Sociology and Social Work Review
Volume 10 (Issue S1)/2026 | pp. 22-38
DOI: 10.58179/SSWR10S102
https://journals.globalresearchpublishing.com/index.php/sswr/

Original Article

Ageing and Quality of Life: The Institutionalisation of Caregiving

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Abstract

Population ageing is reshaping welfare systems and intensifying pressures on long-term care. Drawing on evidence from the AGE-IT programme, this article examines the institutionalisation of caregiving in Italian Residential Health Care Facilities (Residenze Sanitarie Assistite, RSA) and its implications for older people's quality of life. The study adopts a multilevel, cross-sectional research design that combines analysis of organisational practices and experiences of residential care. Data were collected through structured questionnaires administered to RSA managers (N = 92) and residents and family members (N = 117) in three Italian regions (Abruzzo, Emilia-Romagna and Puglia), selected to reflect territorial heterogeneity in welfare structures and long-term care provision. A non-probabilistic purposive sampling strategy was adopted. Most items were measured on standardised 1–10 scales and were inspired by validated quality of life frameworks (WHOQOL; OPQOL), adapted to the Italian residential context. Results indicate high perceived quality of care and professional standards, alongside weaker evaluations of symbolic, relational and biographical dimensions of everyday life in residential settings. Admissions are predominantly driven by the breakdown of informal caregiving capacity, highlighting institutional care as a late, reactive transition rather than a planned life-course move. The article argues that long-term care policies should support earlier, gradual and territorially integrated transitions, reframing RSA as social spaces capable of sustaining autonomy, participation and continuity in later life.

Keywords: *ageing; long-term care; residential care; caregiving; quality of life; life-course; welfare regimes*

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1. Introduction

Population ageing represents one of the most significant demographic transformations of contemporary societies. In Europe, and particularly in Southern European countries, increasing longevity has been accompanied by a growing prevalence of chronic conditions, functional limitations, and long-term care needs. In Italy, demographic ageing has progressed rapidly, placing sustained pressure on welfare systems and exposing long-standing structural weaknesses in the organisation of care for older people.

While policy frameworks have increasingly promoted concepts such as *active ageing*, *ageing in place*, and community-based care, the demand for residential long-term care has not diminished. On the contrary, Residential Health Care Facilities (Residenze Sanitarie Assistite, RSA) continue to play a crucial role when health deterioration, cognitive decline, or the intensity of care needs exceed the capacity of families and community services. Despite their centrality, RSA remain one of the most contested components of long-term care systems, often framed as residual or last-resort solutions rather than as integral elements of care trajectories.

This ambivalent position is particularly evident in familistic welfare regimes such as the Italian one, where care responsibilities are predominantly assigned to families and institutional solutions are activated only after informal caregiving resources are exhausted. As a result, admission to residential care is frequently experienced as a critical and disruptive event, associated with feelings of loss, dependency, and social marginalisation. These dynamics raise important questions regarding the relationship between institutional care, quality of life, and social inclusion in later life.

Existing research on residential care has extensively documented the importance of service quality, staffing levels, and organisational standards. However, sociological analyses have increasingly highlighted the limits of approaches that equate quality of care with quality of life. While professionalised care may ensure safety, medical supervision, and basic comfort, it does not automatically guarantee autonomy, personal identity, or continuity of life histories. Understanding residential care therefore requires moving beyond organisational performance indicators and examining how institutional arrangements intersect with individual biographies and broader welfare structures.

Within this framework, the AGE-IT programme (*Ageing Well* in an Ageing Society) was designed to provide updated empirical evidence on ageing and care in Italy, integrating quantitative and qualitative perspectives. The present article focuses on the institutionalisation of caregiving in RSA, analysing how organisational quality, lived experience, and welfare regime characteristics shape older people's quality of life in residential settings.

By adopting a sociological and life-course perspective, we conceptualise institutionalisation not merely as a change in living arrangements, but as a biographical turning point embedded within cumulative life trajectories. From this standpoint, residential care is understood as the outcome of long-term processes involving health, family relations, gendered care responsibilities, and policy frameworks. This approach allows for a more

nuanced interpretation of the tensions observed between quality of care and quality of life, situating them within broader patterns of inequality and social regulation.

The article contributes to sociological and social work debates in three main ways. First, it provides updated quantitative evidence on residential care in Italy, focusing simultaneously on organisational actors (RSA managers) and care recipients (residents and family members). Second, it highlights the structural gap between professional care provision and lived well-being in institutional contexts. Third, it advances a life-course-oriented interpretation of institutionalisation, emphasising its timing, sequencing, and cumulative consequences. In doing so, the study aims to inform both academic debates and policy discussions on the future of long-term care in ageing societies.

2. Methods

The study adopts a multi-level research design aimed at analysing quality of life in later life through the combined examination of organisational practices and lived experiences in residential long-term care. Data were collected within the framework of the AGE-IT programme and focus on Residential Health Care Facilities (Residenze Sanitarie Assistite, RSA) as complex institutional settings where care provision, professional practices, and social relationships intersect.

The research was conducted in three Italian regions – Abruzzo, Emilia-Romagna, and Puglia – selected to reflect territorial heterogeneity in welfare arrangements, socio-economic conditions, and long-term care provision. These regions represent different configurations of service availability and institutional capacity within the Italian welfare system, allowing for a more comprehensive understanding of residential care dynamics.

The study employed a cross-sectional design based on structured questionnaires administered to different categories of respondents involved in residential care. The analytical focus was not on causal inference but on the identification of patterns, regularities, and tensions across organisational and experiential dimensions of institutional care.

A purposive, non-probabilistic sampling strategy was adopted. Two main groups of respondents were included:

1. RSA managers (N = 92), responsible for organisational coordination, service delivery, and staff management within residential facilities.
2. Residents and family members (N = 117), providing insights into everyday life, care experiences, and reasons for admission to RSA.

Managers were selected on the basis of their direct involvement in facility governance, while residents and family members were recruited through participating RSA. In cases where residents were unable to complete the questionnaire due to cognitive or health limitations, family members acted as proxies, a common practice in research on older populations.

Data were collected using structured questionnaires designed to capture both organisational and experiential dimensions of residential care. The instruments included items measuring:

- organisational characteristics and service quality (for managers);
- perceived quality of care and quality of life (for residents and family members);
- relational aspects of care;
- autonomy, personalisation, and everyday life in RSA;
- reasons for admission to residential care.

Most items were measured on standardised 1–10 scales, where higher values indicate more positive evaluations. The construction of the questionnaires drew on validated frameworks and instruments commonly used in research on ageing and long-term care, including WHOQOL and OPQOL (Bowling, 2009), adapted to the Italian residential care context.

The analysis presented in this article is primarily quantitative and descriptive, aimed at identifying central tendencies and patterns across respondent groups. Descriptive statistics were used to summarise evaluations of care quality, organisational functioning, and quality of life dimensions. Comparative readings were conducted between managers' assessments and those of residents and family members in order to highlight convergences and divergences.

Quantitative findings were interpreted through a sociological lens, situating institutional practices within broader welfare regime dynamics and life-course trajectories. Rather than treating numerical indicators as self-explanatory, we deliberately chose to connect empirical patterns to theoretical debates on care regimes, institutionalisation, and biographical disruption.

The study was conducted in accordance with ethical standards for social research involving human participants. Participation was voluntary, informed consent was obtained from all respondents, and data were collected and analysed anonymously. Particular attention was paid to the protection of vulnerable participants, especially older residents with health or cognitive impairments.

The empirical fieldwork was carried out in close collaboration with a network of Residential Health Care Facilities affiliated with UNEBA (Unione Nazionale Istituzioni e Iniziative di Assistenza Sociale), which facilitated access to organisations, professionals, residents and family members. Despite this institutional support, the administration of questionnaires to residents in RSA proved to be methodologically demanding. Cognitive impairment, fatigue, and health instability significantly limited the possibility of direct participation for a substantial proportion of residents.

As a consequence, the resident sample included in the study is composed exclusively of older people who were cognitively preserved and able to understand and respond autonomously to the questionnaire. This represents a necessary methodological choice rather than a normative assumption about residential populations. While this strategy ensured the reliability and validity of self-reported data, it also implies a partial

representation of the broader RSA population, particularly excluding individuals with advanced cognitive decline. This limitation was consciously accepted in order to preserve the quality of responses and to avoid proxy distortions in the assessment of subjective quality of life.

Given the non-probabilistic purposive sampling strategy and the limited size of the residents and family members group, the findings presented here should be interpreted as analytically informative rather than statistically generalisable to the overall Italian RSA population. In addition, the direct resident sample includes only cognitively preserved older people who were able to complete the questionnaire autonomously. While this methodological choice strengthened the reliability of self-reported evaluations, it also implies a partial representation of the broader residential population, particularly excluding residents with more severe cognitive impairment. The regional design was intended to capture territorial heterogeneity; however, the present article focuses primarily on aggregate patterns, and regional differences are not examined in depth because subgroup sizes do not support robust comparison.

3. Results

The empirical evidence collected within the AGE-IT study offers a detailed picture of institutionalised caregiving and identifies a set of recurring and internally coherent patterns. Across all data sources, the results point to a configuration in which high perceived quality of care coexists with more cautious evaluations of quality of life. This pattern emerges when comparing organisational assessments provided by RSA managers with experiential evaluations reported by residents and family members, and it is further reinforced by the analysis of admission pathways into residential care. Although the study includes three regions in order to capture territorial heterogeneity, the present analysis focuses on aggregate patterns rather than on systematic regional comparison.

The organisational profile of the participating RSA managers outlines a professional group characterised by high levels of education, long-standing experience, and relative organisational stability. Descriptive statistics on the socio-professional characteristics of RSA managers are reported in Table 1.

Table 1. Socio-professional characteristics of RSA managers (N = 92)

Characteristic	**Value**
Women (%)	77.2
Mean age (years)	48.6
University degree or higher (%)	75.0
Mean years of experience in RSA	12.0
Managerial role with clinical background (%)	41.3

The predominance of women among managerial roles reflects broader gendered dynamics in care-related professions, while the average length of professional experience within the same facility suggests consolidated organisational cultures. These characteristics are relevant for interpreting subsequent evaluations of care quality, as they indicate that assessments are produced by actors who are deeply embedded within institutional routines and regulatory frameworks, rather than by transient or marginal figures.

Managers' evaluations of care quality reveal a consistently positive assessment across almost all examined dimensions. Mean evaluations of the main dimensions of care quality, as reported by RSA managers, are summarised in Table 2.

Table 2. Managers' evaluation of RSA quality (mean values, 1–10 scale)

Dimension	Mean
Courtesy and availability of staff	8.83
Quality of nursing care	8.79
Staff–resident relationships	8.74
Medical care	8.61
Quality of food services	8.32
Work shift organisation	8.00
Accessibility by public transport	7.40

In addition to the generally high evaluations reported above, a more detailed reading of managers' assessments highlights a clear internal differentiation among the examined dimensions of quality. Relational and clinical aspects of care consistently occupy the upper end of the scale, with courtesy and availability of staff, nursing care, and staff–resident relationships all scoring close to or above 8.7. These dimensions appear tightly clustered, suggesting a shared perception of strong performance in areas that are central to professional identity and daily care practices.

By contrast, infrastructural and organisational dimensions display systematically lower scores. Accessibility by public transport represents the weakest evaluated aspect, with a mean value more than one point lower than the highest-rated relational dimensions. Work shift organisation also receives a comparatively lower evaluation, although remaining within a generally positive range. The distance between these sets of indicators is non-trivial on a 1–10 scale and points to a structural rather than incidental differentiation in perceived quality.

This pattern suggests that while RSA managers express high confidence in domains that fall directly under professional control—such as care delivery, interpersonal relations,

and clinical practices—they also recognise limitations in areas that depend on broader organisational or territorial conditions. Accessibility and work organisation are, to a significant extent, shaped by external constraints, including urban infrastructure, transport networks, and labour market conditions, which may limit the capacity of individual facilities to intervene effectively.

Overall, the internal differentiation observed in managers' evaluations indicates that high aggregate quality scores coexist with specific and recognisable organisational limits, rather than reflecting a uniformly positive assessment across all dimensions of residential care.

Indicators related to interpersonal relations, such as staff courtesy, availability, and the quality of staff–resident relationships, receive particularly high scores, often approaching the upper end of the scale. Nursing care and medical care are also rated very positively, suggesting strong confidence in the clinical and professional dimensions of service provision. These findings indicate that, from an organisational standpoint, RSA are perceived as capable of delivering reliable, standardised, and professionally adequate care, in line with regulatory expectations and quality assurance mechanisms.

At the same time, the results also highlight specific areas in which evaluations are comparatively lower, though still positive overall. Accessibility by public transport emerges as the weakest dimension, followed by aspects related to work shift organisation. While these scores do not indicate critical deficiencies, they point to structural constraints that are not fully under organisational control and that may indirectly shape residents' experiences. Limited accessibility can restrict the frequency and ease of family visits, while work shift organisation may affect staff workload and continuity of care. These elements suggest that high-quality care is achieved within contexts characterised by ongoing organisational and structural pressures.

When shifting the analytical focus to residents' and family members' evaluations, a partially convergent yet distinct pattern emerges. Residents' and family members' evaluations of everyday life in RSA are reported in Table 3.

Table 3. Residents' and family members' evaluation of life in RSA (mean values, 1–10 scale)

Dimension	**Mean**
Cleanliness of facilities	7.6
Kindness and availability of staff	7.7
Nursing care	7.7
Medical care	7.3
Possibility of receiving visits	7.9
Recreational activities	7.0

Possibility of room personalisation	6.9
Overall evaluation of life in RSA	7.0

A closer examination of residents' and family members' evaluations reveals a clear internal hierarchy among the assessed dimensions of life in RSA. Care-related and material aspects consistently receive higher scores than dimensions associated with autonomy, personalisation, and meaningful engagement. Cleanliness of facilities, kindness and availability of staff, nursing care, and medical assistance all cluster around relatively high values, indicating that the core functions of residential care are widely perceived as satisfactory. These evaluations suggest that residents and families recognise the effectiveness of RSA in addressing health needs and ensuring acceptable living conditions.

By contrast, dimensions that refer more directly to residents' capacity to shape their everyday environment and routines display systematically lower scores. The possibility of personalising one's room and the evaluation of recreational activities both fall below the overall average of care-related indicators. Although these scores do not signal overt dissatisfaction, they point to a more constrained experience of institutional life, in which opportunities for self-expression and meaningful activity are limited. The consistent gap between care provision and autonomy-related dimensions suggests that residents' evaluations are not merely a reflection of service quality, but also of the extent to which institutional arrangements allow for individual agency.

The overall evaluation of life in RSA occupies an intermediate position within this hierarchy. Notably, this global assessment is closer to the lower-scoring dimensions related to autonomy and personalisation than to the higher-scoring care-related indicators. This pattern suggests that residents and family members weigh limitations in autonomy and everyday meaning more heavily than the positive aspects of care provision when forming an overall judgement of life in residential care. In other words, high-quality care appears necessary but not sufficient to produce a correspondingly high evaluation of overall quality of life.

This internal configuration of evaluations indicates that quality of life in RSA is shaped less by deficiencies in care delivery and more by the structural characteristics of institutional living. While residents acknowledge the presence of competent and supportive care, they also express, implicitly, the costs associated with living in a regulated environment. The hierarchy observed among evaluated dimensions thus reflects a distinction between being well cared for and living well, highlighting the central role of autonomy, personalisation, and meaningful activity in shaping subjective assessments of institutional life.

Respondents generally express satisfaction with material conditions and core care services. Cleanliness of facilities, kindness and availability of staff, nursing care, and medical assistance all receive mean evaluations that indicate a positive overall experience. In particular, the possibility of receiving visits from relatives and friends is evaluated very

favourably, underscoring the central role of maintaining social ties beyond the institution. This convergence between managers' and users' assessments with regard to care provision suggests that professional standards are not only formally implemented but also perceived and recognised by care recipients.

However, residents' and family members' evaluations diverge more clearly from managerial assessments when attention shifts from care provision to everyday life and personal experience within the institution. Indicators related to autonomy, personalisation, and meaningful activities systematically receive lower scores than those related to care quality. The possibility of personalising one's room and the availability and quality of recreational activities are among the weakest dimensions. While these evaluations remain above the midpoint of the scale, they point to a more constrained experience of institutional life, in which individual preferences and biographical continuity are only partially accommodated.

The overall evaluation of life in RSA stabilises around a moderate positive value, suggesting acceptance rather than strong satisfaction. This finding is particularly relevant, as it synthesises residents' and family members' perceptions across multiple dimensions. The absence of extremely negative evaluations indicates that institutional life is not experienced as overtly detrimental; however, the lack of high satisfaction suggests that residential care does not fully meet expectations related to autonomy, self-expression, and personal fulfilment. Quality of life in RSA thus appears as a negotiated and ambivalent condition, shaped by the balance between safety and constraint.

The analysis of admission pathways provides further insight into the context in which institutional life is experienced. The main reported reasons for admission to residential care are presented in Table 4.

Table 4. Main reasons for admission to RSA (family members' reports, %)

Reason for admission	**%**
Inability to provide care at home	70.0
Worsening health conditions	15.4
Lack of family network	8.6
Personal choice of the older person	6.0

While mean values provide a useful synthetic overview of residents' and family members' evaluations, they inevitably conceal a degree of variability in lived experiences of residential care. The distribution of responses across several dimensions suggests that institutional life is not experienced in a uniform manner, even within broadly similar organisational contexts. In particular, dimensions related to autonomy, personalisation, and

everyday meaning appear more heterogeneous than those associated with core care provision.

This variability can be partially inferred from the dispersion observed in evaluations of room personalisation, recreational activities, and overall quality of life. Unlike care-related indicators, which tend to cluster around relatively high values, autonomy-related dimensions display a wider range of assessments. This pattern indicates that while basic care needs are addressed in a relatively standardised way, residents' experiences of everyday life are more uneven and sensitive to individual circumstances.

Several empirical factors may contribute to this heterogeneity. Differences in health status and functional capacity are likely to shape residents' ability to participate in activities and to exercise autonomy within institutional routines. Similarly, the presence or absence of strong family support may influence how institutional life is perceived and evaluated. Residents who maintain frequent contact with relatives and friends may experience residential care as less isolating, whereas those with weaker external networks may rely more heavily on institutional resources for social interaction.

Adaptation processes also appear to play a role. For some residents, institutionalisation may represent a gradual adjustment to changing needs, while for others it may constitute an abrupt disruption of established routines. These different trajectories are reflected in how residents and family members evaluate opportunities for personalisation and engagement. The same institutional environment may thus be experienced as supportive by some and constraining by others, depending on prior expectations and coping strategies.

The observed variability underscores the limits of aggregate indicators in capturing the full range of experiences within residential care. While average evaluations point to generally adequate conditions, they mask significant differences in how residents negotiate institutional routines and construct a sense of everyday life. Recognising this heterogeneity is essential for interpreting quality-of-life assessments, as it highlights that moderate mean values do not imply uniform experiences, but rather the coexistence of relatively positive and more constrained forms of institutional living.

A large majority of respondents identify the inability to provide continuous care at home as the primary reason for admission to RSA. Other motivations, such as personal choice or proactive planning, are comparatively marginal. This pattern clearly positions institutionalisation as a necessity-driven transition, activated when informal caregiving resources are exhausted rather than as part of a planned care trajectory. Admission to residential care thus tends to occur late, often following cumulative health deterioration and caregiver strain.

This late and reactive nature of institutionalisation is crucial for understanding subsequent evaluations of quality of life. When admission is perceived as unavoidable, residents and family members may approach institutional life with lowered expectations and a sense of resignation. In this context, even high-quality care may be evaluated positively without translating into high levels of subjective well-being. The moderate

overall evaluations of life in RSA can therefore be interpreted not as a reflection of poor care, but as an expression of the symbolic and biographical weight associated with institutionalisation.

A comparative reading of organisational and experiential data highlights both convergence and divergence across perspectives. Convergence is most evident in the consistently positive evaluation of care quality, especially with regard to nursing care, medical assistance, and staff relationships. Divergence emerges more clearly when attention shifts to everyday life within the institution, where autonomy, personalisation, and meaningful activities receive lower evaluations. The analysis of admission pathways further contextualises these findings, showing that entry into RSA is predominantly necessity-driven and linked to the breakdown of home-based care. Taken together, these results identify three core empirical patterns: high perceived quality of professional care, more ambivalent evaluations of quality of life, and a predominantly late and reactive transition into residential care. These patterns provide the empirical basis for the sociological discussion that follows.

4. Discussion

Building on the empirical evidence presented above, this discussion interprets institutionalised caregiving in Italian Residential Health Care Facilities (RSA) through the combined lenses of welfare regime analysis and life-course theory. The findings suggest that the central issue is not a simple deficit in care provision, since professional standards are widely recognised across respondent groups, but rather a structural disconnection between organisational effectiveness and lived well-being. In other words, the study shows that being well cared for does not automatically coincide with living well in institutional settings.

This distinction between quality of care and quality of life represents the article's main analytical contribution. The data indicate that residential facilities are generally effective in delivering clinical support, basic protection, and orderly care routines, yet less able to sustain autonomy, personalisation, and biographical continuity in everyday life. This gap should not be read as a contingent failure of individual facilities alone. Rather, it reflects a broader institutional tension: the same organisational logics that ensure safety, standardisation, and professional reliability may also reduce residents' control over time, space, and self-definition.

From this perspective, institutionalisation is best understood not simply as an organisational arrangement, but as a biographical turning point. Entry into RSA tends to occur late, when home-based care has become unsustainable, and is therefore embedded in cumulative processes of health decline, caregiving strain, and family reorganisation. This temporal sequencing is sociologically important because it helps explain why overall evaluations of residential life remain more ambivalent than evaluations of care provision itself. Institutional care is often entered under conditions of necessity rather than choice, and this shapes both expectations and lived experience.

Residents' and family members' evaluations further illuminate this tension. While care provision is widely recognised and valued, everyday life within residential facilities is experienced in more ambivalent terms. Autonomy-related dimensions consistently emerge as more fragile, indicating that institutional living entails a reconfiguration of control over space, time, and daily routines. This reconfiguration does not necessarily result in overt dissatisfaction, but it reshapes expectations and frames institutional life as a condition of constrained agency (Peace et al. 2007; Mol, Moser and Pols 2010). In this sense, quality of life in residential care appears as a negotiated outcome between protection and limitation, rather than as a straightforward reflection of service quality.

A life-course perspective provides a key interpretative lens for understanding these dynamics. Institutionalisation does not represent a discrete or isolated event, but rather the culmination of cumulative processes unfolding over time, including health deterioration, changes in family structures, and the progressive intensification of care needs (Elder 1994; Mayer 2009). The predominance of necessity-driven admissions suggests that entry into residential care is typically delayed until informal caregiving arrangements become unsustainable, a pattern widely observed in familistic welfare regimes (Saraceno 2016; Naldini and Jurado 2013).

The timing of this transition has important implications for how residential life is perceived and evaluated. Entering an institution at an advanced stage of frailty may reduce opportunities for adaptation and engagement, reinforcing perceptions of dependency and biographical disruption (Settersten 2003; Phillipson 2013). From this standpoint, moderate evaluations of quality of life should not be interpreted as evidence of inadequate care, but as reflections of the biographical context in which institutionalisation occurs. Residential care thus marks a turning point in later-life trajectories, redefining social roles, identities, and expectations (Elder and Shanahan 2006).

These findings must also be situated within the specific configuration of the Italian welfare regime. In Southern European contexts, care responsibilities are predominantly assigned to families, and institutional solutions retain a residual status (Ferrera 1996; Saraceno, 2016). RSA tend to be activated only when family-based care can no longer be sustained, reinforcing their symbolic association with dependency and end-of-life transitions. This residual positioning shapes both expectations and experiences of residential care, contributing to the ambivalence observed in quality-of-life evaluations.

The Italian case is particularly instructive because it shows that welfare regimes shape not only the distribution of care responsibilities, but also the symbolic meaning of institutional care. In a familistic system, residential admission is easily framed as a residual and morally charged solution, associated with failure, urgency, or the exhaustion of family obligation. This helps explain why even relatively positive evaluations of care may coexist with more cautious assessments of overall quality of life. The issue, therefore, is not only what institutions do, but when they enter older people's trajectories and under what social and cultural conditions they become thinkable or acceptable options.

From a sociological perspective, the Italian case illustrates how welfare regimes influence not only the organisation of care, but also its subjective meaning. The residual framing of residential care amplifies the biographical disruption associated with institutionalisation, even when care quality is high (Daly 2011). This suggests that improving quality of life in residential settings requires more than organisational reforms; it calls for a reconfiguration of care trajectories that integrates institutional solutions earlier and more gradually within the life course (Leisering 2003).

The heterogeneity observed in residents' experiences further underscores the importance of moving beyond aggregate indicators. While institutional environments impose common constraints, individuals negotiate these constraints differently depending on personal resources, family support, and prior experiences (Grenier 2012). This variability highlights the limits of standardised approaches to quality of life and points to the need for more flexible and person-centred practices within residential care.

For social work practice, these findings emphasise the importance of mediating between institutional requirements and individual biographies. Supporting residents' agency, facilitating meaningful routines, and preserving continuity with past identities emerge as critical challenges for practitioners operating within highly regulated environments (Healy 2005; Payne 2020). Social work thus plays a key role in mitigating the biographical costs of institutionalisation, even when structural constraints cannot be fully overcome.

In sum, the discussion highlights that the core challenge of residential care lies not in the delivery of professional care, but in reconciling institutional effectiveness with lived well-being. The empirical distinction between quality of care and quality of life reflects a deeper structural tension inherent in institutionalised caregiving, shaped by welfare regimes, organisational logics, and life-course trajectories. Addressing this tension requires rethinking residential care not as a terminal solution, but as one element within a broader continuum of ageing and care (Phillipson 2013; Walker 2018).

5. Conclusions

This article has examined the institutionalisation of caregiving in Italian Residential Health Care Facilities by combining descriptive quantitative evidence with a sociological interpretation grounded in welfare regime analysis and life-course theory. Drawing on data from organisational actors, residents and family members, the study contributes to ongoing debates on ageing, long-term care and quality of life by highlighting a structural distinction between the effectiveness of professional care and the lived experience of institutional life.

The findings confirm that Italian RSA are generally successful in delivering high-quality professional care, particularly with regard to nursing, medical assistance and interpersonal relations. These dimensions are widely recognised across respondent groups, indicating a shared perception of institutional competence and reliability. At the same time, the analysis shows that quality of life in residential care remains more fragile and ambivalent, especially in relation to autonomy, personalisation and meaningful everyday engagement. This gap between quality of care and quality of life should not be interpreted

as a managerial or organisational failure, but as an expression of deeper structural tensions inherent in institutionalised forms of caregiving (Kane 2001; Bowling 2005).

A central contribution of the study lies in its life-course-oriented interpretation of institutionalisation. Residential care emerges not as a neutral or isolated change of residence, but as a late-stage transition shaped by cumulative processes of health deterioration, family dynamics and caregiving strain (Elder 1994; Mayer 2009). The predominance of necessity-driven admissions indicates that institutionalisation is typically delayed until informal caregiving arrangements become unsustainable, positioning RSA as residual solutions within the Italian long-term care system. This timing profoundly shapes how residential life is experienced and evaluated, reinforcing perceptions of loss, dependency and biographical disruption (Settersten 2003; Phillipson 2013).

Situating these findings within the broader context of the Italian welfare regime further clarifies their significance. In familistic systems, care responsibilities are primarily assigned to families, while institutional solutions retain a marginal and often stigmatised status (Ferrera, 1996; Saraceno, 2016). As a result, residential care is rarely integrated into ageing trajectories as a legitimate or desirable option but is instead framed as a last resort. This cultural and institutional framing amplifies the symbolic weight of institutionalisation and contributes to the moderate quality-of-life evaluations observed in the study, even in the presence of high-quality care provision (Daly 2011).

From a policy perspective, the findings suggest that improving quality of life in residential care requires more than incremental organisational reforms. While investments in staffing, training and service quality remain essential, they are insufficient on their own to address the biographical and relational dimensions of institutional life. A more fundamental rethinking of long-term care trajectories is needed, one that integrates residential solutions earlier and more gradually within the life course, rather than concentrating them at the very end of ageing trajectories (Leisering 2003; Walker 2018). Such an approach may reduce the disruptive character of institutionalisation and enhance residents' capacity for adaptation and engagement.

For social work practice, the study underscores the importance of mediating between institutional constraints and individual biographies. Social workers operating in residential settings play a crucial role in supporting residents' agency, fostering meaningful routines, and maintaining continuity with past identities and social roles (Healy 2005; Payne 2020). By addressing not only care needs but also the social and symbolic dimensions of ageing, social work can help mitigate the biographical costs associated with institutionalisation.

These conclusions should be read in light of some limitations. The study is cross-sectional and primarily descriptive, and it relies on a non-probabilistic sample of facilities and respondents. In addition, the direct resident sample includes only cognitively preserved older people, which necessarily limits the representativeness of subjective evaluations of residential life. The inclusion of three regions strengthens the analytical breadth of the study, but the present article does not develop a systematic regional comparison. Future research should therefore extend this line of inquiry through larger samples, longitudinal designs, and more explicit territorial comparison.

Future research should further explore how welfare regimes, institutional arrangements, and life-course trajectories interact in shaping experiences of residential care. Comparative analyses across national and regional contexts, together with longitudinal approaches, would help clarify how institutionalisation is embedded in broader patterns of social inequality, cumulative disadvantage, and differential access to care resources. Addressing the challenges of ageing societies requires not only effective care services, but

also welfare systems capable of supporting autonomy, participation, and continuity of life throughout later life.

Authors' Contributions

PC was involved in the conception and design of the study, coordination of the research activities, data analysis and interpretation, and drafting of the manuscript. RR was involved in the research design, data collection and interpretation, and critical revision of the manuscript. Both authors were involved in approving the final version of the manuscript.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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Received: 19 February 2026 / **Revised:** 14 April 2026 / **Accepted:** 19 April 2026