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Chapter 4

ITALY AND THE AGING SOCIETY: OVERVIEW OF DEMOGRAPHIC TRENDS AND FORMAL/INFORMAL RESOURCES FOR THE CARE OF OLDER PEOPLE

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ABSTRACT

Population aging is a challenge for human societies. In the European context, Italy appears to be the "oldest country", as evidenced by all of the main demographic indicators of population, which have experienced a growing trend of the oldest age groups since the 1970s. The current state of the Italian population is the result of a development process similar to that now occurring in other European countries and took place earlier in relation to contextual events of the country. After presenting and discussing the characteristics of aging in Italy, the chapter will address the issue of assistance and care for the elderly through two insights: the first will cover a deepening of the welfare system in Italy, with an overview of health and care services for the older population; the second will concern the topic of informal resources generated through personal relationships. This subject will be discussed using data gathered from a survey on a sample of older Italian people.

INTRODUCTION

The unrestrainable aging of the population is changing the Italian society in depth because the percentage proportion of the elderly primarily affects the dimensions of needs and resources that should be devoted to them. The forecast of rising costs for health and social care due to longevity is behind the currently prevailing doubts about the ability to

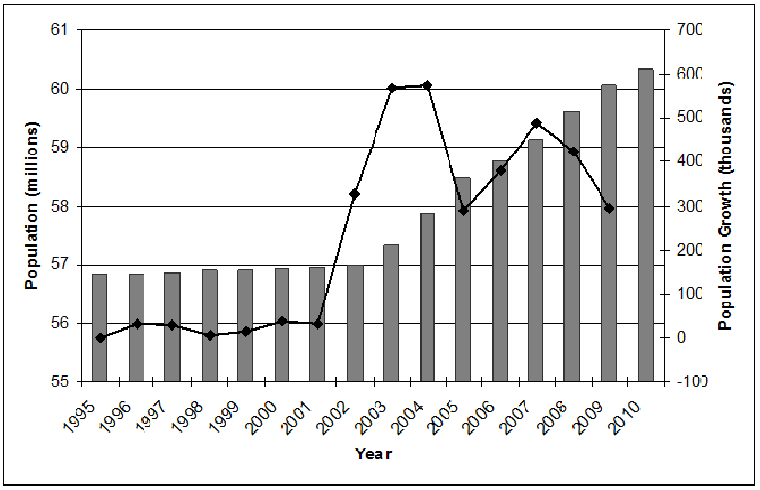
sustain the quality and quantity of the health supply. First, it is important to be reminded that Italy has a public system of healthcare with private participation. This type of organization is one of the pillars of the Italian welfare state and has its legal bases in the healthcare reform law No 833/1978. This law assigns to the State all the competences to ensure the equality of citizens to receive health care services. One of the prominent aims of this law concerns assistance for older people, defining it in terms of prevention, treatment and rehabilitation. The National Law 328/2000 for the reform of social services and integration of social and health services, aimed at promoting home care for keeping older people in the place where they were used to live, wherever possible. In 2001, a national plan of interventions and social services was indeed presented, with the objective to support dependent and disabled people through home services, thus valorizing family responsibilities. With regard to health organization, article 117 of the Italian Constitution leaves it entirely to Regions, which are the first-level subnational entities of the Italian state. Regions are in charge of directing policies, providing support and developing the supply of care services. Health services provided by the National Health Service are free of charge for people with minimum income and aged over 65, otherwise a ticket for co-payment is requested. During the last decade, some mechanisms to reduce waste and to achieve a greater integration between health and social services have been introduced. Currently, the expected rising healthcare expenditure has created a financial alarm. In the health sector, the existent supply of social and healthcare services for older people will face the growing number of those aged over 65 years in need of formal and informal care, as well as social and health assistance, for increasing periods of time. Starting from the existing context, new solutions have to be found. Recently, the White Paper on the future of the Italian social model, "The good life in an active society" [1], drew the perspective of the new welfare system, arguing that demographic change is the most relevant factor that will redirect the characteristics of the Italian Welfare. Society is changing and the country wonders about the possible equilibrium and economic compatibility to redevelop a modern welfare system. Current state and trends of the Italian population are therefore a starting point for understanding future prospects of the Italian society.

1. THE ITALIAN POPULATION SCENARIO

With a population of 60,626,442 at 1 January 2011 according to ISTAT (Italian National Institute of Statistics) [2], Italy is the fourth country of the European Union by population (after Germany, France and the UK) and 23rd in the world. Italian population growth has been stagnating between 1981 and 2001 (zero growth), then a moderate population increase started in the first decade of the third millennium, mainly due to the migration flow, being the natural balance of the population slightly above 0 [3].

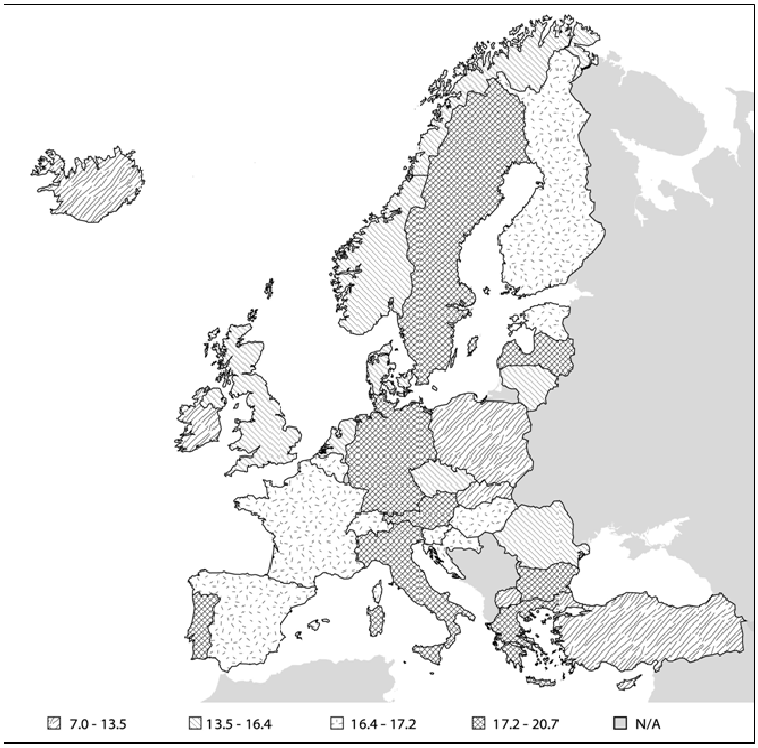
The almost three million more Italians registered in the period 2001-2011 were young immigrants who have contributed in this way to slow down the aging of the Italian population. The migratory wave was constantly increasing and foreign-born residents rose to 7.1% of the total Italian population in 2010 [2]. However, the Italian population is aging quickly. People aged 65 and over increased 113,000 units in 2010 and now represent 1/5 of the population [2]. The population aging was particularly rapid in the last decades: the aging index rose from 68.1% in 1971 to 80.4% in 1981 and to 129.3% in 2001. In 2010, it was

144.0% [1] a value which is well above the European average of 108,6%, just after Germany (150.2%) [4].



Source: our calculation on ISTAT database 2011: http://demo.istat.it/.

Figure 1.1. Italian population growth, 1995-2010.



Source: Eurostat, Demography: http://epp.eurostat.ec.europa.eu/portal/ page/portal/eurostat/home/.

Figure 1.2. Population aged 65 years and over on total population in Europe.

The negative natural population growth which occurred since the 1990's accelerated the Italian aging process in comparison with the European trend. In fact, the average birth rate per woman was 1.22 children in 1995, the lowest in the world. Concurrently, life expectancy (the average number of years a person can expect to live at the time of her/his birth) increased sharply of 2.4 years on average from 1981 to 1991, reaching 73.4 years for men and 80.2 for women [4]. This trend caused the rapid aging of the Italian population, which, for years, has been the oldest country in the world. Nowadays, life expectancy at birth is of 78.6 years for men and 84.0 for women (last data available in 2008). These values put the country in the third position in the European Union both for men, after Sweden (79.1) and Spain (78.9) and women, after Spain (85.0) and France (84.3) [4].

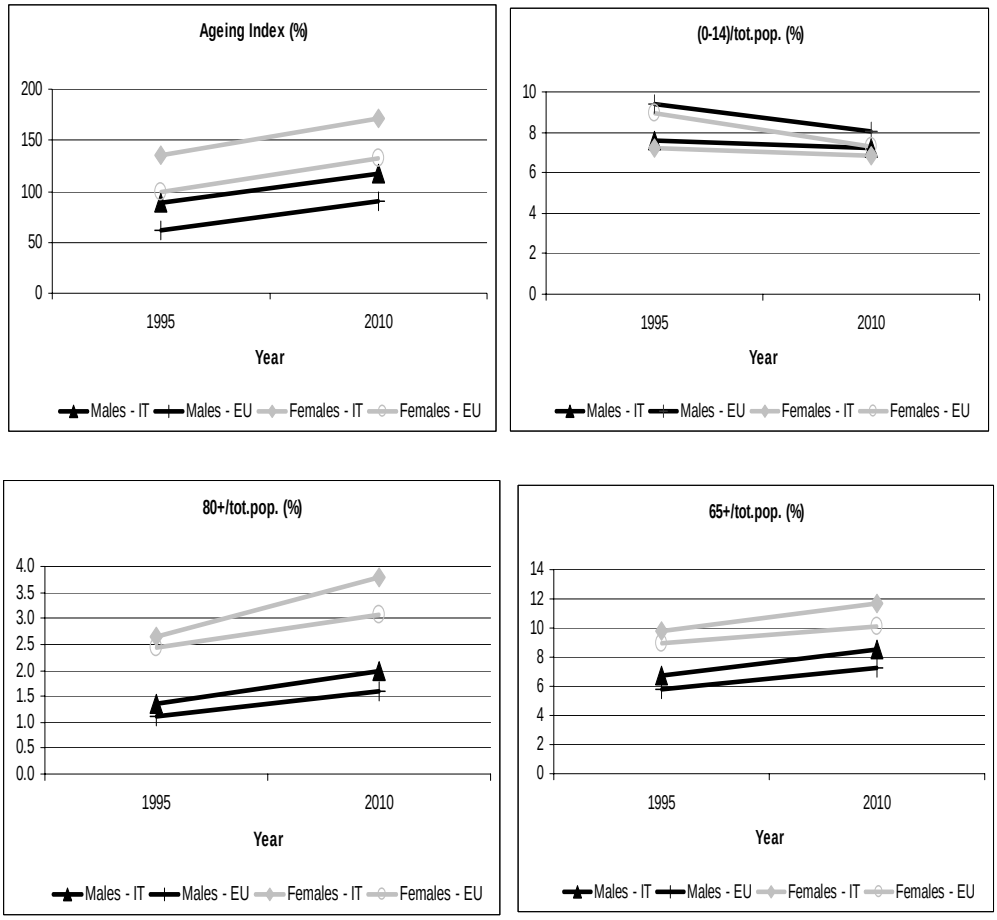
Higher female life expectancy is correlated to a strong rate of older/younger women, equal to 172% in 2010; consequently, the proportion of women in the older generation increases with age: to current data, on 12,206,470 older people aged over 65 years, 7,067,935 are females and 5,138,535 males [2].

Italy has one of the lowest birth rates in the world, that was 9.3% in 2010, with 1.41 children born/woman [2], a fertility rate showing a slight increase with respect to the 1990's, but lower than EU27 (1.6) [5], and lower than the replacement fertility rate which is roughly 2.1 births per woman for industrialized countries. Recent studies attributed this increase to both an increment of the fertility rate of women aged over 30 (a recovery of the so-called postponement of motherhood, one of the most important trend in fertility behavior in Europe) [6], and to the higher fertility rate of immigrant women, which in 2008 was 2.3 [7]. However, according to the latest ISTAT data, in 2010, young people aged up to 14 years were 53,000 more than the previous year and represented 14% of the total population [2].

The age pyramid represents the distribution of the Italian population by gender in 2010. The figure is rhomboid or top-shaped with a heavy erosion at the base, typical of developed countries.

The most numerous groups are those born during the post-war baby boom, which lasted about twenty years between the 1950s and 1970s. With respect to the EU27, Italian distribution shows a lower proportion of younger people up to 14 years, (respectively, 14% vs. 15.6%) and a higher one of those aged over 65 years (respectively, 20.1% vs. 17.2%) [2, 4]. The demographic trend of recent years shows that the Italian population is in a steady decline, resulting in alarming scenarios for the operation of the welfare state, especially in relation to the collapse of the pension system. Recently, analysts hypothesized that immigration could be a viable option to counterbalance Europe's labor market and welfare state problems. For instance, in Italy, recent estimations indicate that constant migration flows could lead to a renewal of the Italian population.

In demographic terms, this could be possible with an annual entry of about 300,000 units for the next 20 years, allowing people in working age (20-59 years) to remain stable, approximately 3 million and a half units recorded in 2008. According to these estimates, this would allow to cope with the baby boomers' transit into the over 60 years group [8]. This prospect seems to be common to the EU27 as a whole, for which it is expected that immigration will tend to renew the population, since those who come in are usually of working age. However, the change in demographic structure, characterized by an increasing proportion of older people, will inevitably produce a series of changes in the needs of the population on the one hand and a need to review social policies on the other. Essential to understand needs and appropriate responses, is to get a stratified picture of older people.



Source : our calculation on EUROSTAT database, 2011.: http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database.

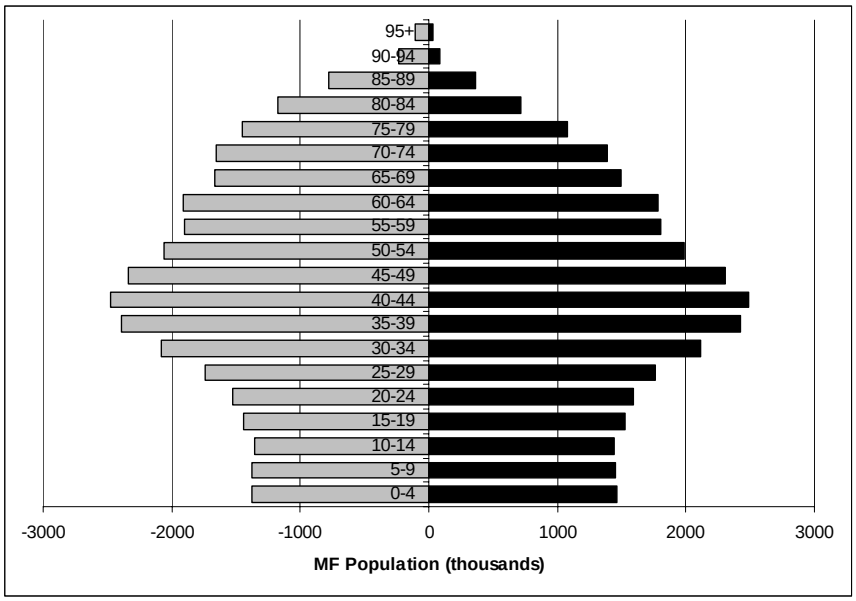
Figures 1.3 to 1.6 - Aging Index and proportion of population aged 0-14, 80+ e 65+ years on total population in Italy and Europe at 1995.

Within the elderly category, different age thresholds can be distinguished to discriminate subgroups. The main age grouping is the one which distinguishes between third and fourth age, which is generally attributed to the threshold of 75 years.

The two groups are considered to have different lifestyles, needs and expectations. Another discriminating variable is the state of health, which is closely interconnected with age. In this context, the increase in the number of disabled people is definitely the most important phenomenon accompanying the increase in life expectancy.

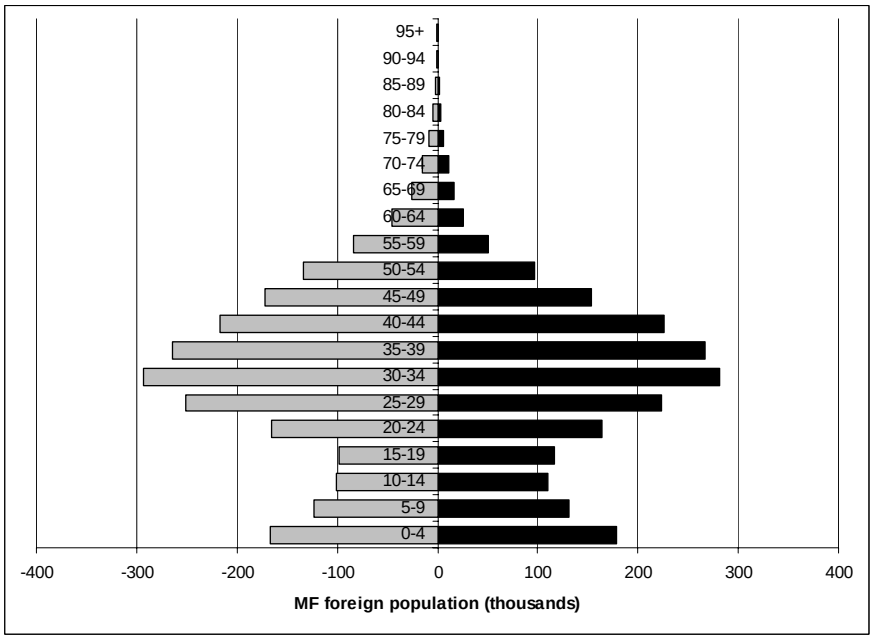
In fact, starting at about 75-80 years, the risk of disability increases steeply [9]. Giving a measure of the disabled population is not simple, since this dimension is characterized by a number of factors (physical, social, environmental) involved in [9].

In Italy, ISTAT provides an estimate of the disabled population by referring to ICDH (International Classification of Disease, Disability and Handicap), the assessment tool developed by the World Health Organization, in order to standardize the detection of disability in different countries [10].



Source: our calculation on ISTAT database 2011: http://demo.istat.it/.

Figure 1.7. Italian age pyramid.



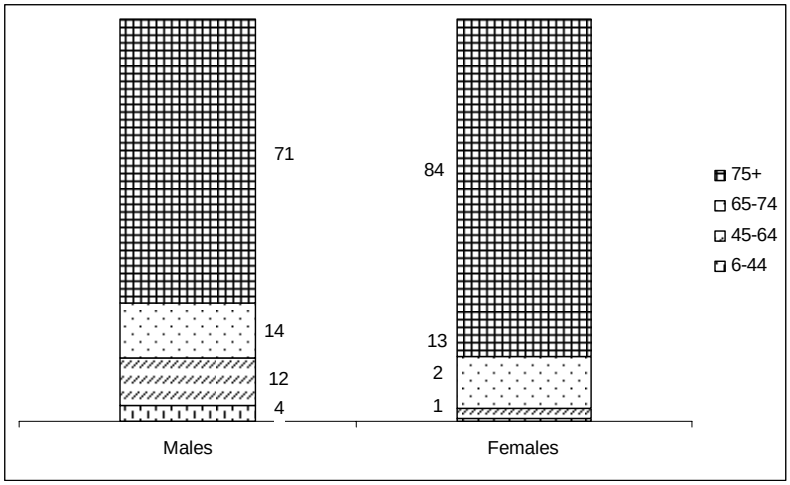
Source: our calculation on ISTAT database 2011: http://demo.istat.it/.

Figure 1.8. Foreign residents age pyramid.

People with disabilities are considered those who declared themselves not able to perform usual functions of daily living, excluding conditions related to temporary limitations, while

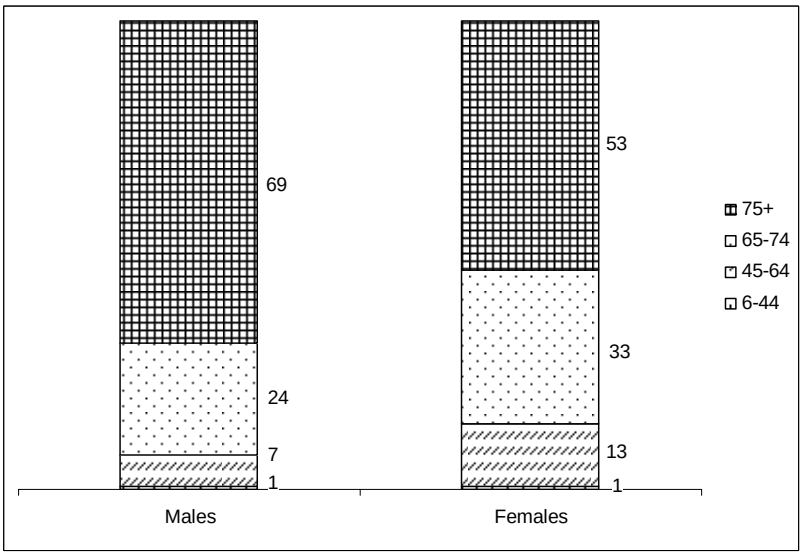
taking into account the use of medical devices (prosthesis, canes, glasses, etc..). Available data is referred to 2005. The disabled population aged over 65 years living at home was about 2,609,000 units equal to 4.8% of the elderly population.

This figure, however, is generally divided into different age groups, as prevalence of disability grows together with age. Disaggregated data shows a proportion of 17.8% in the 75-79 age group which rises to 44.5% in the 80 and over age group [10].



Source: our calculation on ISTAT database: http://www.istat.it/dati/ dataset/20080131_00/.

Figure 1.9. Disabled people living alone by gender and age group, 2004-2005 (%).



Source: our calculation on ISTAT database: http://www.istat.it/dati/ dataset/20080131_00/.

Figure 1.10. Disabled people living as a couple without children by gender and age group, 2004-2005 (%).

However, older people can experience intermediate stages of disability status, leading to a variety of individual situations. This leads to a differentiation of needs that may range, for example, from the need of some daily help at home to a total dependence of the person from the outside. For this reason, the state of health is intertwined with the need of social care and the provision of health and social services [9]. With regard to living conditions, there has been a progressive increase in families made of the older couple or single older people, mostly unmarried women or widows (by virtue of their longer life expectancy).

In contrast, only 3% live in institutions [11]. This gives rise to many problems that involve not only the older population, but also social and health services, as elderly require, at the time of their loss of independence, social and health assistance.

Nevertheless, Italy, as withother Mediterranean Countries, shows a very high proportion of proximity to children. In fact, the proportion of parents and children who live within 25 km is among the highest in Europe, equal to about 80%, furthermore, approximately 40% of children say they meet their parents every day [12].

2. HEALTH AND SOCIAL CARE SERVICES FOR OLDER PEOPLE IN ITALY

2.1. Introduction

Generally speaking, when we talk about health and social services for older people, including cash benefits, we refer to Long-Term Care (LTC), defined as services, both social and medical, required by people with a reduced physical or cognitive capacity, and who are so dependent for a long period of time on help with basic and instrumental activities of daily living (ADL and IADL). LTC may be provided to people with functional restrictions who stay at home and also in institutions or residential care facilities (other than hospitals) [13]. On the whole (Table 2.1), the National Health Service (SSN) and Regions are responsible for planning and managing health services (at home and in residential settings) through Local Health Authorities (ASL), whereas Municipalities, under the control of Regions, are responsible for managing personal-domestic social services (provided at home and in institutions), mainly in kind.

Table 2.1. Main public LTC for older people

Service	Main public actors
Home and residential health services	National Health Service (SSN) Regions Local Health Authorities (ASL)
Home and residential personal-domestic services	Municipalities, under the control of Regions
Attendance allowance	State, through the National Institute of Social Security
Local care allowances	Regions through ASL, Municipalities

The State, through the National Institute of Social Security (INPS), provides and funds the attendance allowance to disabled persons, independently from their economic conditions. Other cash benefits, such as local care allowances, are provided by some Regions and Municipalities [14]. In this paragraph on services for older people, we refer to public LTC as three main kinds of formal assistance – home care or community services, residential-institutional care, various monetary transfers or cash benefits - including semi-residential or day care centers and migrant care workers employed in Italian households as private paid assistants (the so-called "badanti").

2.2. Home Care

When we talk about home care in Italy, we must refer to the figure of General Practitioner (GP), an independent professional working by contract for Local Health Authorities and responsible for primary healthcare.

The GP is considered the most important reference point both by older people and by their relatives. With specific regard to home care, the GP:

- provides *Programmed Home Care Assistance* (ADP - Assistenza Domiciliare programmata), medical home care through regular home visits to patients who are unable to go to their GP's studios . The authorization of the SNN and the ASL is required [15];
- is responsible for the *Home Hospitalization Service* (OD - Ospedalizzazione Domiciliare), that is the activation, at the patient's home, of some diagnostic and therapeutic services which are provided by ASLs and hospitals [16].
- has also the responsibility of the care process in the *Integrated Home Care* (ADI - Assistenza Domiciliare Integrata). This particular home care service is funded by the public sector - SSN through Regions and ASLs - and includes both health home care (rehabilitation, nursing, medical visits) and home help (social care). ASLs are competent for the whole service and Municipalities are responsible for the social home care [14, 17].

With regard to *Home Care Services* (SAD - Servizio di Assistenza Domiciliare), as home help or personal care (help in housework, shopping, hygiene, dressing, eating etc..), and meals-on-wheels, are provided by Municipalities through their social services. The activation of these services may be solicited by GPs, but also by the older person, relatives, social services, voluntary groups [17].

According to the official data available on home care (Table 2.2), users are on the whole only the 5.0% of older people aged 65 years and more in late 2000s - from the 3.8% in early 2000s and 2% in early 1990s - and this increase is mainly due to ADI (from 2.0% to 3.3% in the same period), whereas users receiving SAD have substantially remained the same in the last decade. Older people aged over 75 years, with a severe physical and cognitive disability, are the great part of home care users and, with regard to ADI, they are the 2/3 of the patients. With regard to SAD, the diffusion in the territory is low and so the support for the most complex cases remain marginal [11].

Table 2.2. Older people by type of home care received – evolution over time (% of people aged 65 and over)

	Early 1990s	Early 2000s	Late 2000s
Home care	2.0	3.8	5.0
ADI	*(no available data)*	2.0	3.3
SAD	*(no available data)*	1.8	1.7

Source: various official data available in NNA Report 2010 and 2009 [11, 18].

Moreover, ISTAT (Italian National Institute of Statistics) calculates that the yearly average amount spent for one treated case (in 2005) is about 800 Euros with regard to ADI (about 24 hours/year) and 1,700 Euros with regard to SAD (for which there aren't data on intensity of the service as number of hours provided for each user) [19].

2.3. Residential Care

In Italy, there are three main different kinds of residential/institutional services [17, 18]:

- *Nursing Homes* (RA - Residenze Assistenziali) with permanent and continuative nature, mainly "hotel treatment", supply of various care-social services, above all for independent older people, aiming at promoting social integration through leisure and cultural activities;
- *Protected Homes and Community-Based Settings* (RS - Residenze Socio-Sanitarie), facilities principally designed for dependent older people, with specialized medical and nursing staff. The performance supplied is highly integrated in its social and health aspects, aimed to recover as much as possible the cognitive and physical capabilities of the residents;
- *Social Health Residential Structures* (RSA - Residenze Sanitarie Assistenziali), for dependent older people or people with disabilities who require special care and support of medical, nursing and rehabilitation services. The assistance provided includes an average level of health care, integrated with a high level of social care.

Regions have the authority to organize and finance their Residential care structures, with Healthcare system financing part of the costs, and users contributing with co-payments. Municipalities provide the "social" part of residential care. With regard to the total average cost (2,260 Euros/month in 2004), 43.6% of it (983 Euros) is covered by the SSN, 9.4% (212 Euros) by Municipalities, and 47.1% (1,065 Euros) by users. It is to highlight that the part covered by users ranges from 39.6% in RSA to 60.8% in RA [14, 18]. According to the official data available on Residential care institutions over time (Table 2.3), overall about 3% of Italian older people live in them, and this percentage has remained the same in the last decade. With regard to the different typologies, in the period 2001-2005 [18], elderly patients in RSA increased from 98,940 to 132,052, whereas those housed in RA decreased from 98,565 to 84,040. In 2005, older people housed in residential facilities have found placement in RSA in a proportion of 38.3%, 33.1% in RS, and 24.3% in RA (4.3% in other structures).

Table 2.3. Older people and beds in institution – evolution over time (% of people aged 65 and over)

	Early 1990s	Early 2000s	Late 2000s (end 2005)
Patients	2.9	3	3

Source: various official data available in NNA Report 2010 and 2009 [11, 18].

In this way, RA is no longer the principal residential facility and it is replaced by RSA for dependent individuals.

In the context of formal residential services for older people, the institution of *Day-Care Centers* (CD - Centri Diurni), integrated in different kinds of communitysettings, should be mentioned also. Indeed, although these are semi-residential socio-sanitary structures, they address the same target of older users, i.e. completely or partially disabled older people which are transported there during daylight hours, to be cared for and to receive a series of medical and social support, such as rehabilitation and recreational services, personal care, hygiene and meals services [17]. These services are organized jointly by Regions and Municipalities, and allow the possibility to maintain older people at home, and they also give support and relief to families from caregiving tasks [15]. The CD have had a fairly spread in recent years, but on the whole, there is a scarcity of available seats, between 1.02 and 1.29 per 1000 older people. [18]. ISTAT estimates that on the whole, 125.,00 older Italians use these semi-residential units, and an average yearly amount spent for each user is 500 Euros [19].

2.4. Monetary Transfers

As already highlighted, in Italy, the availability of formal home care is very low, like the percentage of older people in institutions. In our Country, with a mainly cash-oriented care system, support measures and services for dependent elderly consist of extensive distribution of cash handouts as monetary transfers or cash benefits delivered both at national level (attendance allowance) and at local - regional and municipal - level (voucher, care allowance).

In particular, the *Socio-Sanitary Voucher* (Buono Acquisto) is an economic means-tested provision in the form of a "purchase title", supplied by the Regions through the ASLs, to assist dependent users, and it can only be used to purchase specific services - integrated socio-medical home care - provided by public or private professional caregivers authorized (accredited) by the public authority [17, 20]. Actually, this organizational model, not based on the traditional direct provision of services, has been largely implemented in the Lombardy Region, where in 2008, 19,073 people (not only elderly) have been supported with socio-sanitary vouchers ranging about from 300 to 600 Euros/month [11].

The *Local Care Allowances* (Assegni di cura) are basically a financial contribution - means and needs-tested - to be freely spent by the user for assistance and provided to older people (or their families) to pay for the assistance [17]. They are financed and managed by Regions (through ASL) and Municipalities for highly dependent older people with low financial resources. This contribution is intended to act as economic acknowledgement of the care offered to the elderly by a family or by a social support network. Cash instead of care is

so the innovative aspect of this local care allowance, that in 2006-2007 ranged from 300-500 Euros/month [21], with ISTAT data indicating that in 2005, about 0.5% of the elderly received care allowances by the Municipalities [19, 18].

Table 2.4. Older people receiving National Attendance Allowance - evolution over time. (% of people aged 65 and over)

	Early 1990s	Early 2000s	Late 2000s (1.1.2008)
Users	5.0	5.5	9.5
*Aged 65-79**	*(not available data)*	4.5	7.4
*Aged 80+**	*(not available data)*	16.1	23.8

Source: various official data available in NNA Report 2010 and 2009 [11, 18]

* People aged 65-79 and 80+ receiving the National Attendance Allowance as % of the respective age groups in the total elderly population.

Besides local allowances, and among Italian financial provisions administered by the State through the National Institute of Social Security (INPS - Istituto Nazionale di Previdenza Sociale) [15], the *National Attendance Allowance* (Indennità di accompagnamento) is actually the most spread form of care benefit in our Country [14]. It is distributed as a set amount, independently of age, income and household composition, to the completely disabled population who cannot walk without help or who are unable to perform the routine actions of daily life, thus requiring continuous assistance [17, 18]. The amount for 2011 is 487.39 Euros/month for 12 months, increasing up to 807.35 Euros in case of blindness [22]. The vast majority of users (3 out of 4) is aged and mainly spends the revenue to pay for private care. The percentage of older people (aged 65 years and over) receiving it has regularly increased from 5.0% in early 1990s, to 5.5% in early 2000s (6% in 2002) and to 9.5% in late 2000s (i.e.2008) (Table 2.4). In particular, in 2008, about 24% of people aged over 80 has benefited from it, compared to 7.4% of the age group 65-79 [18, 23].

2.5. Migrant Care Workers: The So-Called "Badanti"

Italian families caring for their older relatives, have also found help in the support provided by foreign labor, made available thanks to the increasing globalization, including the shortage of indigenous caregivers [11, 24].

The following factors have then facilitated this trend: the low availability of the solutions provided by the system of formal (publicly funded) home care services; the possibility to have mainly cash benefits to pay these assistants, due to the traditional preference of the Italian welfare system for care payments, rather than for the provision of in-kind care services; the rising female labor-market participation reducing the potential availability of female carers, who are traditionally the main people responsible for informal care in Italy. The Italian National Attendance Allowance is indeed often used to receive privately paid care at home (the so called "*Badanti*"), by employing *migrant care workers*, often on a live-in basis (i.e. assistants co-residents with the cared-for person) who work (in 2005-2008) in about the 7% of households with older people aged 65 years and over [18].

In 2009, CENSIS estimated, in Italy, of about 1.5 million of personal carers at home (private paid home assistants as colf and "badanti"), 72% were immigrants [25]. These foreign caregivers, mainly women, come in great part from Eastern Europe (Ukraine, Romania, Poland) but also from South America (Ecuador, Peru) and the Philippines, and often work in a "black" irregular market [24]. These figures are so very important in the Italian context, due to the possibility of coexistence of the family assistant with the older person as a crucial resource in the most severe cases requiring continuous surveillance, and also for the possibility to delay or avoid the admission of the elderly to facilities residential structures [26, 27].

3. SOCIAL SUPPORT NETWORK OF A SAMPLE OF ITALIAN OLDER PEOPLE

A great resource for older people with health problems is made up of people close to them or otherwise available, on which the elderly can rely for support and in particular, to face any uneasiness resulting from health problems. However, not all seniors can have an equal measure of that resource [28]. To assess more precisely this aspect, we explored the network of social support of a sample of Italian older people in relation to their perceived health status. The analysis was conducted on a sample of 600 older people using the database of the European Project MOBILATE developed in 2000 and financed by the European Commission (Project QLRT –1999-02236). The sample was stratified by gender (50% men and 50% women) and age group (55-74 and 75 or more years) and randomly extracted from the registry office of the municipality of Ancona (Italy).

We analyzed the characteristics of this sample of older people taking into account the variables that could serve to describe their situation in terms of social support. First, whereas one of the major problems of old age can be loneliness and a situation of abandonment, we examined the housing situation of our sample. It must be said that the selected sample involved only elderly residents at home and not institutionalized. The respondents were asked on how many people live in their house. Figures on household situation showed that the respondents, as Italian older people in general, had a good family system around them. In fact, the majority of the sample, equal to 82.5%, declared to live with another person. Within this group, 96% lived with spouse or with children, while 4% lived with other persons. The remaining 17.5% of the sample lived alone.

This last group of older people highlights a social problem, which has many implications on the care system. However, data concerning the proximity of children of our sample showed that most of the subjects declared to have children living in the same town (67%). This figure may be taken as an indication of the availability of strong family ties for the care of older people. This is also a key factor when the older person is ill: usually kin are the main source of support in case of illness [29]. In order to understand the characteristics of the informal support network of the sample, we examined the consistence of the available social network. The respondents were asked to indicate if they have important persons (no one, one, two or more) outside the household. Results showed that the majority of the respondents did not suffer social isolation, in fact, only 2% declared that they have no important persons. A large proportion of the sample (89.2 %) declared to have one or more important persons,

while the remaining 8.8% only one. Afterwards, they were asked which persons were important for them. Table 3.1 shows the relationships network around older people we questioned. Data showed that the family network is considered very important for Italian older people, as almost 50% of the sample indicated son and daughter and 38% sister and brother as important persons. Nephews are also very significant to them. Outside the family, 34% considered friends and 20% neighbors as important persons. Then, the availability of social support of respondents was evaluated in relation to their state of health. In the analysis, a self-assessment of health impairments was used to evaluate general health status (being constantly/occasionally/never impaired). Therefore, we first analyzed the distribution of this variable by age groups.

Table 3.1. Network of important persons

Important person	%
Son	49
Daughter	48
Sister/Brother	38
Nephew	56
Son/ Daughter-in-law	25
Mother	6
Father	2
Other relatives	15
Friends	34
Neighbors	20
Parson	10
Colleagues	4
Formal carers	3

* Multiple answers.

Table 3.2. Health impairments by age groups (% values)

Age groups	Never impaired	Occasionally impaired	Constantly impaired	Total
55-64	68	22	10	100
65-74	49	24	27	100
75-79	32	33	35	100
80+	24	28	48	100
Total	42	26	31	100

$X^2 = 83.9$ $p<0.001$/

Table 3.2 shows that the incidence of health impairments on the subjects of the sample was quite considerable: overall, subjects with no impairment were 42% of the total sample, while those who have occasional impairment were 26% and those with constant impairment

31%. The incidence of impairments showed to be closely linked to the age of the subjects. Persistent symptoms showed a significant increase among the age groups shifting from a value of 10% in the younger group up to an incidence of 48% in the over eighty one group. Variations between the four age groups are more limited for those with occasional impairment and are contained in an interval lower than 10%.

In order to evaluate the availability of support, the respondents were asked to indicate how many persons they could rely in case of illness. Table 3.3 shows the number of support providers by incidence of impairments. The analysis showed that only a small percentage of respondents declared they could not rely on anyone. On the contrary, the distribution showed that more than half of each category can rely upon 1 person and high percentages of older people upon 2 persons.

Table 3.3. Number of support providers in case of illness by health impairments (% values)

	No one	1 person	2 persons	3 persons	Total
Never impaired	1	55	41	3	100
Occasionally impaired	2	57	39	2	100
Constantly impaired	2	60	34	4	100

$X^2 = 0.78$ p=n.s.

Looking at who are the people making up this network of social support, differences among the three groups of subjects were significant.

Table 3.4. Typology of support providers by health impairments (% values)

	Spouse	Children	Other relatives	Friends	Formal carers
Never impaired	66	64	9	6	2
Occasionally impaired	50	74	9	4	4
Constantly impaired	36	66	20	11	7
	$X^2 = 37.8$ p<0.001	$X^2 = 4.6$ n.s.	$X^2 = 14.0$ p= 0.001	$X^2 = 5.6$ n.s.	$X^2 = 6.7$ p= 0.035

* Multiple answers.

Table 3.4 shows that the presence of a spouse in the network of social support tended to decrease significantly among the groups. This figure is due to the increasing incidence of impairments with age determining that those with more symptoms also have a greater likelihood of being widowed. This deficiency, which in the group with persistent impairments became very large, seems to find a compensation by an increase of the availability of other relatives and assistants sent by private or social services. The availability of friends was higher in the group with persistent impairments, but not significantly.

The study showed that our sample of older people had a good social support network at their disposal, mainly consisting of family members. Older people showed to feel they have more than one relationship on which to rely and this is a very important psychological factor. This is due to the beneficial effect that social relationships can have on health, thanks to the

sense of mutual responsibility linking each one to others. In case of illness, they declared a good network of support providers, largely made up of spouse and children.

CONCLUSION

The Italian population scenario shows that the young component decreases gradually due to the collapse of fertility under the replacement rate. The steady rise in life expectancy causes the simultaneous growth of the older segment of the Italian population. The dynamics of migration seems to constitute, at least in the medium term, the only demographic phenomenon in contrast with the natural decrease of population. In fact, in the last decade, the rapid aging of the Italian population has decreased, despite the continuous increase of older people's life expectancy, with the entry of three million new young residents from foreign countries. It is expected that in the next decades, the phenomenon of immigration will still be active, allowing the Italian population to renew. Consistent with this scenario, the population will see a growth, but with a very different composition in comparison with today, therefore with different potentials and needs. For what concerns aging sustainability of the Italian welfare system, several factors are considered important. Immigration is one of these and in this perspective, one of the challenges of the welfare system will be to integrate the flows of foreign population in a context of social stability. However, a general rearrangement of the labor market, social security and fiscal policies following the changed conditions of environment is now considered by the government as urgent and essential. On the health system front, the incidence of assistance to the elderly will determine a further increase in the total health spending. Moreover, disease prevention and the renewal of lifestyle of the population are expected to contribute remarkably to the growth of healthcare costs. The White Paper on the future of the Italian social model, "The good life in an active society "[1], is the main document of the Italian Government drawing the guidelines of the new Welfare system. In this document, it is declared that a new model based on "opportunities and responsibilities" has to gradually replace the current model type mainly based on compensation. The main goal of the new model of welfare should be oriented to offer personalized answers with respect to population needs. The document identifies some key issues related to the dysfunctions of the traditional model: the excessive weight of the pension section is considered to penalize health spending especially and in perspective, raises questions about sustainability. Health spending is expected to double up to the year 2050 in the absence of corrective and re-balancing policies. The document underlines that however, at present, the main problems do not lie in a lack of means but principally in a low quality against high cost of health services supply.

It must be considered that Italian services of health and care for older people progressively passed from a system centered on hospital and institutionalization to an integrated system of health and care services. Institutional care has been the first and most important service for older people in Italy up to the 1990s. Often, the institutionalization of a self-sufficient old person was an instrument to face social and economic problems, therefore living alone and with a low pension meant ending up in a geriatric home. In the meantime, some Regions in northern Italy started to organize the supply of home help, nursing services and tele-aid in order to maintain older persons in their home [30]. Now, several studies highlighted that despite the increasing demand for care, the level of the Italian public service

provision remains low. The main characteristics of the current supply of health and social care for older people can be summed up in [11, 18, 21]: constant shortage of Municipal home care in-kind as help in basic activities of daily living, domestic help, surveillance; a great number of ADI users (Integrated Home Care) but composed of elderly people receiving a care with a low level of intensity, usually home nursing, to respond to a specific pathology and lack of integration with social care; broad distribution of financial provisions such as the National Attendance Allowance widely used for the disabled population and the local care allowances provided by various Regions; residual use of residential structures due to the persistent family tradition with relatives still providing much of the assistance to elderly people (informal care), and to the phenomenon of foreign carers ("badanti"), which has allowed thousands of older people to remain at home. In other words, in Italy, the basic characteristic of the Welfare State, that is its "cash-for-care" orientation, compensates the marginal role of formal elder care services, and dependent persons can receive care and use the allowances from the State and Local Authorities to employ migrant care workers as assistants. We must also consider some Italian regional differences: in most Southern-Center Regions (mainly Calabria, Campania, Umbria and Sardinia), we find mainly monetary provisions such as the wide use of the Attendance Allowance [18, 24]. On the other hand, the Northern-Central ones (mainly in Friuli-Venezia Giulia, Trentino Alto Adige and Emilia-Romagna) [11, 18], where the culture of public service in LTC is rather widespread, show a system in great part based on services [14, 18].

Inside the European context, Italy shows many differences compared to the other European Countries; one of the most important is the lowest percentage of users of home care and of elderly patients in institutions, but also, on the opposite, the higher coverage of national economic benefits [18]. The supply of public home care services has grown in Italy, but it remains one of the lowest in Europe. Italy is also one among the European Countries, with both the greater involvement of family members and foreign paid carers in assisting older people.

Concluding, Italy is considered a country of strong ties, where the family is very important and where ties are continuously strengthened, with a constant and reciprocal exchange of emotional and material support. In the case of the elderly, proximity to children facilitates the exchanges of housing aid. This becomes very important for older parents and even more when a parent is very old and alone. Such a low proportion of older people in institutions would not be possible without the close proximity between parents and children and without the help of migrant care workers. Anyway, the enormous spread of carers contributed to the creation of personalized care pathways, which are essential in the case of chronic disease [8]. Recognizing the strengths of home care and the role of the family in assisting older people, the White Paper, "The good life in an active society"[1], affirms that social and health policies must continue to articulate a plan of home assistance for older people through the development of integrated health and care services, the diffusion of care allowances to support families, the activation of respite services and day care centers, the spread of an integrated and universal system of "good work", through which deliver personalized service and good quality, in the framework of an harmonization of State, Regions and Local authorities interventions. Therefore, the new structure of the system is expected to pass through the development of the positive aspects of this feature, however, limiting the negative aspects, such as the relative disengagement of the state in organizing adequate support services.

REFERENCES

[1] Ministero del Lavoro, della Salute e delle Politiche sociali (2009). La vita buona nella società attiva [The good life in an active society]. *Libro bianco sul futuro del modello sociale*. www.lavoro.gov.it.

[2] ISTAT, Geodemo. http://demo.istat.it/.

[3] ISTAT, Population census, 1981, 1991, 2001.

[4] EUROSTAT, Demography.

[5] http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database.

[6] EUROSTAT. (demo_frate).

[7] D'Addio, A. C., and Mira D'Ercole, M. (2005). Trends and determinants of fertility rates in OECD Countries: the role of policies. *OECD Social, Employment and Migration Working Papers* No. 27. Paris: OECD.

[8] Ferrara, R., Giorgi, P., Mamolo, M., and Strozza, S. (2010). Il ruolo della fecondità degli stranieri in due Paesi di recente emigrazione: il caso dell'Italia e della Spagna. [The role of fertility of foreign residents in two Countries of recent migration: the case of Italy and Spain]. *Rivista di Economia, Demografia e Statistica*. vol. LXIV, n.1-2, pp. 119-126.

[9] Billari, F. C., and Dalla Zuanna, G. (2009*).* La rivoluzione nella culla. [The revolution in the cradle]. Milano: Università Bocconi Editore.

[10] Mengani, M., and Gagliardi, C. (1992). Malattia, menomazione, handicap, disabilità e dipendenza. [Illness, impairment, handicap, disability and dependence]. In D. Cucinotta (Ed.), Curare L'anziano (pp.24-29). Milano: Sorbona.

[11] ISTAT (2005). Condizioni di salute e ricorso ai servizi sanitari. [Health and use of health services. http://www.istat.it/dati/dataset/20080131_00/.

[12] NNA - Network Non Autosufficienza (Ed.) (2010). L'assistenza agli anziani non autosufficienti in Italia. Secondo Rapporto [Care for dependent older people in Italy. Second Report]. Santarcangelo di Romagna (RN): Maggioli Editore. http://www.maggioli.it/rna/ 2010/pdf/rapporto2010-assistenza_anziani.pdf.

[13] SHARE, Survey of Health, Aging and Retirement in Europe. http://www.share-project.org/t3/share/fileadmin/pdf_documentation/ FRB2/Chapter_5.pdf.

[14] Colombo, F., Nozal, A.L., Mercier, J. and Tjadens, F. (2011). Help Wanted? Providing and Paying for Long-Term Care. OECD Health Policy Studies, OECD Publishing. http://dx.doi.org/10.1787/ 9789264097759-en.

[15] Tediosi, F., and Gabriele, S. (2010). Long-Term Care in Italy. ENEPRI Research report N. 80. Contribution to WP1 (Overview of long-term care systems. Country report: Italy) of the ANCIEN PROJECT (Assessing Needs of Care in European Nations). Roma: ISAE. http://www.ancien-longtermcare.eu/node/27.

[16] Polverini, F., Principi, A., Balducci, C., Melchiorre, M. G., Quattrini, S., Gianelli, M. V., and Lamura, G. (2004). EUROFAMCARE. Services for Supporting Family Carers of Elderly People in Europe: Characteristics, Coverage and Usage. National Background Report on Italy. Ancona: INRCA. http://www.uke.unihamburg.de/ eurofamcare/.

[17] Pesaresi, F. (2007). Le cure domiciliari per anziani in Italia [Home care for the elderly in Italy]. Prospettive sociali e sanitarie, vol. 37, n. 15, pp.1-6.

[18] Zanon, D., and Gregori, E. (2011). Quality Care for Quality Aging. Home care services in six European countries and regions. Milano: Franco Angeli.

[19] NNA - Network Non Autosufficienza (Ed.) (2009). L'assistenza agli anziani non autosufficienti in Italia. Rapporto 2009 [Care for dependent older people in Italy, Report 2009]. Santarcangelo di Romagna (RN): Maggioli Editore. http://www.maggioli.it/rna/pdf/rapporto2009-assistenza_anziani.pdf.

[20] ISTAT (2008). L'indagine censuaria sugli interventi e i servizi sociali dei comuni, Anno 2005 [The census survey on municipal social services]. Nota 26.6.2008, Roma. http://www.istat.it/salastampa/comunicati/ non_calendario/20080626_00/testointegrale20080626.pdf.

[21] Melchiorre, M. G., Quattrini, S., Chiatti, C., Lucchetti, M., and Lamura G. (2009). L'esperienza dei caregivers famigliari nell'uso dei servizi di supporto in Italia: l'evidenza empirica dallo Studio EUROFAMCARE [The experience of family carers in the use of support services in Italy: empirical evidence from the EUROFAMCARE Study]. *Economia Marche*, n. 1, pp. 91-118.

[22] Lamura, G. (2011). Long Term Care (LTC) in Italy: recent trends in policy and practice. *Aging Clinical Research*, vol. 23, n. 1, p. 26. (Paper presented at the IAGG's VII European International Congress - Healthy and active aging for all Europeans II, Bologna, 14 -17 April 2011).

[23] HandyLex.Org (2011). L'indennità di accompagnamento [The Attendance Allowance]. http://www.handylex.org/cgi-bin/hl3/ cat.pl?v=aandd=,1500,1502andc=1502.

[24] E-INPS (2010). INPS Database. http://servizi.inps.it/ banchedatistatistiche/vig9/ index.jsp.

[25] Di Rosa, M., Melchiorre, M. G., Lucchetti, M. and Lamura G. (2011). The impact of migrant work in the elder care sector: recent trends and empirical evidence in Italy. *European Journal of Social Work* (in press - DOI: 10.1080/13691457.2011.562034). Available online: 06 May 2011.

[26] CENSIS (2009). Una famiglia su dieci è badante-dipendente [One out ten families is badante-dependent]. Comunicato stampa 12.8.2009, Roma http://www. stranierinitalia.it/attualita-una_famiglia_su_dieci _ha_la_badante_8899.html.

[27] Da Roit, B. (2007). Changing intergenerational solidarities within families in a Mediterranean welfare state - Elderly care in Italy. *Current Sociology*, vol. 55, n. 2, pp. 251-269.

[28] Lamura, G., Melchiorre, M. G., Polverini, F., Principi, A., and Lucchetti, M. (2007). Trans-regional migration of care workers of older people to Italy. Paper presented at the second meeting of the Joint Seminar Series "Migrant Labor in the Eldercare Sector" (MILES) and "*Working Family Carers of Older Dependents in Europe*", Berlin, June 4-7.

[29] Gagliardi, C., Spazzafumo, L., and Leonardi, F. (2000). Mobilità, tempo libero e relazioni interpersonali. [Mobility, leisure and social relationships]. In F. Marcellini, C. Gagliardi, F. Leonardi and L. Spazzafumo (Eds.), *Mobilità e qualità della vita degli anziani* (pp.49-67). Milano: Franco Angeli.

[30] Gagliardi, C., Vespa, A., Piccinini, F., and Papa R. (2011). Testing the quality of social network and social support of women suffering from breast cancer: the role of family ties. *Paper presented at MASCC/ISOO International Symposium*, June 23-25, Athens, Greece.

[31] Mengani, M., Gagliardi, C., Tonucci M., and Lamura G. (1994). Italy. In J. I. Kosberg (Ed.), *International Handbook on Services for the Elderly* (pp. 213-223). Westport, CT: Greenwood Press.

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