burden.
- **Integrate Mental Health Support for Staff:** Following Spain's note that mental health support is usually by social workers, improve this by contracting a part-time psychologist or

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counsellor who can be available for home care staff (perhaps across multiple private companies or at the municipal level). This gives workers a professional outlet for stress beyond their immediate supervisors.

- **Increase Funding and Oversight:** Encourage the Andalusian government and local councils to allocate higher budgets for home care services, considering the recommendations above require financial support. With greater investment, ensure rigorous monitoring that the funds translate into more hours delivered, better training, etc. The regional government might set targets or incentives for municipalities to meet quality indicators (such as user satisfaction levels, average hours per user, training hours per staff, etc.).

For Spain, these proposals emphasize a more person-centered and well-resourced home care system, where care is tailored to individual needs (through specialization and more hours) and all stakeholders (users, families, workers) are engaged and informed. The underlying goal is to reduce friction and gaps by making the home care triad – provider, user, family – a more cohesive team, supported by sufficient funding and coordination.

Greece – Country-Specific Recommendations

In Greece, the focus is on formalizing and expanding the still-developing home care sector, addressing both workforce issues and service limitations:

- **Stabilize and Professionalize the Workforce:** Transition the municipal Help at Home workers from temporary contract status to permanent employment positions wherever possible. Offering job security will improve staff retention and morale, ensuring that older people and PWD have continuity in their caregivers. Alongside stability, increase the wages of home care staff to be commensurate with their responsibilities. Higher pay will attract more qualified individuals to the field (potentially even drawing some trained nurses or therapists to consider home care roles) and acknowledge the skilled nature of their work. Introduce a clear career path or progression (e.g., senior home care aide, coordinator roles) to professionalize the sector and encourage skill development.
- **Expand Service Coverage and Intensity:** The Greek government (national and local) should commit more funding to expand the Help at Home program, allowing:

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- **More beneficiaries to be served** (reducing any waiting lists and possibly raising the eligibility income threshold so that slightly less poor elderly who also need help can enroll).
- **More hours of service per beneficiary**, especially for those living alone with high needs. This could mean moving from, say, 2 visits per week to 4 visits for some, or from 1 hour visits to 2 hours, depending on need. The emphasis is to better cover daily needs like meal prep, cleaning, or multiple daily hygiene routines that currently might not be fully addressed due to time limits.

- **Integrate Basic Medical Services:** Modify the program design to include some healthcare components. For instance, ensure that each Help at Home team has access to a visiting nurse or can coordinate with local health centers for home visits. This may involve creating joint protocols between the Ministry of Health and municipalities. If direct staffing of nurses in the program is not immediately possible, establish a referral system where if home aides identify a medical need (e.g., wound dressing, injection, physiotherapy), a nurse/physio from the health service is dispatched within a short time frame. Essentially, work toward a more integrated social-health home care model so that "medical needs not covered by the program" can be addressed. In parallel, train home care aides in basic health monitoring (like checking blood pressure, recognizing pressure sore risks, etc.) so they can handle minor health-related tasks safely and know when to call a nurse or doctor.
- **Increase Training and Qualifications:** Invest in training programs for home care workers. Many current workers may not have formal training in elderly care or disability support beyond on-the-job experience. Offer certified courses in geriatric care, disability awareness, first aid, and communication skills. Encourage or require existing staff to attend these trainings (with paid time or incentives to do so). For new hires, consider raising qualification requirements gradually, and/or recruiting individuals with social work or nursing assistant backgrounds. Given Greece's reliance on migrant caregivers in private care, also consider ways to extend training or certification opportunities to those informal carers, integrating them into the formal system where possible or at least improving overall care standards.
- **Improve Organizational Support:** Establish mechanisms for regular supervision and team meetings among Help at Home staff. Municipal social services departments could have a

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social worker or psychologist lead monthly debriefings with the home care aides to discuss challenges and provide support (similar to Italy's group supervision idea). Additionally, ensure staff have needed supplies: e.g., if a worker needs gloves, disinfectants, uniforms, or even a smartphone to coordinate care, the municipality should provide these. Also, standardize operational guidelines across municipalities – perhaps through the central government issuing a detailed manual – so that all workers know their scope and whom to contact for various problems, reducing variability in service.

- **Public Awareness and Expectation Management:** Conduct an awareness campaign about the scope of Help at Home for potential users and their families. Many Greek users might expect full medical care or daily help which the program isn't currently designed to provide. Clear communication (via local citizen service centers, pamphlets, or community meetings) about what services one can expect (and their limits) will align expectations. Simultaneously, gather feedback from communities on what they feel is lacking (likely more medical care and hours, which we address by integrating health and expanding hours). This can help in planning future expansions or adjustments to the program's offerings.

- **Leverage Community and Technology:** To complement limited staff, municipalities can leverage volunteers or community groups for additional support (e.g., volunteer drivers for taking seniors to appointments, or NGOs that provide meals-on-wheels), ensuring coordination with Help at Home so efforts are not duplicated but rather fill gaps. Also, consider implementing telecare solutions – for instance, providing emergency call buttons or tele-monitoring for users, and using phone check-ins on days when no visit occurs (some municipalities did this during COVID). While not a substitute for in-person help, telecare can add a layer of safety and support especially for those who live alone.

- **Monitor and Equalize Service Quality:** The national government should monitor the implementation in various municipalities and strive to reduce disparities. This could include earmarked funds for poorer municipalities to hire more staff, or performance-based grants. Sharing best practices between municipalities (perhaps through an annual conference or network for program coordinators) would also help everyone rise to the level of the best-performing areas.

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For Greece, these recommendations aim to solidify the foundation of home care (by securing the workforce) and then build upward by broadening services to approach what is available in countries with more developed systems (like incorporating healthcare and extensive coverage). Greece's situation calls for both catching up on basics (job security, enough staff) and innovating to cover gaps (medical integration, community support). Ultimately, implementing these would move Greece from a mostly informal care model to a robust, formal home care service that can reliably support its aging and disabled population.

General Recommendations (Across All Countries)

In addition to country-tailored measures, the comparative analysis reveals several overarching recommendations relevant to all three countries (and likely beyond). These general proposals address the common issues and trends identified:

Increase Funding and Resources for Home Care: Boost investment in home care programs nationally and locally. All three countries face the fundamental challenge of rising demand outstripping current resources. More funding should be allocated to hire additional caregivers, pay them fairly, and provide sufficient service hours to users. This includes emergency funds (as learned from COVID) to ensure continuity of care and supply of protective equipment during crises. Across the board, greater funding correlates with improved service quality and reach.

Improve Working Conditions and Recognition of Home Care Workers: Home care workers should be given the status and support due to essential frontline professionals. This entails:

- Offering competitive wages and benefits to reduce financial strain and show societal value for their work.
- Ensuring job stability (minimizing precarious contracts) so workers can commit to the career.
- Providing schedules that are humane and flexible, avoiding overbooking caregivers with too many clients per day. Introduce policies that limit the number of visits or travel distance per day to manageable levels, and give workers input into their schedules.
- Instituting regular breaks, leave, and respite for workers. Given the emotional toll, they should be encouraged to take annual leave and provided with back-up staff to cover so they can recharge (particularly important in intense assignments).
- Formally recognizing and celebrating the work of home care staff (through awards, public acknowledgments, opportunities for advancement) to boost morale and public respect.

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Mandate Training and Continuous Professional Development: Make ongoing **training a standard part of home care employment**. Governments and organizations should require a baseline training certification for all home care workers (covering elder care, disability support, first aid, etc.) and periodic refresher or advanced courses. Topics should include not only practical care skills but also communication, cultural competency (relevant for migrant caregivers or diverse clients), and respecting client autonomy. Continuous education will ensure caregivers stay updated on best practices and emerging knowledge (for example, new techniques for dementia care or lifting). It also professionalizes the workforce, making it more like nursing or social work in its expectation of career-long learning.

Provide Psychological Support and Supervision for Caregivers: Emotional and mental health support systems for home care providers should be established universally. This could involve hiring or contracting counselors/psychologists who regularly meet with care teams, setting up peer support meetings, and offering confidential counseling services for those who seek one-on-one help. Group supervision (case conferences) not only helps with emotional support but can improve care strategies for difficult situations by collective brainstorming. Given the stresses identified (burnout, grief, conflicts), this support is crucial for retention and for caregivers to maintain compassion and patience in their work.

Enhance Coordination and Integration of Services: Break down silos between health and social care and between different providers:

- Integrate **multidisciplinary teams** where feasible, so that home care includes cooperation between aides, nurses, social workers, physiotherapists, etc. This ensures holistic care (covering medical, functional, and psychosocial needs).
- Improve **coordination of care schedules** to reduce inefficiencies like long travel and overlapping visits by different services. Use technology (scheduling software, shared digital care plans) to coordinate between agencies (for example, if a nurse and a home aide both visit the same person, schedule them in a complementary way or on the same day to maximize effect).
- Involve **family doctors/general practitioners** more actively in home care plans – they should be aware of what support their patient is getting at home and can adjust medical care accordingly. Conversely, home care workers should have a direct line to contact healthcare providers if they notice health issues.

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- Foster clear protocols for situations that require escalation (if a home care worker finds a client's health deteriorating, there should be a known pathway to quickly get medical intervention).

Empower Users and Respect Autonomy: Across all countries, users voiced the need for respect and involvement in their own care. General measures should include:

- Ensuring **care plans are person-centered**, developed in consultation with the user (and family if appropriate) rather than imposed. Users should have a say in what times of day they prefer visits, which tasks are most important to them, and even which caregiver (to maintain compatibility).
- Training caregivers in techniques that promote independence, like "do with, not for" whenever possible – allowing the person to do parts of tasks themselves to maintain skills and dignity.
- Establishing feedback mechanisms (surveys, user councils, regular check-ins by supervisors) so that users can voice concerns or suggestions about their care without fear, and see those concerns addressed. This will catch issues like a poor match with a caregiver early, or identify if a user's needs have changed requiring an updated care plan.

Educate and Involve Families as Partners in Care: Recognize families as crucial components of the care equation. General initiatives:

- Provide **family caregiver training programs** (as Spain suggests) and informational resources so they know how to collaborate effectively with professional caregivers.
- Encourage a **team mindset** where family and professional caregivers communicate regularly (e.g., via a notebook or app that logs what was done, any issues, so everyone is on the same page).
- Set boundaries and clarify roles: help families understand the limits of the professional's role to prevent unreasonable demands, and conversely, educate professionals to respect the knowledge and involvement of family members.
- Support families too, through respite services or support groups, so that they can continueto assist their loved ones without burning out or becoming adversarial with care providers.

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Responsive Adaptation Post-COVID: Use the lessons from the pandemic to strengthen home care resilience:

- Maintain **enhanced hygiene practices and infection control training** for all home visits.
- Develop contingency plans for remote support (telehealth, phone check-ins) in case of future emergencies that limit physical contact.
- Ensure that caregivers are classified as essential workers so they get priority access to protective equipment, vaccinations, and resources in any public health crisis, thereby protecting both them and the users they serve.

Monitoring, Evaluation, and Continuous Improvement: Implement regular **evaluation of home care services** through both quantitative metrics (e.g., number of users served, average hours per user, caregiver-to-client ratio, etc.) and qualitative feedback (user and caregiver satisfaction surveys). Use these evaluations to identify where improvements are still needed and to drive policy updates. Encourage a culture of continuous improvement where suggestions from the field (both workers and users) are integrated into service development.

By applying these general recommendations, Greece, Spain, and Italy can collectively move towards more robust, equitable, and high-quality home care systems. These measures address the heart of common challenges: undervalued workforce, under-resourced services, and sometimes under-engaged families. Implementing them would improve not just working conditions but also outcomes for users – ensuring safer, more effective, and more person-centered home care across diverse settings. Ultimately, these changes contribute to the overarching goal shared by all: enabling people with support needs to live with dignity and autonomy in their own homes.

Key Similarities

Despite differences in governance and context, the home care systems in Greece, Spain, and Italy exhibit **strikingly similar challenges and themes**. The comparative analysis highlights the following key commonalities:

- **Emotional Toll of the COVID-19 Pandemic:** In all three countries, the pandemic had a profound emotional and practical impact on home care. Both caregivers and users experienced increased anxiety, isolation, and stress during lockdowns. Caregivers had to

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adapt to safety fears and new tasks, often without adequate preparation, while users felt cut off from essential support. The shared experience underscored the resilience of home care relationships – many caregivers continued serving as much as possible and users deeply appreciated their efforts – but also revealed vulnerabilities (like lack of PPE and emergency protocols) that each country faced similarly. Across Greece, Spain, and Italy, one silver lining was greater awareness of hygiene and infection control in home care going forward.

- **Work Overload and Rigid Schedules:** A major similarity is that home care workers in all three countries are **overburdened with high workloads and often inflexible care schedules**. Italian and Greek workers described burgeoning client lists and too little time per user, and Spanish workers similarly cited work overload as a constant issue. The structure of services tends to allocate minimal hours to many clients, leading to rushed visits everywhere. Additionally, rigid regulations or care plans were criticized in Italy, and a parallel can be drawn to formalized task lists in Spain and the narrow scope in Greece – all of which **limit caregivers' flexibility** to respond to individual needs. The result in each country is worker stress and user needs sometimes going unmet due to the clock. This similarity points to a fundamental tension in home care: balancing efficiency (covering many clients) with personalization (giving each enough time), a challenge seen across all contexts.

- **High Value on Emotional Bonds, Coupled with Lack of Specialized Training:** In Greece, Spain, and Italy, users and caregivers alike emphasized the importance of **strong emotional bonds** formed through home care. Users in all countries often view their caregivers with affection and trust – "like family" – and caregivers invest emotionally in their clients. This human connection is a cornerstone of home care success everywhere. However, users in each country also noted that caregivers sometimes lack **specific expertise or training** for certain conditions, which can be a drawback. For instance, an Italian user felt not understood due to a caregiver's lack of mental health training, and Spanish users suggested more disability-specific training for staff. All reports converge on the critique that while caregivers are compassionate and kind, the **absence of specialized knowledge** (e.g., in handling particular disabilities or complex health issues) and occasionally **overprotective attitudes** limit the full effectiveness of care. Thus, across the board, there's a call for better training to complement the natural empathy caregivers bring.

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- **Lack of Support Structures for Caregivers:** Caregivers in all three settings voiced insufficient **organizational and mental health support**. Italian and Greek workers reported no formal supervision or counseling services to help them cope with stress, and Spanish workers noted that while some support exists, it's not by mental health professionals. In all cases, the job's emotional demands (dealing with deaths, family conflicts, etc.) are not adequately addressed by current support systems, which are ad hoc or minimal. This is a universal gap – home care, as an occupation, tends to be undervalued and thus under-supported. Likewise, issues like lack of reimbursement for expenses (in Italy and possibly Greece) and job insecurity (short-term contracts in Greece, and many Spanish caregivers employed by private firms on likely modest terms) highlight that **work conditions need improvement across all countries**.

- **Need for Better Funding and Coordination:** All three reports implicitly or explicitly call for **increased funding and better coordination** in home care. Whether it's Italy needing funding to implement PNRR home care initiatives, Spain needing budget increases to extend service hours and workforce, or Greece needing more resources to stabilize and expand Help at Home, the theme is the same: current funding is insufficient given demographic and social needs. Coordination issues, such as Spain's travel inefficiencies or Greece's variability by municipality, also emerged as common problems that better planning and integrated management could alleviate. Essentially, **scaling up investment** and **streamlining service delivery** are recognized steps in all countries to improve home care outcomes.

- **Shared Commitment and Pride in Home Care:** Another more positive similarity is the **dedication of both workers and users to the concept of home care**. In all focus groups, despite airing grievances, there was a strong underlying belief in the value of home care. Italian operators "believe very much in the service they provide", Spanish professionals showed great interest in improving service quality, and Greek stakeholders (implicitly) carry on even under less-than-ideal circumstances, indicating a commitment to helping the vulnerable at home. Users across countries express gratitude for being able to remain at home and for the assistance that allows that. This shared ethos suggests that any investments in improving home care will be met with motivated uptake by those on the ground.

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In summary, **the three countries share common ground in the stresses on their home care systems**: overstretched workers, undervalued support, the lasting echo of COVID-19 strains, and user experiences of both great support and certain unmet needs. They also share **common aspirations** – all reports highlight the need for more training, more funding, and more user-centered flexibility to make home care safer and more effective. These similarities mean that cross-country learning and collaboration could be fruitful; a solution or innovation in one country (like Italy's developing training modules, or Spain's family education initiatives) could likely benefit the others, given the parallel challenges they face.

Key Differences

While the foundation of home care challenges is similar, there are important distinctions in emphasis and context between Greece, Spain, and Italy. These key differences shape the specific approaches needed in each country:

Regulatory Structure and Focus: Italy has a long-established legal framework and thus focuses on issues like rigid regulations and bureaucratic constraints. The Italian report highlights a new municipal regulation that is too inflexible and efficiency-driven, hampering care quality. Also, a peculiar Italian issue is the lack of reimbursement for travel expenses for workers using personal vehicles, which was a pointed grievance in Italy (this was not explicitly raised in Spain or Greece to the same extent). **Spain**, by contrast, operates under a more recent and region-specific regulation (Andalusia 2023 Order) and emphasizes operational challenges like confrontations with families and the "depersonalization" of users in decision-making. The Spanish narrative is heavily about relational dynamics and rights (users' autonomy vs family control), reflecting Spain's focus on user rights within a family context. **Greece** stands out as it historically lacked a formal system – its focus is on work stability and ramping up basic services. Greek professionals stress the lack of stable employment (temporary contracts) and standardization. So, whereas Italy's discourse is about tweaking an existing robust system (more flexibility, reimbursements, rotation) and Spain's about managing stakeholder relationships and expectations, Greece's is about building the foundation (job stability, consistent program implementation).

Psychological Support vs. Available vs. Absent: In **Spain**, there is at least some form of mental health support (though provided by social workers) accessible to employees, meaning the concept of caring for caregiver mental health exists institutionally (if imperfectly). In **Italy and Greece**, formal psychological support or supervision is largely absent. Italian and Greek reports both flag

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the lack of formal supervision as a major issue, whereas Spain's implicitly suggests improvement by switching to psychologists, not establishing from scratch. This indicates a difference in how far each system has recognized and addressed caregiver mental wellness – Spain seems a step ahead in acknowledging it, though execution could improve, whereas Italy/Greece still need to integrate it into their systems.

Family Involvement and Training: Spain places a strong emphasis on the role of family and the need to educate and integrate families into the care process. The Spanish suggestions include detailed proposals for family training and awareness (even labeling overprotection as a form of "violence") – reflecting a cultural context where family plays a big part in care and sometimes clashes with formal services. **Italy** did not highlight family education as much; its issues with families were more about surveillance (cameras) and trust, and proposals were more inward-looking (improve contract, training workers, etc.) rather than about families. **Greece** is focusing on user expectations of services – basically educating the community about what Help at Home can and cannot do. That is slightly different from Spain's focus on disability rights awareness for families. In Greece, because the formal service is limited, families already do the bulk of care (often via privately hired helpers), so the issue is not family overreach but rather family needing more support from the state. Thus, Spain's difference is an emphasis on rebalancing family and professional roles, whereas Greece's is about expanding professional roles to support families, and Italy's family issues revolve around trust and boundaries.

Specific Innovations Proposed: Italy places focus on internal service improvements like job rotation and reinstating vocational training that had lapsed. The idea of job rotation, for instance, is particularly highlighted in Italy as a way to handle emotional overattachment and burnout, whereas neither Spain nor Greece explicitly mention job rotation – likely because in Spain and Greece, rotation or turnover happens anyway (Spain has high turnover, Greece workers cover multiple clients by necessity). **Greece** is focusing on raising awareness "of the limits of the services provided" – essentially an acknowledgment that users might expect more (like medical care) than the program offers. This is a uniquely Greek concern given its program's constraints. **Italy** doesn't have to explain service limits as much since the LEA ensures a comprehensive intent, and **Spain** explicitly outlines what's included/excluded in regulations (though users/families might not always know). Additionally, Italy's push for things like petrol bonuses or meal vouchers for rural travel is a very context-specific detail (reflecting Italian geographical diversity and cooperative employment conditions) not seen in Spanish or Greek discussions.

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Level of Formalization and Implementation: Ultimately, a key difference is maturity of the home care system:

- Italy's system is formalized and nationally integrated, so its issues are about execution (making a formal system more humane and efficient).
- Spain's (Andalusian) system is formal and regional, mixing public and private implementation; its issues revolve around consistent quality and managing multi-actor involvement (users, families, private contractors).
- Greece's system is partly formal (municipal Help at Home) but still relies heavily on informal care, so its issues are about expanding formal care to meet needs historically met by the private market.

These differences lead to different primary challenges: **Italy** wrestles with bureaucracy and resource allocation within a guaranteed service, **Spain** with ensuring comprehensive, rights-based service delivery under decentralization and private-public mix, and **Greece** with fundamental service availability and workforce stability.

- **Cultural/Geographical nuances:** Another subtle difference is cultural norms: In Italy and Spain, there's mention of emotional involvement and difficulty maintaining professional distance (especially Italy), whereas in Greece, such discussion is less prominent – possibly because Greek caregivers might have somewhat more emotional distance if they are contract workers who know their job could end, or because many Greek families still provide the deeply emotional caring role with pros supplementing. Spain highlights depersonalization of users by relatives as a problem, reflecting a push in Spain towards user empowerment; that specific framing doesn't appear in Italy or Greece. Italy might implicitly have it, but it was not a key theme, and Greece is still addressing basic access rather than nuances of autonomy in care decisions.

In conclusion, while working towards similar goals, **Italy is fine-tuning a comprehensive system with flexibility and support, Spain is balancing roles and enhancing training within a growing system, and Greece is establishing and scaling a reliable system**. Recognizing these differences is important: reforms must be tailored. For example, strategies to engage families on disability rights (a key in Spain) might not be as high a priority in Italy, where the bigger immediate issue is to reform rigid municipal rules and contracts. Similarly, calls for formal supervision in Italy/Greece address a gap

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not as acute in Spain. Each country thus has distinct immediate priorities: **Italy – flexibility and full support for workers within a regulated system; Spain – harmonizing family-professional cooperation and refining service delivery; Greece – stability, coverage, and integrating basic healthcare into home care.** These differences inform the country-specific recommendations earlier and show that a one-size-fits-all solution would not work equally well in each context.

General Conclusions

Home care services in Greece, Spain, and Italy are indispensable for supporting aging populations and people with disabilities, enabling them to live at home with dignity. This comparative analysis reveals that despite different administrative models and stages of system development, the three countries face convergent challenges: supporting an overburdened workforce, ensuring sufficient resources and training, and adapting to both longstanding needs and recent shocks like the COVID-19 pandemic. The research conducted through the *Safer Path* project has provided a rich, ground-level perspective on these issues, highlighting the voices of those most intimately involved – caregivers and care recipients.

Converging Lessons: All three countries must grapple with the reality that demand for home care is rising (due to demographic aging and social changes) while the job of caregiving remains undervalued. The pandemic amplified this, casting a spotlight on the critical role of home care workers as front-line responders and the isolation that users face without consistent support. A clear lesson is that investing in home care is not a luxury but a necessity for resilient healthcare and social support systems. This means increasing funding, as repeatedly called for in user and provider recommendations, to hire more staff, pay them adequately, and extend services to all who need them. It is evident that underfunding leads directly to the issues seen: too many clients per worker, high turnover, limited visit times, and stress – which in turn can compromise care quality and user well-being.

Another shared conclusion is the importance of **training and professional development**. The passion and empathy that caregivers bring are tremendous assets across countries, but these need to be complemented with skills and knowledge. Regular training (including reintroducing those paused by COVID) will help caregivers manage complex needs and new challenges, from advanced dementia care techniques to digital tools for care coordination. Policymakers should establish national standards or certifications for home care workers, elevating the profession's status and ensuring uniform quality of care.

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The Role of Policy and Frameworks: Policy frameworks greatly influence service delivery. Italy's comprehensive laws (Law 104/1992, etc.) provide a strong foundation – the task ahead is to modernize implementation (more flexibility, better enforcement of support provisions like LEA) and fill gaps in practice (like travel reimbursements, supervision). Spain's regionalized approach allows innovation (Andalusia's 2023 regulation is quite detailed in defining services and rights), but it requires robust oversight to ensure private contractors meet quality standards and that family carers are integrated, not pitted in conflict, with professional services. Greece's recent legislative efforts (Help at Home law 5027/2023) are promising, but need scaling and consistent rollout; national support to municipalities will be crucial so that help is not uneven or too limited. In all cases, a stronger policy emphasis on home care within the health and social care continuum is needed – for example, including home care expansion in national development plans (as Italy did with its PNRR), or tying central funding to local performance in home care delivery (which could motivate improvements in Greece and Spain).

User-Centered Care as the End Goal: Ultimately, the success of home care should be measured by the quality of life and satisfaction of users. The studies show that users greatly value their independence and the personal bonds with caregivers, but also have clear ideas for improvement – they want more time, more say, and more competent care. Adopting a user-centered approach means involving users in care planning and feedback. For instance, co-designing care schedules with users (and adjusting them when not working well) would address many grievances about rigid timing. Ensuring continuity of relationships (by reducing turnover and avoiding unnecessary rotation) respects the importance of trust for users. Empowering users – e.g., through periodic surveys or including them in local advisory boards for home care services – will keep services accountable to those they serve.

Policy Recommendations: Based on the comparative findings, we put forward broad policy recommendations:

1. **Increase Public Investment in Home Care:** Government budgets should reflect home care as a priority service, not an afterthought. This includes leveraging EU funds or recovery funds (as applicable) for home care infrastructure, workforce training programs, and pilot projects for innovative models (like tele-homecare, integrated care teams).
2. **Standardize Training and Certification:** Develop national curricula for home care workers and require certification/licensing. Provide incentives for existing workers to obtain

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certification (e.g., wage increases, paid training hours). Certified training should cover not just practical tasks but also communication, cultural competency, and stress management.

3. **Strengthen Workforce Policies:** Implement policies to make home care a more attractive and sustainable career. This could involve minimum wage standards for the sector, guaranteeing working hours (to avoid underemployment), offering paths for advancement (e.g., senior aide, team leader roles), and protecting workers' rights (including health insurance, mental health leave, etc.).

4. **Integrate Care Services:** Position home care as equal in importance to institutional care within health systems. Facilitate partnerships between health services and social care – for example, allow home care programs to be gateways for referrals to health services and vice versa. In practice, a user should seamlessly receive both personal care and medical care at home through coordination between agencies.

5. **Family Caregiver Support:** Recognize that family caregivers are critical in all three societies. Policies should provide training, respite care, and possibly financial recognition (stipends or tax credits) to family members providing substantial care. This relieves pressure on formal services and acknowledges the collaborative approach advocated in Spain.

6. **Monitoring and Quality Assurance:** Establish clear metrics and inspection regimes for home care providers (including private contractors). User satisfaction, worker conditions, and care outcomes (like preventing hospitalizations) should be tracked. Public reporting of these can drive competition on quality, especially where private companies are involved, and guide resource allocation decisions.

Final Observation: The comparative study underscores that home care is not just a service, but a relationship-based lifeline. The human factor – the compassion of caregivers and the gratitude of users – is the backbone of home care in Greece, Spain, and Italy. Policies and management practices should therefore nurture this human connection, not undermine it with overly rigid or under-resourced frameworks. By acting on the recommendations laid out – investing in people, promoting flexibility, and fostering collaboration – each country can move toward a more resilient home care system. Such systems will better withstand future challenges (like pandemics or demographic shifts) and ensure that vulnerable individuals receive respectful, effective support at home.

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In conclusion, **strengthening home care requires a multidimensional effort**: legislative refinement, increased funding, workforce development, and cultural shifts in how we value care work and autonomy of those receiving care. The findings and proposals from the *Safer Path* project provide a roadmap. Implementing these changes will lead to improved outcomes: reduced burden on hospitals (as more care is effectively given at home), improved job satisfaction for care workers, and most importantly, enhanced quality of life for thousands of individuals who rely on home care every day across Greece, Spain, and Italy.

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