Presidenza del Consiglio dei Ministri

CNB

COMITATO NAZIONALE
PER LA BIOETICA

THE LIVING CONDITIONS OF WOMEN IN THEIR THIRD AND FORTH AGE: BIOETHICAL ASPECTS OF SOCIAL HEALTHCARE

16th of July 2010

INTRODUCTION

The document tackles some social healthcare and bioethical issues regarding women over 65 years old, a section of the population which is at high risk of going over that threshold of deprivation, in a psychological as well as material and relational sense, above which it is impossible to make any choices, due to not being able to access the most basic resources necessary to lead a life that is more than mere survival. This document is part of the so-called "everyday bioethics", which complements "cutting-edge bioethics" (focused on extreme cases of human life manipulation).

In particular, it tackles the issue of distributive justice and equality in the access to (not unlimited) resources, referring to gender and age differences. The document highlights how, when dealing with healthcare issues, we must adopt a morally justifiable criterion of priority, offering everyone equal opportunities to reach the maximum potential of health allowed by their age, supporting the most disadvantaged individuals.

Reporting social, medical and psychological data, the Italian Bioethics Committee highlights how women over 65 years of age, with the passing of time, find themselves in situations that can diminish or hinder their ability to be self-sufficient, plan and make conscious choices, being particularly vulnerable from a bio-psychological and social point of view. The reduction in income is immediately reflected in a worsening of their quality of life, especially if their expenses increase due to the onset of chronic pathologies, if they live alone (there are about three million married women in this age group and just as many widows) and are deprived of social roles and functions. It therefore appears evident that personal *happiness* (which can be assessed today with precise social-psychological surveys) cannot be linked only to an increase in financial and material wealth, measured by the GDP (Gross Domestic Product) or by the goods they own and their potential as consumers, but it must take into account how each individual perceives her bio-physical reality.

With regards to the third and forth age, great value must therefore be given to the essential factors leading to what is called a "flourishing life", like enjoying significant relationships and developing self-esteem and optimism, always in view of "being happy", which is the fundamental objective not only of the investments decided by financial policies, but of a medical care that takes into account, as well as the cure, also the "taking care". The document suggests prioritising a social-healthcare intervention for this section of the population, believing that it is one of our ethical duties at this moment in history.

The document is the result of many years of commitment from a working group coordinated by Prof. Romano Forleo: it was drafted by Prof. Monica Toraldo di Francia and Prof. Antonio Da Re, with the participation of Prof. Luisella Battaglia, Prof. Cinzia Caporale, Prof. Riccardo Di Segni, Prof. Laura Guidoni, Prof. Claudia Mancina, Prof. Demetrio Neri, Prof. Giancarlo Umani Ronchi, Prof. Grazia Zuffa. The working group's discussions were integrated with contributions by the following: Doctor Carla Collicelli (vice-director of the Censis Foundation and professor of Sociology of public organisations and services at the Universita' degli Studi di Roma Tre), Doctor Francesca Loporcaro (ISTAT researcher), Prof. Vincenzo Marigliano (Director of the Department of "Sciences of Aging" at the University of Rome La Sapienza).

The document was unanimously approved by those present, with Prof. Amato, Prof. Battaglia, Prof. Bompiani, Prof. Colombo, Prof. D'Agostino, Prof.

d’Avack, Prof. Flamigni, Prof. Forleo, Prof. Garattini, Prof. Gensabella, Prof. Isidori, Prof. Morresi, Prof. Neri, Prof. Nicolussi, Prof. Palazzani, Prof. Scaraffia, Prof. Toraldo di Francia, Prof. Umani Ronchi, Prof. Zuffa voting in favour. Prof. Canestrari, Prof. Da Re, Prof. Dallapiccola, Prof. Di Pietro and Dott. Guidoni, absent from the meeting, expressed their agreement.

Prof. Francesco Paolo Casavola
President of the NBC

PREMISE

From 2007, which was declared the European Year of Equal Opportunities for All, with particular reference to issues concerning healthcare, the literature about this issue has grown with numerous studies and reports, highlighting particular intervention needs. This premise to our work does not intend to be a summary of the scientific contributions on this topic; instead, it sets out to collect some useful ideas when reflecting on a specific section of the Italian population, which we believe is at risk of not being given "equal opportunities" in healthcare, and on the bioethical issues involved: elderly women (conventionally we consider elderly women who are over sixty five years old, even though the most serious problems arise later, after seventy five years of age, as illustrated in attachment (1).

The use of the notion of equal opportunities immediately brings to mind issues of public ethics, namely, of distributive justice in sharing resources which are, for their own nature, limited or in any case not unlimited, according to a perspective that tends to identify as wrong, that is, unjust, the inequalities in the destiny of populations and individuals which can be ascribed to human responsibilities. With regards to the issue of health, the studies on this subject confirm that in the last decades, with the acceleration of the process of globalisation, the dramatic gap between the North and South of the planet has been exacerbated further, and in Italy as well, the difference between the health conditions in the various geographic areas and sections of the population has increased.

Using the distinction, now widespread, between "cutting-edge bioethics" and "everyday bioethics", which identifies two possible approaches to the issue – corresponding to theoretical and legal interests which are partially different – we can immediately see that the problem of distributive fairness belongs to the so-called "everyday bioethics". Cutting-edge bioethics concentrates, in fact, on the more problematic and controversial bioethical issues with regards to personal and public choices, in particular, with regards to the so-called limit situations (birth and death); the problem linked to these issues is often due to their radically innovative character, because of the continuous development of biomedical sciences and technical applications. Everyday bioethics, instead, moves in a dimension that is closer to people's daily experience; rather than the exceptionality of extreme cases, it considers – so to speak – the normality of certain situations. It is clear that, between the two approaches (the one aimed at stressing exceptionality and the one focusing more on normality instead) there is inevitably a relationship, and it is evident that it would be simplistic to imagine that bioethics could move away from considering extreme cases, or, on the other hand, that it should only study extreme cases. The specificity of everyday bioethics consists, in any case, in adopting an analytical and critical point of view about the big issues concerning everyone's life (Berlinguer, 2000): what emerges, therefore, is a more specific attention to the aspects of distributive unfairness in accessing the advantages of progress in biomedical science, in the same country and in the different areas of the world, and a stronger interest in the issues of justice, seen from a global perspective.

From this interest come:

- the investigations on the causes of inequalities in health conditions, due to absolute poverty – of income, education, infrastructures, healthcare services, access to medicines, etc. – in a perspective that considers relevant,

- the research on the profound geographical differences in maternal, perinatal and infant mortality rates, and on the many early deaths, which could be avoided and are due to a lack of medical assistance, famines, wars and violent behaviours, but also on the "double burden of disease" that today affects the inhabitants of the poorest countries[1];
- the reflections on the various facets of the "medical-biological revolution" of the last decades, which has brought great benefits from a clinical point of view, but not for all, because at the same time it has worsened the gap between the various sections of the population in developed countries, and also between these countries and the rest of the world, from the perspective of people's "capability" of staying alive and healthy.

As we have said, all the data available today reveals a growing increase of the inequalities in the impact of an illness on the population, in their psycho-physical discomfort and life expectancy, which require, to be understood in its genesis and fought with effective measures, an accurate scrutiny of the variety of factors that affect it and of the different people and levels of responsibility involved, both in national politics and in the dynamics redefining the relationship of power at the global level. With regards to this point, it is necessary to highlight that the inequalities in accessing healthcare and its services are not due only to a difference in social class. As stated in her contribution on this topic also by Carla Collicelli (vice-director of the Censis Foundation)[2], it is important to try and identify this issue's characteristics and current form.

Using the classification of health determinants proposed by Angelo Stefanini, Marco Albonico and Gavino Maciocco[3], which illustrates how "health" is dependant from the possibility of accessing a multiplicity of direct and indirect resources, we can then think of a series of "concentric sections", corresponding to different levels of influence on the onset and evolution of illnesses, matching different levels of possible interventions, by various agents, on the factors that are susceptible to change and corrections (always however, taking into account their close interrelation). According to the model proposed by the

[1] The document *Progress for Children: A World Fit for Children – Statistical Review*, presented by the UNICEF on the 10th of December 2007, highlights that in 2006 the number of children dying before their 5th birthday because of illnesses, hunger and wars, fell for the first time below 10 millions. Despite this, "Each year, around 4 million children die within the first 28 days of life, in the neonatal period"; in addition "Across the developing world, maternal mortality levels remain too high, with more than 500,000 women dying every year as a result of complications during pregnancy and childbirth. About half of these deaths occur in sub-Saharan Africa and about one third occur in South Asia. The two regions together account for about 85% of all maternal deaths. In sub-Saharan Africa, a woman's lifetime risk of maternal death is 1 in 22, compared with 1 in 8,000 in industrialised countries".
The "double burden of disease", typical of the poorest countries, refers to the phenomenon which sees, to high infant mortality rate due to infectious diseases – malaria, Aids, tuberculosis, etc. – the added increase in deaths due to chronic-degenerative diseases like tumors, cardio-vascular diseases, diabetes, etc.

[2] C. Collicelli, *Disuguaglianze in sanità: l'evoluzione interpretativa a partire dalla ricerca sociale*, Fondazione Censis, 2007, *paper* made available by the working group.

[3] Cf. A. Stefanini, M. Albonico, G. Maciocco *I determinanti della salute,* in A.A.V.V., *Le diseguaglianze nella salute*, monographic number in "*Salute e territorio"*, number 158, 2006, pp.267-274.

abovementioned authors, which proceeds from the central sections to the outer ones:

- at the centre, we find the individual with his/her biological characteristics, which are considered as a given: sex, age, genetic inheritance;
- the next section includes instead behaviour and lifestyle – smoking and alcohol, diet and sexual behaviour, physical activity, etc. – which can promote or damage health. At this level, it is about individual choices, which however can be more or less conditioned by the economic-social and cultural situation, as well as by the message disseminated by the medical community;
- next is the section of the interactions with family, friends and the surrounding community. Everyone's quality of life is in fact strictly dependant from a network of people we care about and who care about us, and social relationships, the presence or absence of which can influence the state of health because of the psychological states it triggers (e.g. emotive balance/depression and anxiety), and that often depend on favourable or adverse conditions (e.g. presence/absence of a network of family and/or social support);
- there is then a very complex and heterogeneous number of factors affecting psychological wellbeing and physical health, amongst them: the environment people live and work in, income, occupation, level of education, diet, housing, hygienic conditions, transport and traffic, healthcare and social services, etc.;
- with the outer section, we finally arrive at taking into consideration the general conditions – political, social, cultural, financial, environmental – in which individuals and communities live, amongst which we must also mention the level of social justice and solidarity a certain society is able to express. As some studies have highlighted, a widespread feeling of solidarity, which can institutionally translate in policies of effective distributive fairness, is an important factor of social cohesion, which can work as a flywheel for the improvement of the life expectancy of a population even in "emergency" situations (like for example post-war times) (Sen, 1999).

This classification helps us to understand:

- how the issue of health must be framed in the wider context of the discussion on fundamental human rights (*Universal Declaration of Human Rights*, 1948, art. 25)[4], those rights who should be enjoyed by all, without discriminations, as necessary condition to guarantee to every individual equal opportunities to promote and develop their capabilities and, at the same time, to reach their potential of psychophysical health;
- how many inequalities in health, between populations and social groups, are unjust because they reflect an unfair distribution of social determinants which, in turn, can be ascribed to a multiplicity of interventions (or non-interventions) and levels or responsibilities.

From this point of view, the notion of *"possible health"* – which will necessarily be different from person to person – is a useful tool to examine

[4] Article 25:
1) Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security on the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

distributive unfairness and identify, taking into account the empirical investigations on the social stratification of such an essential good, the legal perspective in order to suggest effective corrective solutions.

As highlighted in the previous NBC document on this issue (NBC, 2001)[5], which it's appropriate to mention in order to reconstruct the theoretical and conceptual framework of our work, the concept of *possible health,* as well as being in line with the point of view that values health as the condition to express a variety of capabilities (Nussbaum and Sen, 1993), also presents other advantages. It has the benefit, on the one hand, of linking medical care with an idea of health and prevention that is not reductive, and on the other hand, of introducing what is one of the major problems of healthcare justice: the impossibility of deciding distributive issues, giving everyone the same amount of resources because of the different "natural and social" distribution of illnesses and of psychophysical deficiencies.

It follows, therefore, that we cannot respond to issues concerning health by simply emphasizing distributive equality, but we must rather look for a morally justified criterion for selecting priorities, so that everyone can be offered equal opportunities in reaching the maximum potential of health allowed to those in the same age group. In other words, it is important to support, when distributing limited resources, the most disadvantaged groups and individuals (Rawls, 1971); and this also means a greater commitment in researching measures capable of contrasting the "inverse care law" – the phenomenon for which the availability of good healthcare services varies inversely with the need of the population served – which still seems to characterise healthcare in many areas.

Moving on a different level, still concerning the issue "equality/difference" in distributive justice, it can be helpful to recall some ideas presented in the "classic" essay by the English philosopher Bernard Williams on the idea of equality (Williams, 1973). What William proposes is one of the possible ways to give value, not simply rhetorical value, to the notion of "respect for human dignity". This author invites us, in fact, to reflect on what can still advocate the statement, apparently tautological, of the equality of men as men: an incomplete but not banal statement, as it serves to remind us of the "significance" of our common humanity. The concept of equality is relational ("equality between who?") and abstract, in the sense that it presumes a mental process conceptualising the concrete characteristics of the individuals under consideration ("in what, or compared to what, are the individuals in question equal and/or must be considered equal?"); it follows that the judgement of equality always applies not to two or more individuals being the same, but to their equivalence, or similarity, from a point of view that we consider relevant and the relevance of which we are prepared to justify with good reasons (Revelli, 1995).

A pertinent response to tackle the issues linked to the topic under consideration, is that which deems relevant, from an ethical point of view, two aspects of our "common humanity", from which derive moral expectations we can recognise as worthy of respect:

- the first one unites us for our most common aspects of fragility, vulnerability, mutual dependence: having primary needs that must be met, the ability to feel pain, suffer because of immediate physical causes, as well as

[5] NBC, *Bioethical Guidelines for Equal Access to Healthcare*, 25th of May 2001, http://www.governo.it/bioetica/eng/opinions.html.

various situations we perceive or think about, and also the ability to be fond of others and suffer the consequences of such fondness in terms of frustration, or losing the individual we care about. This regards the scope of our moral equality concerning the things we have a vital need for and about which we can suffer, which involves us in moral relationships as the recipients of a certain type of treatment relative to our wellbeing and, at the same time, identifies us as moral "patients";

- the other dimension our attention is focused on, regards instead more positive aspects, believed to be harder to define, and relative to our ability to reflect on ourselves, have a conscience: the ability to recognise ourselves as beings who have a biographical continuity, beings who aspire to being respected for their ability to responsibly take on commitments and loyalties of various nature, set themselves goals and objectives, make plans and identify themselves with these plans to give meaning and value to their lives (equality in what they can do and achieve) (Veca., 2001). It is the dimension in which we recognise ourselves as "moral agents". With the warning that being autonomous is not a given, nor is it without different levels; it is largely dependant on society and the particular, relational and emotional environment in which individuals live.

The interpretation of moral equality, which sees as morally relevant the two abovementioned ideas, can offer a guideline to tackle some of the most significant issues of everyday bioethics, but only if we interpret it dynamically. In fact we must look at "patients" and "moral agents" as two dynamic dimensions, which, although often superimposed, can change in time and turn into one another. The boundary between the two conditions is blurred and dependant on the different situations and phases of life. Namely, we must always take into account that there are situations and conditions that can reduce or prevent the ability to be autonomous – like the capacity to plan and make "conscious" choices – and that the relational, financial-social and political context the individual is in, often has a relevant role both in hindering as well as aiding its development, or its recovery once such ability has waned.

There is a sort of deprivation, both from a material and a psychological perspective, beyond which is almost impossible to exercise any kind of choice, due to the lack of access to the most basic resources necessary to carry out a life that is more than mere survival. From the point of view of "public ethics", a fair distribution of the determinants of health should then have as ideal objective that of trying to, first of all, make sure that no individual and group, or population, can fall below such threshold, acting, for this purpose, on the factors that can be affected by focused social and political interventions of re-distribution. This can be a first concrete step to formulate the "right" answer to the challenging question "how much inequality can we accept?"[6], which takes for granted the impossibility of a total elimination of the unfair inequalities in human destinies, but not the possibility (moral need) for their significant decrease.

With regards to Italy, the abovementioned objective finds a significant confirmation in the first three article of the Italian Constitution, in which freedom and equality have an explicit legal character; they become, in other words, an idea that regulates constitutional politics, because the starting point here is the

[6] Cf. C. Arnsperger, P. Van Parijs, *Éthique économique et sociale, 2000*.

acknowledgement of the absence, in effect, of the conditions necessary to fully develop each and everyone's personality[7].

1. A particularly "vulnerable" section of the population: women over sixty-five years of age

This premise seemed appropriate to better frame and justify our choice to focus our attention on a particularly vulnerable section of the population, which risks to see their generic and specific health needs underestimated: those of the so-called "elderly" women.

Opening a parenthesis relative to the notion of *vulnerability,* it is important to remember that it was the "*Barcelona Declaration*" – signed in 1998 by twenty-two European specialists, coming from different disciplines and philosophical perspectives, to give value to this notion, as well as those of *autonomy, integrity, dignity.* These are four regulating ideas, useful not only to analyse the crucial issues of bioethics and bio-law, but also to give direction to the current debate on biomedicine and biotechnologies in a legal context, within an ethics of solidarity, responsibility and justice intended as fairness. The principle of vulnerability, which essentially expresses the idea of the limit and fragility of human existence, is at the basis, for those who are autonomous, of the possibility and need of every moral discussion and every ethics appealing to responsibility and care[8].

Returning to our topic, without intending to discuss the various classifications of aging, we include in the concept of "old age" the "range of problems" conventionally thought to begin at 65 years of age, which become increasingly relevant with the passing of time and, generally, in our society after 75 years of age[9].

Many studies today tackle the issues raised in developed countries by a growing elderly population, but there isn't always adequate recognition of the strategies of cultural, social, economic, biomedical, etc. policies, necessary to counteract the ethical prejudice of "ageism", namely, so that the elderly population is recognised as a possible social resource and not as a burden encumbering on the whole of society and, in particular, on the younger generations. In a world where the prevalent cultural and media images daily instruct us to "take care of ourselves" in order to fight, at least in our outward

[7] Italian Constitution, *Fundamental principles:* art. 3 "… It is the duty of the Republic to remove those obstacles of an economic and social nature which constrain the freedom and equality of citizens, thereby impeding the full development of the human person…".

[8] We must also stress that this notion has both descriptive and legal value: in fact, describing a person as vulnerable means suggesting, at the same time, an ethical response of protection and responsibility towards him/her. From this, the profound link between vulnerability and the ethics of care. But in order for this idea to be more than a utopian principle, it is necessary for society to indicate with absolute clarity what type of vulnerability it intends to focus on and with what resources: in this way, the ethics of care meets the sphere of justice. As it is easy to see, the overall message emerging from the *Declaration* is that vulnerability is, for the most part, due to certain situations and that therefore everyone's commitment must be aimed at reducing it in its different aspects. In this way, we try to make sure that vulnerability is not an element of exclusion but of particular consideration and more care, taking into account the equal dignity, from a legal point of view, of every person and also of those characteristics that make him/her a unique individual.

[9] Cf. NBC, *Bioethics and the Rights of the Elderly*, 20th of January 2006, http://www.governo.it/bioetica/pareri.

appearance, the signs of aging, whilst life, work and social safety is increasingly precarious for the younger generations, aging is perceived, even by the individuals themselves, almost as a crime; and it is increasingly seen as a process of irreversible losses – of role, status, health, personal relationships, etc. – which leads to more or less severe forms of marginalisation and social exclusion.

All issues, these, which have in any case already been tackled in a previous document by the NBC, concerning the condition of the elderly, in which we urge to "consider in more depth the dignity and the rights due to people in this particular phase of their life" (*Active Aging*) (NBC, 2006).

To integrate the abovementioned document, we have therefore focused our interest on some particular aspects of bioethical relevance, regarding the condition of women over sixty-five years of age, with particular attention to issues linked to the opportunities of accessing social-healthcare goods and services. Namely, we felt the need to adopt the critical perspective that takes into account the difference between sexes in order to highlight, once again, the need to overcome, in biomedicine as well as other fields, the concept of a "neutral" individual, with which we tend to assimilate women and men and, consequently, ignore both their psychophysical specificity and their different needs and vulnerabilities, which change with the various phases of the living cycle.

The awareness of the significance of sexual differences is one of the outcomes of the growing influence of women's views in bioethics. These views, even in a plurality of perspectives, move from the intention of remedying some of the limits affecting the first phase of bioethics:

- the tendency towards deductivism, of a bioethics based on principles and therefore not very inclined to consider the importance of the context, the situation in which the moral action is carried out – towards which feminine and feminist approaches are instead very sensitive;
- the prevalence of an individualistic-abstract perspective, with the emphasis on rights to the detriment of the responsibility of "care", in the sense of "taking care";
- the connection of bioethical debates with institutions – like National Committees – in which women are not yet sufficiently represented (although they are more present today in Committees than in other institutions).

It was especially Susan Wolf[10] who highlighted, from a philosophical perspective, how the bioethical debate, in medicine as well, is often carried out on the basis of a model patient who does not exist, has no sex, age, race, status, etc.: a "generic patient". Namely, no sufficient attention has been given to how the differences between patients can introduce significant changes in the approach to how we know and care for them. In particular, amongst other factors, it was felt that "sexual difference" deserves a more in depth analysis because women live in a society that is still marked by "sexist" attitudes, which tend to not take sufficiently into account how female patients know themselves and their needs, especially if disabled, elderly and alone.

Making room for female differences in bioethics means not only giving particular consideration to the specificity of the woman-patient as the object of care and attention, but also giving voice to the woman's subjectivity from an ethical and bioethical point of view. The thesis supported by Wolf, as well as

[10] S. Wolf, *Feminism and Bioethics: Beyond Reproduction*, Oxford Univ. Press, N.Y. 1996.

other female specialists in the field of bioethical issues referring to the research by Carol Gilligan[11], is that the traditional formulation based on the paradigm of rights and self-determination is insufficient, because it does not take into account the relational and environmental "context" of a particular situation. The suggestion of this current of thought goes rather in the direction of an ethics of care inspired to *principled caring*, which takes on Carol Gilligan's suggestion of integrating rights and care, along the lines later indicated also by other female specialists, like Martha Nussbaum and Virginia Held[12]. In order to gain a "gender perspective" in bioethics[13], it is therefore important to fight, first of all, against the idea of an abstract individual, devoid of determinations (and of significant reactions), that is, of those traits that define his/her condition and status. In this perspective we can then say that valuing sexual differences, even in bioethics, if we think about it, is founded on the legal principle of equality, if we give this principle the meaning of recognising the equal value of the differences that are the basic characteristics of a person's identity[14]. As already mentioned in the premise, the legal idea of "equality of fundamental capabilities", presented by Amartya Sen and Martha Nussbaum as the assessment criterion for the different social aspects, takes on this perspective, having as its ideal objective the promotion the self-fulfilment of all the specific and different capabilities of every individual, putting everyone in the best conditions to exercise and develop them.

The choice of limiting our reflection to the situation of elderly women can also be considered as a continuation of the issue discussed in the recent document *Pharmacological Trials on Women*, drawn up in 2008 by the NBC[15], which highlights, in fact, the profound changes women have lived through, and are living through, especially in developed western civilisations, with consequent changes in the relationship between health and illness, always considered as dependent on the "complex relationship between the biological dimension, the psychological as well as symbolic component and historical-social-cultural influences". With regards to this topic, it is important to mention how gynaecology, in the last few years, has re-directed its function towards being a "holistic medicine for women", which had been waning with the development of technology. Many currents of thought in this branch of medicine support, for this purpose, the introduction of "*medical humanities*" in university studies and in the continuing medical education (CME) of gynaecologists.

As proof of the need for a new focus on "gender differences", we can also mention a number of recent initiatives by the Ministry of Health, like for example: the 2005 publication *Women's health and drugs for women*, the 2007 working group *Gender approach to health*, the 2008 report on *The state of women's health in Italy*, etc. All signs of a growing sensitivity towards the health

[11] C. Gilligan, *In a Different Voice*, 1982. This work began a series of contributions, amongst which those by Virginia Held and Martha Nussbaum, aimed at consolidating an ethical perspective integrating the ethics of rights and regulations with a more contextual and relational moral view.

[12] V. Held, *Etica femminista*, Feltrinelli, Milano 1997.

[13] Cf. L. Palazzani (ed.), *Bioetica e differenza di genere*, Studium, Roma 2007. On the different perspectives of women's way of thinking in bioethics, see also C. Botti, *Bioetica ed etica delle donne*, Zadig, Milano 2000: G. Marsico, *Bioetica: voci di donne*, EDB, Bologna 2002.

[14] Cf. L. Ferrajoli, *La differenza sessuale e le garanzie dell'uguaglianza*, in AA.VV., *Diritto sessuato*?, monographic number in «Democrazia e diritto», number 2, a. 1993, pp. 49-73.

[15] NBC, *Pharmacological Trials on Women*, 28th of November 2008, http://www.governo.it/bioetica/eng/opinions.html.

problems of the female population and, clearly, of the intention of proceeding to a more in depth analysis in view of planning interventions, in the fields of prevention and healthcare, which take into consideration the relevant "differences" between the various sections of the population.

Putting emphasis on a different perspective does not mean, therefore, only focusing on the care of women, as the object of a commitment from the medical field, paying attention to feminine peculiarities, but also making room for women as an active resource, their experience of empathy, relationships and care, which allow us to look differently at the issues of care with regards to life and health.

2. General observations on the condition of elderly women

In light of what has been said so far, we feel that it is important to recall attention, also in view of future interventions in healthcare and social policies, on the needs that are particular to the section of the population consisting of women over 65 years of age.

Here, we report a variety of data and issues, in the awareness that:

1) they also raise bioethical questions, which are pertinent to the daily experience of a condition of life that is more and more widespread, rather than to the exceptionality of particularly difficult moral cases;

2) in any case "the third age is heterogeneous with regards to self-sufficiency, physical and mental health, quality of life" and "age in a chronological sense cannot be the only criterion to identify healthcare and/or therapeutic choices and exclude anyone from therapies aimed at curing or prolonging life" (NBC 2006).

The 10th of December 2009, ministers Sacconi and vice-minister Fazio presented a Report on the State of Healthcare in Italy. In it, it is stated that the old-age index (the relationship between the population over 65 years of age and that below 15 years of age) grew to 143, making up 20.1% of the population. Women live longer than men. For this reason they make up most of the growing elderly population in Italy. Considering the number of 65 years olds, and over, in the population, women make up 58.1% of it compared to 41.9% of men[16]. In addition life expectancy at birth continues to grow for all, but even more so for women (life expectancy has increased to 80 years at the beginning of the 1990s and it is 84.2 years at the moment, compared to 78.4 years for men). The phenomenon of the ageing of the Italian population is therefore strongly marked by a gender qualification[17]. It therefore becomes evident how, in time, the number of women going from aging to being "elderly" will increase, and they will find themselves having to tackle a physical

[16] Because of this and other data, and other interpretations of them, see the report by Carla Collicelli, *Donne e salute in Italia: la sofferenza delle donne anziane*, Presented by the NBC's working group; the report is accompanied by many tables elaborated by the Censis on Istat data. Some of these tables can be found in this document's appendix.

[17] Taking into consideration ISTAT data relative to the life expectancy of those born in 2007, with regards to their sex and the region they live in, we can also observe that overall life expectancy is higher in the centre and North of Italy than the South and the Islands: e.g. men's life expectancy has increased to 79.6 years (Umbria) and women's to 85.2 years (Marche), whilst Liguria on the 1st of January 2006 was the Italian region with the highest percentage of women *over* 65 (30,2%) and of men also *over* 65 (22.7%). See ISTAT data in Table 6, attached to the contribution by Francesca Loporcaro.

metamorphosis that can create confusion, to the point that in some cases it causes – we will discuss this later – an identity crisis, an inability to identify themselves with their aging body, to which can follow depression and the consequent shrinking of their emotional and relational circle (cf. Attachment 1).

Women over 65 years of age, in addition, in many cases live in a situation of loneliness. This is evident by the considerable growth in the number of families which comprise of only one member. There are many causes for this phenomenon, but there is no doubt that a relevant cause is the fact that the growth in the average life expectancy of the female population is, as we said, higher than that of the male population. To this, we must add the fact that usually women are younger than their husbands, and therefore the probability that they will find themselves living alone for a number of years, as widows, is very high. If, as well as widows, we consider also unmarried, separated or divorced women, we reach a considerable figure: 56.6% of Italian women over 65 years of age live alone[18]. Naturally, this situation can also be deliberately chosen: it is the case of the *singles*, frequently talked about in the public debate, which involves, to be honest, especially younger sections of the population, whilst the loneliness of elderly women is mostly endured and in most cases it is a source of discomfort and suffering. Relational deficiency is often marked, as well as by the loss of the husband, by the infrequent presence of the children, either because they live far, or because they are absorbed in their work and the intense pace of life of their new family.

With regards to income we see, so to speak, a double discrepancy: between the elderly and the rest of the population and, amongst the elderly, between women and men. There is in fact a considerable difference between the income of the elderly and that of the rest of the population: the second is on average higher than the first; the difference increases if we consider the income of women over 65 years of age. The lower income available to them worsens a condition that can be, already in itself, a source of serious discomfort: to the frequent loneliness, we must add the difficulty of financially covering daily or unexpected medical expenses, which – as we know – increase considerably at this age.

More in general: "The incidence of poverty is above average (13.9%) in families where at least one member is over 65 years of age and it reaches the highest level when there are two or more elderly family members (16.7%). The relative discomfort is more evident in the Southern regions, where the average incidence is 21.3% but 28.2% of couples with one person over 65 years of age are poor and 25.7% of elderly people are poor and alone"[19].

The factors mentioned so far, affect what we could call their perception, on the one hand, of their personal "happiness" and, on the other hand, of their health conditions. With regards to the first aspect, "elderly women who are alone"[20] for the most part (73.7%) declare to be in a very adverse economic-social condition, to be little or not at all happy, to have a social life that is little or not at all gratifying. The participation to leisure and cultural activities during their

[18] See table 3 of the contribution by C. Collicelli, *Donne e salute in Italia: la sofferenza delle donne anziane cit*.

[19] National Healthcare Plan (2006-2008), p. 70.

[20] It is the effective expression suggested by the Censis Foundation Survey and by the Schering Foundation (2006). See also illustration 1 with regards to the so-called "feeling of happiness".

free time is very low; this is due to their low income, but also, often, by a lack of relationships as well as initiatives and opportunities offered where they live.

However, if we examine the issue from a historical perspective, a different way of looking at elderly women and their health/wellbeing can emerge, thanks to the self-awareness process that in the last few years has by and large affected the female world. Women are about to go through their third and fourth age in conditions that were completely unheard of in the past. This is what female sociologist Marina Piazza writes, expressing the self-perception of some sections of the female population, which today face these phases of life: "More educated, more independent, healthier, wealthier, aware of their longevity compared to past generations; with an experience of public life that is incomparably more intense"[21].

Nevertheless women still suffer, in comparison to men, an economic and social disadvantage, particularly serious today for women over 70/75 years of age. We also cannot forget how women's "weakness" is still for the most part symbolic, as the image of the feminine is traditionally linked to their physicality and the ability to procreate: when the body declines and the reproductive function ceases, the female identity itself can enter a state of crisis. It is true that today a new social image of the feminine is gaining pace: the woman always beautiful and in shape, who stops time with plastic surgery and still keeps up with the pace of life. In truth, the imperative to "stay young" risks to be the other side of the same coin: the social "invisibility" of the elderly woman who ages, from which we try to escape.

There's however a different world, namely, different ways of thinking about ageing through "the eyes of a woman". One of these is seeing old age as a season in which women can achieve a new freedom and not be "feminine masks" anymore[22]. And there is another, maybe more sensible viewpoint, because it does not deny the pain of losing a body that was once desirable and able to have children, but tries to elaborate it, transforming the individual ability to reproduce in a relational and social capability. The female experience of "taking care" of the family (which does not exist anymore) turns into more focus on themselves and their health and in a renewed pleasure in weaving relationships with others. Especially with other women. If it's true that a high percentage of elderly women are alone, often they can be less "isolated" than the men in the same age group. Women who today enter their third age belong to the generation that invested in female relationships. This is not only true for the *singles*, or separated or divorced women, as even many women who were part of a couple, by an large, did not follow the model of the "self-sufficient" family, inward looking and exclusive (which is in a state of crisis since the beginning of the 1970s).

Highlighting these aspects of female subjectivity does not mean underestimating the burden of the "criticalities" and reaching the rhetorical idea of a "brilliant second part of life", which can betray a fantasy of omnipotence. It is instead a way to take on the complexity and contradiction of the representation of elderly women. Most of all, it is a way to highlight women's subjectivity, particularly useful to direct social intervention. The work aimed at

[21] M. Piazza, *Le ragazze di cinquant'anni*, Mondadori, Milano 2000, p. 37.

[22] This is what Carolyn Heilbrun states, when she writes: "For most women, the onset of old age brings all those liberties men have always known and women have never had… and first of all not having to impersonate women" (Carolyn G. Heilbrun, *Writing a Woman's Life,* W.W. Norton & Company Inc., New York – London, 1988).

promoting “possible health” must develop individual resources rather than highlight (even to protect them) their shortcomings. It is the point of view of *empowerment*, the approach that in the last few decades contributed in re-directing the action towards so-called “weak” individuals (women, the young, the elderly), starting from the critical assessment of the political tradition of mere “protection”.

3. Observations on the state of health

The vast amount of medical-psychological literature on ageing, normal and pathological, is today grown to such a level that it is difficult to summarise in a few statements what we know about this issue. Ageing is in fact a complex process, which involves not only neuroendocrine structures, but each organ and apparatus. It is a progressive process that evolves in time differently from individual to individual and leads eventually to the loss of some functions in specific organs, first of all the brain, which is widely influenced by personal history and the culture in which each of us moves. It is not always easy to assess the effect of the environment in which we grow up, but no-one today denies the “plasticity” of our CNS, through which the brain captures external images, elaborates them by “heating them up” in light of our emotional investments and feelings, and fixes them in the neuronal circuits. All this determines a progressive change in the individual’s personality, even if each person always maintains his/her unique and inimitable identity. Without a doubt, amongst the factors that remain, there is the fact of belonging to a gender and, clearly, the gender difference in the cognitive and emotional sphere, physiological differences which not only lead to a dissimilar incidence of pathological phenomena and different reactions to them, but also dissimilar ways of managing our own lives. In addition, as shown by recent clinical studies analysing pain in its different components – reception, transmission, modulation of transmission, perception – sexual difference affects the way we experience it. It has in fact been highlighted that women – as well as responding differently to analgesics – feel pain much more than men, a fact that has to be considered not a weakness, but a strength: an adaptation due to a higher exposition, a protective mechanism that contributes to maintaining life.

We want however to stress that human beings are not only the product of biology, but also of history. What we experience, anchored in our consciousness and kept in our memory, full of conflicts between desires and fears, changes our way of thinking, aids or hinders the onset of so-called “positive thought” and generates “divergent thought” at the basis of our creative capabilities. With old age our mind finds it more difficult to perceive the changes in a world that is in rapid acceleration, even though, when it loses nervous cells, our brain uses new structures to link the nervous centres, which flourish with experience.

It is today possible to understand the ageing process in both men and women and, at the same time, consider the fourth age not only as a “period in which we are what we have given”, but also – we repeat – as a phase of life that can still bring positive change. This phase has its peculiarities and its specific physiopathological states, which affect the intrapsychological and relational world, different in the two sexes, male and female, but also in comparison to other phases of life.

The increase in life expectancy has given growing room to geriatrics, a young science as a specialisation, although much older than paediatrics as a medical commitment. In fact, medicine has only in the last few decades come away from a negative judgement of this phase of existence (*senectus ipsa morbus est*) and today, after having contributed to increasing its duration in time, its commitment is that of "giving life to the years". In other words, we are seeing the change from a medicine "of organs and apparata" to a medicine of the person, which as well as curing, takes *care* of the elderly, trying to help them "to live better" and evaluating our existence positively even when we are old.

Assessing our state of wellbeing is today seen, even in economics, as a fundamental factor to judge the appropriateness of social-healthcare interventions. There is, in fact, a difference between the sexes concerning their state of health and also their assessment of it. Their own state of health is perceived by elderly women as worse, on average, than that of men, especially with regards to pathologies of the third age, and not only those that are typically female like osteoporosis and thyroid, breast and vulvar disorders. As Carla Collicelli states, "the data that women declare themselves as "not having good health" stresses the fragility of the relationship between women and health, and especially in the last phases of life, women tend to have more pathological events compared to men"[23]. This is proven also by women's more frequent recourse to healthcare services, from hospital admissions, A&E and emergency doctors, to specialist and preventive check ups[24].

From what we have said so far, we can infer that women over sixty-five years of age are particularly exposed to the negative effects of inequalities in healthcare, as well as to more general conditions of social inequality. Without wanting here to make a detailed sociological analysis, we can state that inequalities in healthcare are worsened, indubitably, by the lower economic capabilities of elderly women and/or by an allocation of resources which is strongly imbalanced regionally and nationally. However we must not underestimate also the difficulties (or even impossibility) of accessing healthcare services due to insufficient or no adequate information and, more widely, to an organisation of the healthcare system that is not always able to respond efficiently and appropriately to the growing needs of the elderly (despite the fact that healthcare expenses concentrate, already at present, in the last ten years of life).

An inadequate organisation of healthcare and a lack of information, advice, direction, can produce particularly distorting effects in a section of the population that, due to age and sex, often lives – as we said – in conditions of loneliness with regards to family. Those who are alone and maybe physically and/or mentally debilitated, or do not have the cultural tools to act autonomously, finding themselves unable to take advantage of the chances and offers that the system of services, at least in some regions, makes available. The phenomenon of the so-called "hidden rationing", still too often

[23] C. Collicelli, *Donne e salute* cit., p. 2.

[24] Regionally, 2005 data tell us that the higher percentages of people *over* 65 who declared feeling "ill or very ill", come, with regards to the female population, from Sicily (33.4%) and, with regards instead to the male population, in Basilicata (22.8%). More in general, still in this age group, the gender difference in mentioning a health discomfort is higher in South of Italy, with 33.2% for women and 27.8% for men. In North of Italy, both in the East and West, the discomfort seems instead to decrease, whilst, at the same time, life expectancy increases. *Ibid.*, table 44 (integrated).

present in healthcare (as already stated by the NBC in the 2006 document), creates then situations of non-transparent deterrents, aimed at discouraging especially elderly patients, - even more so the female population – encouraging them to give up requests of assistance and care. Amongst the deterrents we can list: difficult systems to book specialist visits and diagnostic analysis, or in any case any barrier that in effect makes it particularly difficult to access healthcare services; the lack of clear and easy to understand information about the way the services are organised and the different types of procedures available; the mechanism of deferment, the most typical example of which is represented by extremely long waiting lists; the so-called "dilution" mechanism, namely, discouraging demand by reducing the perceived quality of the procedure; forcing people to move area in order to have some diagnostic or therapeutic procedures; and, not last, the presence of two spheres of activity: one for everyone and one for paying patients, etc. (NBC, 2006).

The lack of family ties, late maternity, the tendency to have only one child, widowhood (6 widows for every 1 widower in the fourth age) means that elderly women are increasingly alone, also when facing medical issues, which affects the duration and, most of all, the quality of their life. This is particularly evident in Italy, which is at the top of the list with regards to the age of mothers having their first child. This also means a shrinking of the function of "grandmother", which affects the growing generation as well as women in the second part of their life (girls who are born today have a life expectancy of 90 years). The recognised social role of the grandparents, which can be so rich in that humanising emotion that is tenderness, helps not only to overcome the sense of loneliness, but it can also have positive effects concerning mood swings, cognitive disorders and alterations in mnemonic processes. Today, unfortunately, this important emotional-relational contribution is increasingly lacking, due to the growing age gap between grandparents and grandchildren.

The causes of inequalities in healthcare – we must stress again – are therefore not only financial, even though these clearly have an impact. As Collicelli states: "the "healthcare divide", in any case, both according to the oldest interpretations, which saw it linked especially to the material conditions of life, and the more recent one, which considers it linked to the healthcare is organised and especially information and advice, is still macroscopic in Italy and poses very serious problems from the point of view of the collective decisions to take and implement."(Collicelli, 2007)[25].

Given that ageing is linked to lifestyle and the experiences each person has during their lifetime, as well as to their endogen component, which is their genetic inheritance, we felt it appropriate to focus, in Attachment I, on some pathologies which, in frequency and quality, are typical of women over sixty-five years of age and in particular women in their fourth age.

Today, a vast amount of research is carried out on the pathologies that affect not only the duration of life but also its quality, measured in terms of efficiency, ability to move and act in our environment and, most of all, of having ideas and affection, a rich intrapsychological and relational world.

Although gynaecology, intended as gender medicine, has roots that are lost in history, it concentrated its clinical attention on the important *climacter*, the seventh of the seventh season of the life of women, only in the middle of last century. This period was chosen, by a gynaecology "focused on

[25] C. Collicelli, *Donne e salute* cit., p. 32.

prevention", as a strategic period to start therapies and give suggestions on how to live better during the increasingly long years following. Andrology appeared only after, and it is more focused on the problems linked to sexual relations and not so much, and exclusively, to the reproductive role. At the recent World Congress in Vienna (8-10 September 2009) this science asked *"Why men die earlier?"*, highlighting how the "weaker sex", once the incidence of illness due to pregnancy and childbirth is reduced, is, from this point of view, "stronger" than the male. Immediately stressing, however, how this discrepancy often affects a couple's relationship and in particular women, who find themselves more frequently having to take care of their partners.

Nevertheless, despite their longevity, we find (cf. Attachment I) amongst elderly women a significantly higher incidence of debilitating diseases – fractures due to osteoporosis, rheumatoid arthritis and osteoarthritis, strokes, incontinence, cancer – than men of the same age. The same can be said about progressive disabilities due to psychomotor deceleration, episodes of confusion and dementia of the Alzheimer's type, the incidence of which increases exponentially with time, although cardiovascular and osteoarticular diseases are, in any case, the most frequent causes of illness in women over 65 years of age.

We can well understand how the assistance of the social-healthcare system, which is involved in the health issues of the various seasons of human life, should have, in the presence of limited resources, measures apt at improving this clinical situation, which will interest an increasingly large section of the population. Socio-political and healthcare intervention would however need competent doctors, sensitive to the unbreakable link between biological and psychological phenomena, namely, able to see the person as a complex psychophysical unit and not as a system of organs, almost autonomous from each other, on which individual "specialities" act separately. There therefore needs to be a profound change of perspective.

Consequently, from a bioethical point of view it is desirable, we repeat, for social and healthcare policies to focus more on the quality of life of the elderly female population, which is progressively growing, putting in place measures that would allow:

1) correct and timely information about the risk factors of illnesses and the best ways to keep them in check and prevent incapacitating poly-pathologies;

2) an healthcare system that is more aware of the fragilities of this delicate phase of our existence, differentiated and shaped on the specific needs of women in the whole country.

The hope is that in the near future we can reach a significant increment in the number of self-sufficient elderly individuals, who have a better quality of life thanks to the improvement in their living conditions, the progress of medicine, prevention activities, but also the dissemination of a new culture in support of *"active aging".*

4. Differentiated offers for the elderly by Public Bodies

At the end of 2009, a new Pact for Health 2010-2012 was agreed upon by the Government and the Regions. This is a financial and programmatic agreement valid for three years, which regards the cost and programming of the NHS, finalised at improving the quality of the services, promoting an

appropriate performance, guaranteeing a unified system. The Government and the Regions have identified the strategic sectors in which to operate in order to improve regional healthcare services and guarantee the satisfaction of the citizens' needs and at the same time more control over expenses. With regards to the elderly, the focus has been placed especially on gradual disability over the years. The main cause of the marginalisation and then isolation of the elderly is not however due only to their possible disability, but it must be identified, as we have seen, in the loss of their social and productive role, which causes a decrease in their financial potential, a feeling of loneliness and finally, not uncommonly, a strong sense of uselessness accompanied by a loss of self-esteem. Moreover, the Pact highlights a need to know these factors, which then affect the regulations, recognising that the need of elderly people are also by and large not only "material". Consequently, the *Guideline for the realisation of an integrated system of interventions and social services* (law of the 8th of November 2000, number 328) expressed the clear intention of intervening on the different sectors of social life, integrating – through the implementation of a system of local networks – the services to the person and to the family, anticipating financial incentives aimed at optimising the resources and avoiding clashes of authority and the sectorialisation of the responses. This overall vision has been taken on by the three-year Plans of the National Healthcare Service agreed upon so far, which have never failed in highlighting how the needs of the elderly must be at the centre of an healthcare service that is varied in its methods and ways of care (unfortunately not always carried out or made possible): this is the so-called "third economy", aimed at making sure that "the elderly who are not supported by a family can, with their own economic activity, express their freedom and at the same time contribute to the individual and collective well-being"[26]. As already highlighted by the National Bioethics Committee (NBC, 2006), when we talk about the elderly we cannot reduce the discussion merely to demographic and economic data without taking into account their equal dignity in comparison to other citizens, regardless of their age, their health conditions and the contribution they are able to make, because their presence in itself contributes to the well-being of society. And more, alongside the Report "*World Population Ageing 2007*" by the United Nations – which states that "there are numerous ways in which the elderly can express themselves and feel fulfilled: continuing to participate to family life, practising voluntary work, acquiring new knowledge, enrolling in courses, expressing themselves through arts and crafts activities, participating in community organisations and associations of the elderly or religious, recreational, touristic activities, working part-time or being part of the political life as informed citizens…"[27] – a variety of ways to participate to activities, courses or other have been planned, and in some cases realised locally, suggested by the various local Administrations (Attachment II).

According to the *White Book on the future of the social model* by the Ministry of Labour, Health and Social Politicies, published in 2009, which register the data of the "the level of generational separation of the elderly who, more and more often, live only with other elderly people, in particular in rural areas that are going through a depopulation", this new situation "imposes

[26] M. Trabucchi, *Perché Terza Economia*, in: Fondazione onlus socialità e ricerche – *La Scienza dell'assistenza. Terza Economia sempre più valore dalla terza età*. Quaderno number 2, The European House Ambrosetti, 22nd of January 2008, p. 4.
[27] www.unpopulation.org.

policies that are specifically aimed at the so-called third and fourth age and at promoting aging in good health thanks to the active prevention of the risks linked also to lifestyle. It is about guaranteeing a condition of physical and mental well-being, ensuring that the impact on the system of social protection can be managed fairly and efficiently" (see attachment).

5. Conclusions

From the previous analysis emerges how simplistic it is to identify only one element of criticality that marks the life of women over 65 years of age. Certainly, the economic and material aspect has its considerable importance: the decrease in income is immediately reflected in a worsening of the quality of life, especially when there is an increase in expenses due to the onset of numerous chronic pathologies. The fragility of psychological-physical health is therefore a further element that exacerbates economic instability; proof of this, is the recourse to cures and drugs that are often costly, having to undergo specialist medical examinations and periods of hospitalisation, the need to request the assistance, partial or continuative, of people outside of the family circle ("carers"). This way, another problematic factor emerges, represented by loneliness with regards to family and the not-infrequent lack of relationships.

The lack of continuative relationships, economic uncertainty, the worsening of the state of physical and psychological health are factors that must not be seen as excluding each other; if anything, they intertwine to the point of seriously compromising people's overall well-being. According to a line of research that in the last few years has been promoted as part of economics and social sciences[28], it seems reductive to link personal and collective happiness exclusively to the growth of economic and material wealth, as something that can be quantified and measured on the basis of some objective parameters, like those measuring income and GDP. A person's *well-being* is rather due to a variety of aspects. With regards to this, Amartya Sen could state that the standard of living is an issue of *functionings* and *capabilities*, and it is not immediately an issue of wealth, services and belongings[29].

Human beings appreciate a variety of functions: from the most basic ones like being adequately nourished, being in good health, being able to live without privations, to more complex ones like respecting themselves, contributing to community life, wanting knowledge; but what is most important is that they then have the *capability* to concretely realise these functions. Again, it is not sufficient giving them an availability of material goods in order to be able to talk about social well-being, nor is it sufficient to introduce a re-distributive principle in order for the social situation to be considered right; even more important are the concrete capabilities the individuals have of actually being able to take advantage of these goods and pursue their aims. Without considering these capabilities, equality is empty and abstract. Freedom becomes real when

[28] A considerable contribution to this line of research has been given by the Nobel Prize for economics Sen and Kahnemann. The data were presented by L. Becchetti in a contribution to the NBC's Working Group and are published by the author in *Non solo homo oeconomicus*, 2008.

[29] Cf. the fundamental essay *Capability and Well-Being* by A. Sen, which can be found in M. Nussbaum and A. Sen, *The Quality of Life*, cit., pp. 30-53).

individuals effectively have capabilities that they can concretely exercise in order to be able to carry out their choices.

Transferring these considerations to our issues, we can easily see how the well-being of women over 65 years of age is threatened by the weakening, or the loss, of some important capabilities. Even the difficulty of enjoying some fundamental goods compromises *life flourishing*; amongst those, we must without a doubt mention the so-called relational goods, due to the value and the intensity of the relationships they are able to have with others. If the well-being and fulfilment of elderly women also depend so strongly from the possibility of enjoying significant relationships, it follows that "material poverty and illness cannot be cured only with economic help and drugs, but are effectively prevented by creating conditions that support relational investment"[30].

5.1. Suggestions – hopes

The new dimensions of old age require the elaboration of new social and healthcare policies. As we have said, family structure has profoundly changed; generational relationships and those between members of the same generation are changing and even the world of work is going through a profound transformation, with a new pace at work and more mobility, which considerably reduces the time destined to family activities. The elderly, therefore, face great instability, which causes uncertainty and discomfort. It is for this reason that we think it is quite useful to suggest new types of services for this age-group, in order to achieve better equality their access and use.

I. Case manager

Starting from taking into account the situation described in this document, we propose to give emphasis, in social and healthcare policies aimed at the elderly, especially women, to the figure of the *Case manager.*

Case Management has been used, since its first applications in social services, in two main ways:

- Supporting processes of de-institutionalisation and the foundation in Italy of some social-healthcare services;
- Guaranteeing the link and coordination of both the different individuals working in medical services and assistance, and between them and the patients.

This second function has become necessary when it was noticed how individuals (for example mental health patients) coming out of hospital, found inadequate and uncoordinated alternative services. Rejecting the logic of institutionalisation, with its risks of withdrawal and repression, did not automatically translate in a more humanising intervention, especially for the most severely disabled and suffering individuals.

Following the experiences in this field, developed in the United States since the 1960s, and the relative theoretical reflection[31], the Case Manager has been entrusted with the following duties and objectives:

[30] L. Becchetti et all., *Income, relational goods and happiness,* in "Applied Economics" number 2, 2008.

[31] Cf. B. Bortoli, *Il lessico della community care*, in R. Di Marzo and L. Gui (ed.), *Proposte per l'integrazione nei servizi sociali e sanitari*, Franco Angeli, Milano 2005, pp. 70-90; B. Bortoli, under "Case Management", in *Dizionario di servizio sociale*, diretto by Maria Dal Pra Ponticelli, Carocci-Faber, Milano 2005, pp. 95-101; M. Payne, *Case management and social services.*

1. “ensuring continuity of care through services, at any moment or periodically (for example when the individual cyclically moves from the institution to the community, between admissions and discharges);

2. Ensuring that the services respond to the entire range of an individual’s needs and to their variation in time, even for a whole lifetime, if necessary”[32];

3. Helping people to “access the necessary services, overcoming the obstacles linked to the access requirements, regulations, administrative decisions, procedures;

4. Ensuring that the services (…) are carried out adequately and quickly and do not unnecessarily overlap”[33].

The figure of the Case Manager is present (although not always put into action) in the National Healthcare Plan 2003-2005, as a point of reference for the elderly who are alone, and has the task of assessing and meeting their needs, using the network of healthcare and social-institutional services, or friendship and solidarity networks. In a complex society like ours, there is certainly no shortage of offer, as we have said, of social-healthcare services and support groups, also voluntary, which can be of help to the elderly who find themselves in difficulty; what is lacking, however, or what is at least felt to be a primary need for this age-group, is a figure of reference, someone they can trust. Too often, the people revolving around individuals of a certain age overlap or multiply, which leads to a sense of insecurity and lack of care. The figure of the Case Manager aims to meet the need of focusing on one person the desire for a “stable relationship”, which is the foundation of a mutual human contact. Its role is also relevant with regards to guiding the person they look after in both understanding and decoding medical language, in organising healthcare, from booking to undergoing the medical check-up etc., and, finally, in their capacity to involve the patient’s family circle. To ensure this task of involving the family members, and, more widely, friendship and solidarity networks, we should avoid the possible risk, mentioned in critical literature, of de-responsabilisation; the Case Manager intervenes not to take the place of family and friendship networks (when they exist), but to increase and support their contribution, by encouraging it and coordinating it. This role does not intend to add another link to the chain, which is already complicated and muddled by its bureaucratic structure; if anything, it aims to lower the incidence of bureaucratisation and depersonalisation, accompanying the person they look after and helping him/her extricate him/herself from the jungle of the services offered. If this role can be a real support for National Healthcare System users in general and for the elderly in particular, it will be of even more help, in light of what we have said above about the condition of women in their fourth age, for this section of the population, becoming the interpreter and guarantor of their particular needs in the social-healthcare field.

Finally, the bioethical importance of the Case Manager cannot be overlooked: it is aimed at individuals with high health risks, in most cases having to face, alone, fundamental questions about end-of-life issues; the person in this role will have to be prepared – with specific training adequate to carrying out its different duties – also to tackle bioethically such eventual situations: often, in fact, poly-pathologies are accompanied by a latent (or even

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The implementation of individualised programs of assistance in community care (1995); P. Donati and F. Folgherairter (ed.), *Gli operatori sociali nel welfare mix*, Erickson, Trento 1999.

[32] B. Bortoli, *Il lessico della community care*, cit., p. 84.

[33] *Ibid.*

apparent) depression, which reduces to a minimum the reaction to any type of medical intervention.

II. Medicine and healthcare that are “tailored to women”.

We hope the Regions will give particular importance to the type of social-healthcare interventions, specifically with regards to female’s problems, also in view of the public’s perception – on the basis of the parameters agreed upon and judgements of merit by the “assisted” female patients – of the hospitals and the healthcare structures that focus, as well as on the quality and appropriateness of the care given, also on investigating and protecting the specific needs of female patients, their particular psychological, relational and informative needs, in those delicate moments in life when fragility and insecurities manifest themselves more often and they are increasing with time[34].

The final hope is, therefore, that we proceed to a more in depth knowledge of the different social and healthcare services actually found in Italy, also at the local level, aimed at the male and female elderly population, and that, in the various areas of Italy, the offer of healthcare services *right for men and right for women*, is incremented and more adequately distributed, taking into account the particular needs of a society where people experiencing the problems specific to the fourth age will be increasingly high in number.

[34] As well as some initiatives by public bodies (which we mention in Attachment II), there are today also associations and private bodies, and scientific associations (first of all the S.I.G.T.) which are committed to the development of a medicine for women.

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ATTACHMENT I

The incidence of pathological alterations in women in their third and fourth age

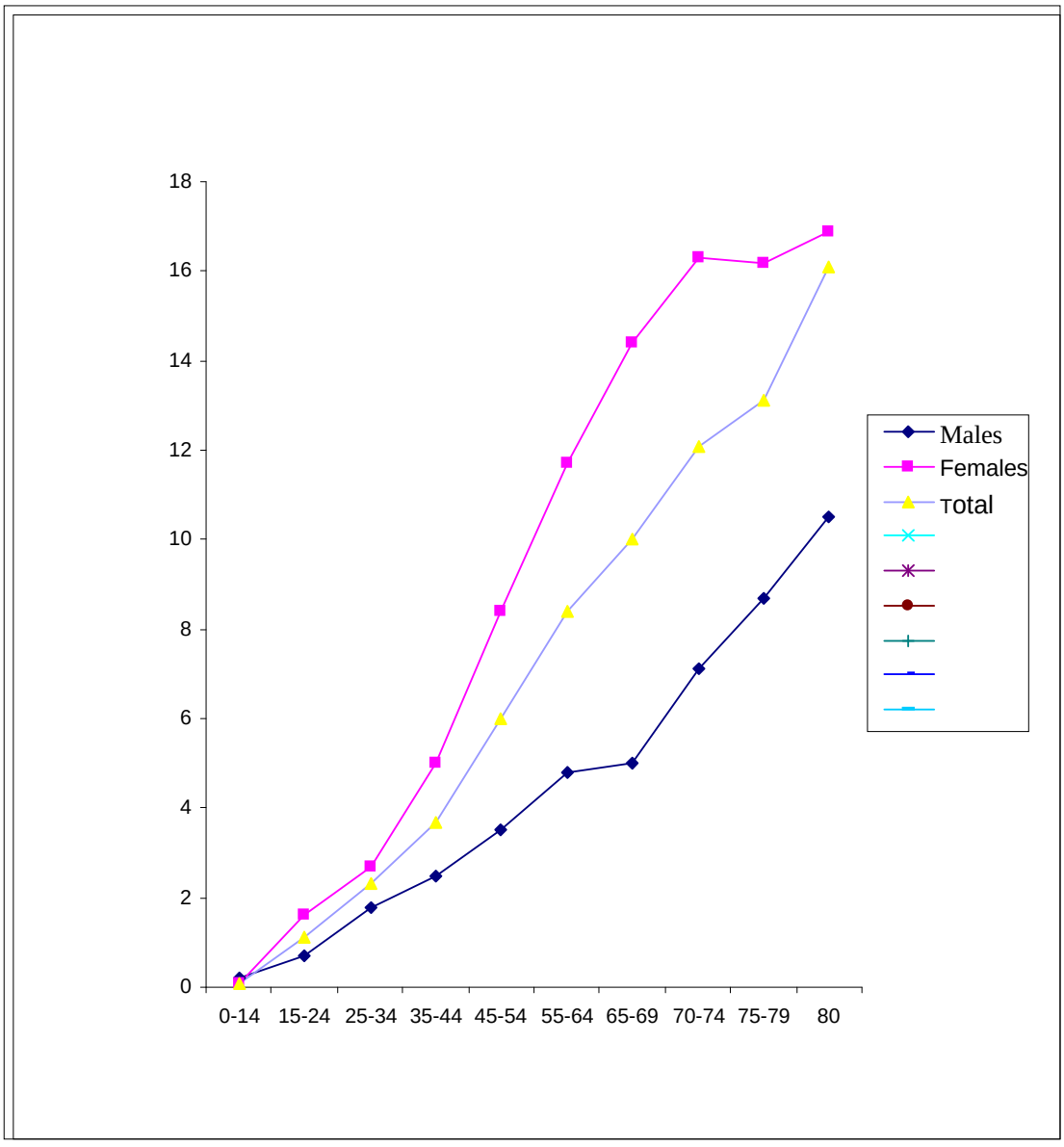
Here, we take into consideration some significant data regarding pathologies that concern especially women over sixty-five years of age, keeping in mind, as we have already said, that physical and psychological pathologies influence behaviour, relationships and, most of all, how we perceive our well-being. The endocrine tempest caused by the disappearance of feminine gametes and the consequent alteration of the steroid and ovarian biosynthesis, which leads to the cessation of the menstrual cycle (menopause), has considerable repercussions on the function of the main female organs, first of all the brain, accelerating the processes of *friability* that is typical of ageing. Although we don't deny the negative effect due to the decrease in estrogens (and partially also androgens) in women, we must however differentiate the post-menopausal period (50-52 years of age) from the one we are considering here (over 65 years of age).

An important syndrome of the last seasons of life is the so-called "*friability*", a clinical state that is inevitably linked to old age. It is a syndrome with factors that can be diagnosed and a peculiar clinical history but also growing therapeutic possibilities. It is characterised by a decrease in the functions of numerous apparata, which leads to a progressive inability to react to stress and accidents, with a consequent increase in illnesses and mortality (AGOG, VIII 2009). The syndrome is also characterised by a so-called "chronic tiredness"; it is easy to get tired, due to the decrease in muscular mass with a corresponding and considerable weight loss (around 6 Kg in a year), a decrease in stride and pace, intolerance or inability to deal with different occurrences, loss of self-esteem and a subjective perception of a state of indisposition, as well as an increase in chronic pathologies (osteoarthritis, autoimmune illnesses, etc.). The "fragility" affects women more than men. One of the consequences is *disability*, defined as a loss of the ability to maintain one or more functions necessary for an autonomous life, independent from the assistance of others (e.g. difficulty of movement, vision, hearing, speech, etc.). This syndrome affects 16% of women between 65 and 74 years of age, increases to 31% between 75 and 84 years of age and it affects more than 50% of women over 85 years of age.

From a nosological point of view, and a perspective of preventive and therapeutic efficiency, is however useful, even in summary critical examinations like ours, to discuss some "pathologies" separately. Let's examine first of all neuropsychological illnesses. The "mental health of elderly women" must be assessed not only in strictly biological terms (CNS nuclei and centres, neurotransmitters, etc.), but even activating the capacity to relate to their internal world and their potential emotional-cognitive resources, which should be developed and directed at the so-called "positive thinking" (Snyder and Lopez, 2002), which is the antithesis of what current cognitive theories define as the main characteristics of depression: "negative view of the self, the world and the future" (Clark and Beck, 1999). The possibilities of intervention to facilitate this trend – which should be consolidating the sense of the lasting value of our existence – are however hindered by the fact that a multiplicity of factors come to play in its genesis and development, both of a biological type,

including gender difference (Roysamb et al., 2002), as well as biographical and cultural.

Ageing, overall, involves the onset of emotive as well as cognitive pathologies: these pathologies, which are often impossible to distinguish from each other or are at least strictly interlinked, affect, as we have said, more women than men and concern a number of women that grows with age. In the graph below (Onda, 2008) – which moreover does not differentiate between the two main mood problems, depression and anxiety, and does not analyse their intensity – it seems already clear that the incidence of these pathologies on the female gender, during a whole lifetime, is significantly higher than on men.



Graph 1. Incidence of anxiety and depression mood pathologies at different ages (ONDA 2008)

Only in old age the pathology rate grows more rapidly in men, presumably for the fall in the quality of their mood due to the loss of a productive and social role. As already documented (Roger et al., 1984), in women persists a higher incidence of episodes of depression, often temporary and not requiring therapy. The worst depression, which affects more than 10% of women over 65 years of

age, is instead a serious psychiatric problem, which cannot be analysed in a few lines, and we mention it only to highlight its importance in daily life.

Similar considerations have to be made for the cognitive problems that go under the name of dementia, in its various forms. This affects more women than men of the same age, even in its most known variety (Alzheimer). Dementia, due to the cerebral damage caused by the destruction of nervous cells, affects 20% of people over 80 years old and 50% of those over 90 (Hy et al., 2000). Here, we simply stress how this pathology affects abstract thought, the ability to resolve daily problems, the logic to construct a speech and long and short term memory (ACOG, VIII 2009). Anyway, we must add that often the most elderly have memory problems (called *benign senescent forgetfulness*), which are also shown in tests; in similar cases, we must reassure the person concerned that this frequent phenomenon does not lead to dementia, it is not the first step in that direction.

Episodes of sudden “delirium” (sudden manifestation of mental confusion, marked disorientation, short term memory loss, various levels of lack of consciousness and mental confusion) can be seen sometimes in elderly women in the post-surgery phase, but also in hypoglycaemia, lack of oxygen due to anaemia, alteration of electrolytes, use of analgesics, CNS drugs, especially diazepam, etc. The phenomenon can be treated and it is reversible, but it needs very costly specific treatments by highly qualified specialists (Leslie et al., 2008).

In addition, changes in the hormonal levels of estrogens and progesterone seem to have an important effect on the psychological condition of women, even if the data is contradictory in literature. Depression manifests itself more frequently in those phases and ages in which there are hormonal changes: puberty, menstrual cycle, childbirth, immediately after the menopause. This last one in fact constitutes a moment of crisis, characterised by profound changes, internal and external, in the different areas of female reality. A woman’s social role is modified, starting with the family context. Generally the children are adults, they don’t need to be looked after anymore and leave home. Then the maternal role decreases in importance. The relationship with the partner also changes and needs to be based on new stimuli. The couple, not being parents anymore, find themselves alone after many years and must recreate their identity.

Women who had an autonomous working life can, additionally, live the crisis of retirement, to which often is added, as we have said, a crisis due to a lack of identification with their aging body, which does not mirror anymore that image of self consolidated during adulthood; and the prevalent socio-cultural stereotypes certainly do not help to tackle these delicate changes serenely. In old age, the loss of our roles and, with them, the usual social recognition, can undermine that self-esteem that in women, in particular, is always “at risk”. Anxiety for the future, the fear of physical and mental illness reduces autonomy, the passing away of loved ones, loneliness and marginalisation, as well as the perception of the objective decrease in the possibilities of self-realisation, can worsen depression and cannot always be kept under control with the recourse to the shortcut of taking medications. Sometimes their collateral effects “collude with many of the afflictions due to old age. For example, they worsen the individual perception of a reduced capability of functioning, increasing asthenia, altering the pattern of sleep and hunger. In addition, the slowing down of the mental processes induced by many medications increases the physiological

slowing down, which makes it difficult to assess the deterioration and tolerate it" (Pratesi and Bolelli, 2009). How to tackle "the disappointment, frustration, fear that sometimes accumulate in the fourth age? This is the task elderly people have before being able to activate the resources they possess in order to think more serenely about ageing". In this direction, the offer of psychotherapeutic treatments could then reveal itself to be, even for the female section of the elderly population, a valid support to pharmacological therapies in order to promote mental health, as it could be "a potent stimulus and exercise to think, as well as an aid to reduce suffering" (Pratesi and Bolelli, 2009).

The responsibility social and healthcare policies have to tackle the needs of this age group appears, also in this sense, fundamental. The carelessness in the diagnosis and care of cognitive and emotive disorders – we stress again that these factors are closely linked – can be considered "violence". Unfortunately, abuse and violence on elderly women is frequent, which takes the form not only of physical acts (gerontophilia exists also as a sexual pathology), often within their own four walls (*domestic abuse*), but also, and especially, with behaviours affecting the psychological and economic sphere. It has been known for some time how not only lack of care and abandonment, but also physical and psychological violence and abuse are frequent, especially on very elderly widows (Giordano and Giordano, 1984).

Other pathological factors influence the quality of life of elderly women considerably, sometimes affecting the female population much more seriously than men of the same age. In the fourth age, chronic illnesses increase. With age, osteoarthritis and arthritis increase, affecting 18.3% of both sexes, hypertension affects 13%, allergies 10% (Report by the Ministry of Health 2009).

Following, we report, although briefly, other data on the main pathologies affecting women over sixty-five years of age. The first cause of death for women in their third age is *cardiovascular disease*, which manifests itself, compared to men, around ten years later and with a peak in the post-menopausal phase (after their 50th year every woman has a 46% chance of contracting a cardiovascular disease and a 20% chance of stroke). In fact until the menopause, women enjoy, compared to men, a biological privilege due to the endogen and cyclic production of ovarian steroid hormones, which, according to some, protect the vascular and cardiac system (Marigliano, 2009; Duzenli et al., 2009). But these data unfortunately have not been confirmed by the studies on the last years of life regarding the effect of administering the main ovarian oestrogen (estradiol) and progesterone. If men develop cardiovascular pathologies before women, once the production of ovarian hormones ceases, they develop them more quickly. Hypertension is the most significant risk factor leading to heart attacks and strokes. In fact, whilst the male organism of the "over 60s" has years of "practice" in battling high blood pressure, the female organism suddenly finds itself facing, after the menopause, a relatively new phenomenon and its impact is therefore more dangerous.

Additionally, another risk factor is the frequent weight gain and accumulation of fat. The concentration of cholesterol in the blood, especially if LDL, is an independent risk factor leading to cardiovascular diseases. In both men and women they are affected, as well as by genetic factors, also by physical exercise and diet and, in the case of women, they vary with ovarian functions. With the menopause, the lipoid balance changes and LDL

cholesterol (the most harmful) increases compared to men. An LDL level above 160 mg/dl, requires an accurate medical therapy.

Mellitus diabetes is one of the most significant cardiovascular risk factors, in fact it doubles the incidence of myocardial infarction, compared to non-diabetic women, and trebles that of cardiovascular diseases. In the third age, the chance of developing diabetes increases, also because the decrease in oestrogen changes the distribution of adipose tissue. It has also been observed that many women's attempt to lose weight quickly, with a drastic reduction in their food intake, can be counterproductive, because the body loses both "fat" mass as well as "lean" mass, namely, muscles. When they then start eating again, the fat quickly re-forms, but the muscles don't; to this, we must add the fact that the ability to lose weight decreases after every drastic diet, as fasting induces our body to treasure fat. Another element that must be highlighted is the little inclination older people have, especially women, to adopt a lifestyle that includes regular physical exercise, whilst it has been stressed numerous times that it would be sufficient to walk for at least half an hour every day to improve our health condition, even when very old (Cress, 1996). For women over 50, physical exercise means, in addition, improving the muscle tone and preventing fractures and osteoporosis. Another important risk factor is, as we know, smoking. The incidence of myocardial infarction is dependent on its quantity in women over 50, increasing 2.5 times in women who smoke 1-5 cigarettes a day and 6-7 times in those who smoke more than 40. Smoking also increases the risk of stroke, arteriopathy and aortic aneurism.

An illness than concerns particularly women is, as we know, *osteoporosis.* In this case the women-men ratio is, over 65 years of age, about 6 to 1. The link between menopause and osteoporosis is known: the lack of oestrogen production in fact is an important risk factor for the onset of the illness. Oestrogens intervene in regulating the activity of osteoblastic and osteoplastic cells (demolition and reconstruction of bone trabeculae): if their control ceases, bone resorption increases and its formation decreases, bone density decreases leaving a porous and fragile structure. Hormone therapy reduces the risk of osteoporosis, but it does not stop the process and it must be administered only if there are other factors to be treated. There are in fact less risky drugs to consider. All women over 65 should have their bone density assessed. As well as the lack of oestrogens, there are also other risk factors, amongst which, again, physical inactivity, a diet lacking in calcium, the difficulty of absorbing it, being naturally thin, having had no menstruation for long periods of time, smoking, a high level of alcohol consumption, prolonged treatments with drugs containing cortisone, as well as, obviously, genetic predisposition. It is important to consider how this illness must not be seen as a physiological aspect of ageing, even though it is a very frequent pathological condition in the fourth age. A considerable number of women over the age of 60 will suffer an osteoporotic fracture and 20% of these fractures concern the proximal femur.

Amongst the osteoarticular disorders linked to the post-menopausal phase, we find, in any case, not only osteoporosis with the risk of bone fractures, but also osteoarthritis. The most recent investigations, in fact, show that muscles, cartilages and nerves also suffer damage due to the menopause. The main symptoms are widespread pain and sudden arthralgia. Osteoarthritis is a complaint that, if not treated, becomes an invalidating pathology for 25% of women over 50. Unfortunately, osteoarthritis affects (especially) women: up to 50 years of age, the ratio men to women is 1 to 1, that is, both sexes are

affected equally. After the disadvantage of having lost both the sexual hormones produced in the ovaries, as well as the precious DHEA, produced by the adrenal gland, it appears in all its strength: women are three times more likely then men to be affected in the knee, hip and hands. In about 25% of women, osteoarthritis increases incredibly quickly in the first two years after the menopause. Today we know that in this 25% of women there is an alteration in the oestrogen receptor, which seems to make them more sensitive to their lack. The fourth age of life, however, seems to be less sensitive to the lack of steroid hormones, almost as if the years bring a progressive adaptation.

Thyroid illnesses, both in the sense of hyper as well as hypo-function, affect mostly women in a ratio of over 15 to 1. Drugs containing cortisone are also taken more by women, due to the high prevalence of auto-immunitary diseases, rheumatic illnesses, etc.

We will mention anaemia only in passing, as it occurs in elderly women due to a lack of iron, vitamin B12 or folic acid (Andersen, 1996).

Finally, there are pathologies which interest exclusively women: urogynecological disorders and changes in the pelvic floor (cystourethrocele and prolapse); vulvar pathologies, and female tumours (breast, uterus, ovaries). The lack of oestrogens after the menopause substantially contributes to the development of *urinary tract* infections (UTI) in elderly women. The incidence of UTI increases vertiginously with age. Repeated infections can affect elderly women, especially if they are already debilitated or suffering from neurologic pathologies associated to urination problems. Urogynecological pathologies in this age group can be one of its major problems, because it interferes considerably with the quality of life, although today the incidence of prolapse and cystourethrocele is considerably lower. *Stress-incontinence*, nocturia and pollachiuria, leading to *urge incontinence,* need specialist surgery and medical treatment and must not be ignored when it first appears. It is therefore necessary to make healthcare institutions more sensitive towards this, so that they can offer adequate information and services.

A chapter should then be reserved to *vulvar* pathologies. As well as aesthetic and sexual issues linked to ageing, in old age there are in fact lesions which can only be identified with a biopsy.

Finally, a frequent pathology in old age, both because of its incidence and as a cause of death, is cancer. In fact, the risk of getting cancer increases with age and about 60% of tumours affect people over 65 years of age. The correlation between tumours and age is due to a prolonged exposition to carcinogens.

Female tumours (breast, uterus, ovaries) differ in their incidence according to the various organs and the histological chart. The cancer of the uterus appears mostly in old age. Breast cancer, the most frequent in women (even though it is less and less deadly thanks to early diagnoses and new therapeutic opportunities) affects, according to ACOG data (2003), 2% of 50 year-old women and 13% of 90 year-olds. Today, it is therefore recommended that women to start having mammograms at 40 years old and then repeat them every year for the rest of their lives. Ovarian cancer in elderly women is difficult to diagnose, so it is suggested that every cist, after the menopause, is removed. Elderly women are instead affected as much as men by lung cancer (smoke related) and cancer of the colon, as well as skin tumours.

A chapter that must be tackled particularly delicately and carefully, and having access to services and treatments fully paid for by the State, is therefore

that concerning tumours in general, their early diagnosis and their surgical and medical treatment. With regards to these needs, the eradication of inequalities, both between regions and within the same region, in the access to resources for the prevention and care, is to be considered one of the aims of the National Health Service.

In addition, with the advancing of age, women face a drop in libido and dysfunctional pathologies. And whilst in this phase of life there is more need for intimate relationship to confirm their "desirability", they have to confront a society in which the sexuality of the elderly, especially if it concerns women, is still taboo, so much so that there is no adequate information about the issues that can arise in old age with regards to having a love life and the best ways to tackle it.[35] It is instead important that the emotional and sexual dimension is experienced in the same way by an elderly couple, even in a diversity of manifestations and actions compared to previous seasons in their lives. Once again, we need for the GP, as well as the gynaecologist and andrologist, to acquire the ability to *counsel* elderly patients in a way that includes also sexuality and can help to tackle with more serenity the problems that a particular to this sphere and might cause pain and anxiety.

[35] Cf. N. Pratesi, D. Bolelli, *Riflessioni sul tema della psicoterapia dell'anziano*, in print.

ATTACHMENT II

Some activities and/or suggestions by local public Bodies for the most elderly in society

- The most important thing, for those living in their house alone or with a *care giver*, is access to information. This access can be promoted and guaranteed by a *call centre* that can explain and make known the initiatives and services of the local Town Hall ("social custodians" responding to these *call centres* are active in many towns) and that can link the network of services in Italy.
- Also useful has been the Samaritans service, of the type: "Hello, I'm listening…". A free service to accompany and support, in every day life, elderly people who are alone. By dialling a free number, activated locally, the elderly contact a person ready to listen, help, give advice and also direct them towards suitable institutions when needed.
- Vegetable gardens for the elderly. Some administrations, activating some *ad hoc* projects, assign a suitable plot of land to people willing to look after vegetable gardens and gardens in general.
- Holiday services, especially for summer. Active especially (but not necessarily) during the summer months, they are agreements between the various private or public structures and the Towns, to offer the elderly with a low income periods in which they can leave their home for a holiday or health/wellbeing problems.
- Social and recreational activities. A social centre for the elderly, voluntary work by the elderly in general, visiting monuments. These activities can be carried out in agreement with groups, associations, social cooperatives.
- Activities (which some local Bodies supply in agreement with suitable structures) for wellbeing or to change the perception of wellbeing by using the so-called "complementary therapies": massage, low impact exercise, music therapy, etc.
- Pet Therapy. There are many research projects about the different activities or therapies provided to the elderly and achieved with the use of animals in their own homes or in assisted housing.
- Silver card, gold card, or various other titles: they are all those economic facilitations supplied in some Towns which, with the use of an appropriate card, allow discounts on transport and food shopping or help with attending shows, accessing loans and libraries, giving the chance to attend gyms or swimming pools or other activities during their free time.
- Care cheques, supplied to the elderly with a low income, to help them meet their healthcare expenses.
- University for the III age, found in many Towns.
- Bank of hours. Active in many Towns, allows an exchange of free activities.
- Active voluntary work by the elderly, like supervising the entrance/exit to schools, pre-reception, etc.
- In many Towns or Regions, permanent Observatories have been set up, generally about the condition of the elderly and, more specifically, on the functional, economical aspects and the quality of assistance offered to the elderly. Particularly important in this field are the Bodies that protect rights, also through pensioners' unions, with the aim of contributing, for what concerns

- There are many projects of a preventive nature, often carried out by Clinics for the elderly, aimed primarily at the prevention of pathologies typical of that age. With regards to osteoporosis, especially in women, and the prevention of the risk of relapse, “Walking groups” are promoted to avoid falls, physical activity is aimed at exercises that improve balance, socialisation to improve temporal/spatial recognition.
- Entrusting the elderly. The service is an alternative to an admission in an Institution, by recurring to people who are not relatives of the elder patient, but are available to take care of him/her.
- There are projects that help the “carers”, promoting ways to complement the family and in particular the elderly who offer work to the carers, by supporting the social recognition of the activity of “care” to reward assistance, both for the family and for the carers.
- Suitable courses are carried out regionally to train care personnel.
- Health houses. It is a suggestion that can be found in the national health Plan, to create Units of primary Care, with a commitment to invest in them which was already in the 2007 Budget, aimed at trialling the health House, as the public place to re-organise the services and social-healthcare integration. Once the healthcare and social foundations have been established in every District-area, it is necessary to make binding and compulsory the Agreement on the plan between individual and/or associated Towns and the local healthcare Agencies for the integration of services and socio-healthcare bodies which need to work in temporal and spatial unity. In this direction also moves the national Convention of general Medicine, which foresees the creation of territorial teams of family doctors for group medicine.
- Daily centres. The centres receive the elderly that need to be housed and looked after, for a limited amount of time during the day. Their aim is to support integration and recuperation, through the carrying out of manual activities like woodwork, ceramics, drawing, using also the help and guidance of organisers, educators, therapists. These semi-residential places, with a high level of socio-healthcare integration, are destined to receive elderly who are partially self-sufficient, or non-self-sufficient, or have physical, psychological, sensorial or mixed pathologies. The daily Centre guarantees, together with home care (HCS-IHC, see below), the permanence of the elderly in their own home for as long as possible, offering also care and support for the family.
- Part of the support given to the elderly so they can stay in their home, are the Home care service (HCS) and the Integrated home care (IHC). With regards to the first, it is a service that guarantees social-care at the home of the patient in conditions of reduced or compromised autonomy, in order to allow him/her to remain in his/her usual living environment, to reduce the need to recur to residential structures, to promote the family’s responsibility and to elevate also the quality of life of the family that needs help. Home care allows the elderly patient to remain in his/her home and it can be managed also by voluntary associations or social cooperatives.
- Integrated home care (IHC) comes instead from a “structured” care system, aimed at ensuring the coordinated and permanent supply of medical care (nursing and rehabilitative medicine) and social care (personal care, delivering meals, domestic care) at the elderly’s home, by different professionals. This type of care therefore satisfies the complex needs of the

- Organiser in care homes for the elderly. The service's main objective is to improve the living conditions of people living in Rest Homes in Italy, by enhancing their capacities and abilities, even residual. The organiser's aim is to alleviate, stem and limit the loneliness and the sense of abandonment that elderly people relegated in care homes often feel.
- Also with regards to care homes – but we mention them here only in passing – we find various classifications of structures: hotel-homes, groups of flats, sheltered housing, home communities for the elderly, community hospitals.

We then have projects concerning the emergency/social sphere:

- Tele-aid. This initiative comes from the need to strengthen the care service for the elderly and to integrate, at the same time, the social structures operating in Italy, in order to satisfy in the best possible manner the needs of the assisted. The services of Tele-control and Tele-aid are active 24 hours a day and they are carried out through electronic devices (remote control, or bell, or particular telephone) linked to a care-central.
- SOS medicines and nursing support.
- Emergency Summer. Active in every Town especially in the month of August, allows monitoring the national territory, providing services and information to the elderly.

ATTACHMENT III

Some statistical data regarding women over 65 years of age in Italy

Table 1 – Italian population of 65 years olds and over, by sex and region, 01/01/2009 *(v.a. and val %)*

	Males			Females			Total		
	V.A.	% of the Italian national total	% of the regional total	V.A.	% of the Italian national total	% of the regional total	V.A.	% of the Italian national total	% of the regional total
Piedmont	422.110	8,3	41,9	584.295	8,3	58,1	1.006.405	8,3	100,0
Valle d'Aosta	11.065	0,2	42,0	15.276	0,2	58,0	26.341	0,2	100,0
Lombardy	800.157	15,8	41,2	1.143.265	16,3	58,8	1.943.422	16,1	100,0
Liguria	176.607	3,5	40,8	255.975	3,6	59,2	432.582	3,6	100,0
Trentino Alto Adige	77.795	1,5	41,6	109.280	1,6	58,4	187.075	1,5	100,0
Veneto	397.393	7,8	41,4	563.184	8,0	58,6	960.577	7,9	100,0
Friuli Venezia Giulia	116.488	2,3	40,8	168.899	2,4	59,2	285.387	2,4	100,0
Emilia Romagna	411.223	8,1	42,2	563.744	8,0	57,8	974.967	8,1	100,0
Toscany	362.210	7,1	42,0	500.470	7,1	58,0	862.680	7,1	100,0
Umbria	87.806	1,7	42,4	119.208	1,7	57,6	207.014	1,7	100,0
Marche	149.904	3,0	42,6	202.356	2,9	57,4	352.260	2,9	100,0
Lazio	463.867	9,1	41,9	642.530	9,2	58,1	1.106.397	9,2	100,0
Abruzzo	121.100	2,4	42,7	162.273	2,3	57,3	283.373	2,3	100,0
Basilicata	51.626	1,0	43,5	67.111	1,0	56,5	118.737	1,0	100,0
Calabria	162.798	3,2	43,5	211.618	3,0	56,5	374.416	3,1	100,0
Campania	387.092	7,6	42,0	535.616	7,6	58,0	922.708	7,6	100,0
Molise	29.636	0,6	42,3	40.494	0,6	57,7	70.130	0,6	100,0
Puglia	314.940	6,2	42,8	420.584	6,0	57,2	735.524	6,1	100,0
Sardegna	134.145	2,6	42,9	178.535	2,5	57,1	312.680	2,6	100,0
Sicily	394.156	7,8	42,7	528.327	7,5	57,3	922.483	7,6	100,0
North Westt	*1.409.939*	*27,8*	*41,4*	*1.998.811*	*28,5*	*58,6*	*3.408.750*	*28,2*	*100,0*
North Est	*1.002.899*	*19,8*	*41,6*	*1.405.107*	*20,0*	*58,4*	*2.408.006*	*19,9*	*100,0*
Centre	*1.063.787*	*21,0*	*42,1*	*1.464.564*	*20,9*	*57,9*	*2.528.351*	*20,9*	*100,0*
South and Island	*1.595.493*	*31,5*	*42,7*	*2.144.558*	*30,6*	*57,3*	*3.740.051*	*30,9*	*100,0*
Italiy	**5.072.118**	**100,0**	**42,0**	**7.013.040**	**100,0**	**58,0**	**12.085.158**	**100,0**	**100,0**

Source: elaboration Censis on Istat data, "Resident population by age, sex and marital status"

Table 2 –Marital status of women who are 65 year old and over, by region, 01/01/2009 *(v.a. and val. %)*

	Marital status								Total	
	Unmarried		Married		Divorced		Widowed			
	V.A.	%	V.A.	%	V.A.	%	V.A.	%	V.A.	%
Piedmont	43.287	7,4	255.306	43,7	11.649	2,0	274.053	46,9	584.295	100,0
Valle d'Aosta	1.142	7,5	6.260	41,0	368	2,4	7.506	49,1	15.276	100,0
Lombardy	99.781	8,7	488.741	42,7	19.926	1,7	534.817	46,8	1.143.265	100,0
Liguria	20.386	8,0	109.379	42,7	6.770	2,6	119.440	46,7	255.975	100,0
Trentino Alto Adige	13.041	11,9	44.588	40,8	1.757	1,6	49.894	45,7	109.280	100,0
Veneto	48.320	8,6	238.594	42,4	6.991	1,2	269.279	47,8	563.184	100,0
Friuli Venezia Giulia	12.665	7,5	68.071	40,3	3.722	2,2	84.441	50,0	168.899	100,0
Emilia Romagna	38.031	6,7	249.197	44,2	10.320	1,8	266.196	47,2	563.744	100,0
Tuscany	30.611	6,1	228.345	45,6	7.963	1,6	233.551	46,7	500.470	100,0
Umbria	6.671	5,6	55.527	46,6	1.379	1,2	55.631	46,7	119.208	100,0
Marche	13.479	6,7	90.840	44,9	1.843	0,9	96.194	47,5	202.356	100,0
Lazio	57.993	9,0	288.313	44,9	15.301	2,4	280.923	43,7	642.530	100,0
Abruzzo	10.877	6,7	73.280	45,2	1.517	0,9	76.599	47,2	162.273	100,0
Basilicata	4.940	7,4	30.812	45,9	390	0,6	30.969	46,1	67.111	100,0
Calabria	18.217	8,6	93.664	44,3	1.980	0,9	97.757	46,2	211.618	100,0
Campania	50.328	9,4	234.473	43,8	5.528	1,0	245.287	45,8	535.616	100,0
Molise	2.912	7,2	18.380	45,4	286	0,7	18.916	46,7	40.494	100,0
Puglia	39.807	9,5	194.012	46,1	4.308	1,0	182.457	43,4	420.584	100,0
Sardegna	25.033	14,0	75.023	42,0	1.693	0,9	76.786	43,0	178.535	100,0
Sicily	50.961	9,6	223.905	42,4	6.462	1,2	246.999	46,8	528.327	100,0
Noth West	*164.596*	*8,2*	*859.686*	*43,0*	*38.713*	*1,9*	*935.816*	*46,8*	*1.998.811*	*100,0*
North Est	*112.057*	*8,0*	*600.450*	*42,7*	*22.790*	*1,6*	*669.810*	*47,7*	*1.405.107*	*100,0*
Centre	*108.754*	*7,4*	*663.025*	*45,3*	*26.486*	*1,8*	*666.299*	*45,5*	*1.464.564*	*100,0*
Sud e Island	*203.075*	*9,5*	*943.549*	*44,0*	*22.164*	*1,0*	*975.770*	*45,5*	*2.144.558*	*100,0*
Italiy	**588.482**	**8,4**	**3.066.710**	**43,7**	**110.153**	**1,6**	**3.247.695**	**46,3**	**7.013.040**	**100,0**

Source: elaboration Censis on Istat data, “Resident population by age, sex and marital status”

Table 3 – Women of 65 years and over by marital status, 1996-2000-2002-2005-2007 *(v.a. and val. %)*

	1996		2000		2002		2005		2007		2008	
	V.A.	% (1)	V.A.	% (1)	V.A.	% (1)	V.A.	% (1)	V.A.	% (1)	V.A.	% (1)
Unmarried	287.436	71,7	302.685	67,8	312.725	65,7	290.009	65,9	294.963	62,6	347.534	66,1
Separated/, Divorced	67.617	63,4	77.046	50,7	79.848	47,0	120.558	54,3	96.798	48,0	129.788	48,2
Widow/widower	1.595.965	84,8	1.845.010	84,2	1.910.248	84,1	2.013.574	83,2	2.086.618	84,3	2.091.728	82,9
Total	**1.951.019**	**81,6**	**2.224.741**	**79,7**	**2.302.821**	**78,9**	**2.424.141**	**78,6**	**2.478.380**	**78,7**	**2.569.050**	**77,4**

(%) For 100 people who are 65 years old and over, alone and having the same marital status

Source: elaboration Censis on Istat data, “Aspects of daily life”

Table 4 - Health conditions and presence of some chronic illnesses in the population who has reached 65 years of age or over – Gender differences

Years 2000-2008 *(for 100 people of the same age and sex)*

	2000		2002		2005		2007		2008	
	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males
In good health (a)	31,1	37,7	32,4	40,7	33,6	41,0	33,3	41,2	-	-
With at least one chronic illness	83,1	77,6	83,3	76,8	84,2	75,7	84,9	76,3	84,1	78,1
With at least two chronic illness	63,4	51,8	64,0	50,4	64,4	50,1	66,7	52,3	64,5	52,6
Chronically ill in good health (b)	24,9	28,1	26,4	31,5	28,0	31,6	27,4	31,4	-	-
Diabetes	12,8	13,8	13,3	13,5	14,3	14,7	15,4	15,0	16,9	15,7
Hypertension	41,3	35,9	42,5	35,8	44,4	40,2	48,7	41,3	49,4	45,3
Chronic bronchities	16,4	24,9	17,0	22,1	16,7	21,3	17,1	21,2	14,9	19,1
Osteoarthritis, arthritis	63,1	47,3	63,9	46,0	63,2	42,4	65,5	45,1	61,1	42,3
Osteoporosis	36,7	7,5	37,2	8,5	37,7	7,3	41,1	8,2	40,0	7,9
Heart diseases	12,7	16,7	12,6	16,4	12,2	16,0	13,3	15,8	10,7	14,6
Allergies	8,4	5,9	8,6	6,2	9,6	6,1	10,9	7,6	10,2	6,9
Nervous diseases	12,8	8,2	12,3	6,8	10,9	6,9	12,9	8,3	11,9	7,9
Gastric or duodenal ulcer	7,8	10,8	6,7	9,1	7,5	8,3	7,5	8,8	5,9	8,3

(a) They express a 4 or 5 level on a scale of 1 to 5, where 1 is the worst state and 5 the best one
(b) For 100 persons affected by at least one chronic illness
(c) Including bronchial asthma

Source: elaboration Censis on Istat data, “Aspects of daily life”

Table 5 – Recourse to healthcare services in the population who has reached 65 years of age and over – Gender differences – Years 2000-2008 *(for 100 people of the same age abd sex)*

	2000		2002		2005		2007		2008	
	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males
Admissions into hospital, care institutions or NHS care homes										
- Number (in thousands)	481	480	489	442	528	444	471	412	518	447
- Quota for 1,000 people	80,1	113,6	80,0	102,4	81,5	95,0	70,5	84,8	76,5	90,2
People with at least one admission:										
- Number (in thousands)	407	380	424	368	410	372	415	349	430	385
- Quota for 1,000 people	67,7	89,9	69,4	85,2	63,3	79,6	62,1	71,8	63,5	77,8
Days of hospitalisation:										
- Data in thousands	4.801	4.807	5.239	4.505	6.037	4.224	4.853	3.604	5.039	4.252
- Average for admision	10,0	10,0	10,7	10,2	11,4	9,5	10,3	8,7	9,7	9,5
- Average for admitted person	11,8	12,7	12,4	12,2	14,7	11,4	11,7	10,3	11,7	11,0
Accident and Emergency:										
- People (thousands)	460	379	498	408	580	479	577	487	608	504
- Quota for 1,000 people	76,6	89,7	81,5	94,5	89,5	102,4	86,3	100,2	89,8	101,7
- Recourses (thousands)	588	475	725	589	804	638	833	658	834	671
Emergency doctor:										
- People (thousands)	304	178	326	220	379	268	331	244	403	262
- Quota for 1,000 people	50,6	42,1	53,4	51,0	58,5	57,4	49,5	50,3	59,6	52,9
- Recourses (thousands)	482	282	632	404	643	458	536	335	627	469

Source: elaboration Censis on Istat data, “Aspects of daily life”

Table 6 - People who in the last four weeks have had preventive check-ups, by type of check up, according to a differentiation by age and sex - Year 2005 *(for 100 persons with the same characteristics)*

	Total of preventive check-ups (a)			Only generic prevention (b)			Specialist preventive check-ups (b)		
	Males	Females	Males and females	Males	Females	Males and females	Males	Females	Males and females
0-14	9,5	10,2	9,9	70,0	67,6	68,8	23,7	25,8	24,8
15-24	3,5	5,3	4,4	26,0	21,4	23,3	69,5	68,3	68,8
25-34	2,7	7,5	5,1	39,0	14,7	21,2	54,5	78,1	71,9
35-44	3,5	6,0	4,7	34,5	25,2	28,7	58,5	67,3	64,0
45-54	5,0	6,6	5,8	37,6	26,4	31,1	52,5	62,7	58,4
55-64	6,3	6,9	6,6	43,3	39,6	41,3	45,6	50,7	48,4
65-69	8,3	7,1	7,7	49,5	50,9	50,2	39,2	34,4	36,8
70-74	7,8	7,6	7,7	48,9	49,5	49,3	43,1	39,3	41,1
75-79	8,5	7,8	8,1	53,6	58,5	56,4	38,9	32,4	35,2
80-and over	8,7	9,6	9,3	57,7	72,7	68,0	31,5	20,4	23,9
Total	5,6	7,3	6,5	49,2	41,3	44,6	42,7	49,9	46,9

(a) for 100 people with the same characteristics
(b) for 100 people who have had preventive check ups with the same characteristics

Source: elaboration Censis on Istat data, *"Health conditions and recourse to healthcare services"*

Table 7 – Sport practices of the population by age – Gender differences - Year 2008 *(for 100 persons of the same age and sex)*

	Practice sport				Practice sport				Practice sport			
	Consistently	Inconsistently	Practice only some physical activity	Do not practice sport or any physical activity	Consistently	Inconsistently	Practice only some physical activity	Do not practive sport or any physical activity	Consistently	Inconsistently	Practice only some physical activity	Do not practice any physical activity
	Males				Females				Males and females			
3-5	16,5	5,1	22,9	49,5	22,0	3,1	19,8	48,7	19,2	4,1	21,4	49,1
6-10	57,5	8,9	13,4	18,4	52,4	6,3	15,8	24,1	55,0	7,7	14,6	21,1
11-14	64,1	8,9	11,6	14,7	49,6	9,7	18,0	21,2	57,0	9,3	14,7	17,9
15-17	53,8	17,8	12,4	15,6	35,3	11,7	23,9	27,9	45,0	14,9	17,9	21,5
18-19	47,8	17,3	12,9	21,0	26,2	13,6	27,6	32,6	36,6	15,4	20,5	27,0
20-24	43,2	17,3	14,4	23,9	25,2	12,8	28,5	32,5	34,5	15,1	21,2	28,0
25-34	33,2	16,4	19,1	30,3	21,1	11,2	30,4	36,5	27,3	13,9	24,6	33,3
35-44	23,2	15,9	25,1	35,2	16,8	10,4	31,6	40,7	20,0	13,1	28,4	38,0
45-54	19,2	13,8	29,2	37,4	13,8	8,0	34,5	43,3	16,5	10,8	31,9	40,4
55-59	14,9	10,4	34,7	39,7	11,9	6,2	37,4	44,1	13,4	8,3	36,1	41,9
60-64	12,4	8,8	38,4	40,3	9,6	4,9	37,6	47,2	11,0	6,9	38,0	43,8
65-74	**8,6**	**6,0**	**42,9**	**41,8**	**7,4**	**2,7**	**33,7**	**55,7**	**8,0**	**4,2**	**37,9**	**49,4**
75 and over	**3,5**	**2,2**	**30,4**	**63,5**	**1,6**	**1,8**	**17,5**	**78,6**	**2,3**	**1,9**	**22,4**	**72,9**
Total	25,8	12,0	26,1	35,3	17,6	7,5	29,2	44,9	21,6	9,7	27,7	40,2

Source: elaboration Censis on Istat data, “Aspects of daily life”

Table 8 - Disable people who are 65 years of age and over, by type of disability and sex – Years 1999/2000 - 2005
(for 100 people of the same age and sex)

	1999-2000		2005	
	Males	Females	Males	Females
Disable	14,3	22,9	13,3	22,5
Type of disability				
Individual confinement	5,9	11,0	5,6	11,0
Functions disabilities	8,7	15,0	8,9	15,0
Difficulty of movement	6,7	11,5	6,4	11,6
Difficulty of sight, hearing and speech	3,8	4,7	3,1	4,6

Source: elaboration Censis on Istat data, *"Health conditions and recourse to healthcare services"*

Table 9 - Disable people who are 65 years old and over, by type of disability, age and sex – Years 1999-2000 and 2005 *(for 100 people of the same age and sex)*

Age	1999-2000					2005				
	Disable	Type of disability				Disable	Type of disability			
		Individual confinement	Functions disabilities	Movement disabilities	Disability of sight, hearing, speech		Individual confinement	Functions disabilities	Movement disabilities	Disability of sight, hearing, speech
					Males					
6-14	1,5	0,3	1,2	0,1	0,2	1,6	0,1	1,3	0,2	0,2
15-24	0,8	0,2	0,4	0,2	0,3	0,6	0,2	0,3	0,1	0,3
25-34	0,9	0,4	0,3	0,2	0,3	0,7	0,3	0,4	0,2	0,2
35-44	1,0	0,4	0,6	0,3	0,3	1,0	0,3	0,6	0,3	0,4
45-54	1,4	0,6	0,6	0,5	0,6	1,4	0,6	0,5	0,5	0,3
55-64	3,0	0,9	1,4	1,5	0,8	2,2	0,8	1,0	1,0	0,7
65-69	6,3	1,8	3,2	3,2	1,5	4,3	1,6	2,8	1,9	1,0
70-74	9,8	3,2	4,8	4,8	2,2	7,7	2,9	4,7	3,6	1,4
75-79	14,4	6,1	8,7	6,6	3,5	13,4	5,1	8,4	6,8	2,5
80 and over	38,7	19,1	27,1	17,6	11,8	35,8	16,1	25,3	17,1	9,3
TOTAL	3,4	1,3	2,0	1,5	0,9	3,3	1,3	2,1	1,5	0,8
					Females					
6-14	1,6	0,4	1,0	0,2	0,2	1,6	0,1	1,4	0,1	0,2
15-24	1,0	0,5	0,5	0,2	0,2	0,6	0,2	0,3	0,1	0,2
25-34	0,9	0,4	0,3	0,2	0,3	0,6	0,2	0,3	0,1	0,2
35-44	1,0	0,5	0,4	0,3	0,3	0,9	0,3	0,4	0,2	0,3
45-54	1,6	0,7	0,5	0,6	0,4	1,3	0,5	0,6	0,6	0,3
55-64	4,3	1,7	1,6	2,3	0,6	2,7	1,0	1,3	1,6	0,5
65-69	7,5	3,0	3,8	3,8	1,1	6,5	2,4	3,1	3,8	0,8
70-74	13,2	5,4	6,4	7,3	1,8	11,4	4,7	5,6	5,9	2,5
75-79	23,0	10,1	13,8	12,1	3,6	20,8	9,6	12,1	10,9	3,8
80 and over	52,0	27,8	39,2	24,9	13,4	48,9	25,5	36,8	24,7	10,5
TOTAL	6,2	2,9	3,7	3,0	1,3	6,1	2,8	4,0	3,0	1,3
					Males and females					
6-14	1,6	0,4	1,1	0,2	0,2	1,6	0,1	1,4	0,2	0,2
15-24	0,9	0,4	0,4	0,2	0,2	0,6	0,2	0,3	0,1	0,2
25-34	0,9	0,4	0,3	0,2	0,3	0,6	0,3	0,3	0,2	0,2
35-44	1,0	0,5	0,5	0,3	0,3	0,9	0,3	0,5	0,3	0,3
45-54	1,5	0,7	0,6	0,6	0,5	1,3	0,6	0,6	0,6	0,3
55-64	3,7	1,3	1,5	1,9	0,7	2,5	0,9	1,2	1,3	0,6
65-69	7,0	2,4	3,5	3,5	1,3	5,5	2,1	2,9	2,9	0,9
70-74	11,7	4,4	5,7	6,2	2,0	9,7	3,9	5,2	4,9	2,0
75-79	19,6	8,5	11,8	9,9	3,5	17,8	7,8	10,6	9,2	3,3
80 and over	47,7	25,0	35,2	22,5	12,9	44,5	22,3	32,9	22,1	10,1
TOTAL	4,9	2,1	2,9	2,2	1,1	4,8	2,1	3,0	2,3	1,1

Source: elaboration Censis on Istat data, *"Health conditions and recourse to healthcare services"*

Table 10 - Perceptiors of work and public transfers income, by age and sex – Years 2004-2006 *(for 100 persons who are 15 years old and over with the same characteristics)*

	Work		Pensions		Other public transfers		Public transfers (a)	
	Females	Males	Females	Maales	Females	Maales	Females	Males
				2003				
Below 35 years of age	55,4	70,8	2,0	2,3	17,9	23,5	19,5	25,3
35 - 44 years of age	68,3	95,1	3,1	3,8	21,4	37,8	23,6	40,3
45 - 54 years of age	60,6	91,7	9,3	10,9	11,8	32,6	20,1	39,9
55 - 64 years of age	26,3	51,7	49,8	62,0	4,6	22,2	52,3	70,2
65 years of age *or over*	*3,3*	*10,5*	*90,5*	*98,3*	*4,3*	*28,7*	*90,6*	*98,4*
Total	41,4	64,5	32,1	30,9	12,4	28,5	42,6	51,0
				2004				
Below 35 years of age	54,9	71,5	2,0	2,4	17,4	22,8	19,0	24,8
35 - 44 years of age	69,0	95,4	3,0	3,7	21,0	39,3	23,2	41,2
45 - 54 years of age	61,1	91,7	10,1	10,2	13,0	33,2	21,8	39,9
55 - 64 years of age	28,7	52,3	49,1	61,5	4,0	21,3	51,3	70,2
65 years of age *or over*	*3,1*	*11,2*	*88,7*	*97,2*	*4,8*	*27,6*	*88,7*	*97,3*
Total	41,7	64,9	31,9	30,8	12,3	28,4	42,3	51,0
				2005				
Below 35 years of age	50,9	67,5	2,0	2,2	18,5	22,1	20,2	24,0
35 - 44 years of age	66,8	93,8	2,9	3,7	22,2	37,3	24,5	39,3
45 - 54 years of age	59,9	92,0	8,9	8,6	13,2	33,8	20,6	38,1
55 - 64 years of age	32,4	55,8	48,2	60,2	4,4	24,9	50,7	69,2
65 years of age *or over*	*7,2*	*13,0*	*88,8*	*97,7*	*5,7*	*31,2*	*88,8*	*97,8*
Total	41,4	64,2	31,8	30,7	13,2	29,2	42,8	50,3
				2006				
Below 35 years of age	48,6	64,4	2,4	2,3	19,1	22,2	21,1	24,2
35 – 44 years of age	65,9	92,8	2,8	3,4	22,2	39,5	24,4	41,6
45 - 54 years of age	59,0	90,6	9,5	9,1	14,2	32,3	22,2	37,2
55 - 64 years of age	28,0	51,7	49,1	62,9	4,6	22,5	51,2	69,6
65 years of age *or over*	*2,8*	*9,5*	*90,2*	*98,7*	*5,8*	*30,8*	*90,2*	*98,7*
Total	38,7	61,5	32,6	31,5	13,5	29,0	43,8	51,1

(a) The sum of the perceptors of pension and non-pension transfers income does not coincide with the perceptors of public transfers as there are individuals who receive both these types of income.

Source: elaboration Censis on Istat data, “Income and life conditions”

Table 11 - Net individual income from work and public transfers, by age and sex - Years 2004-2006 *(average in euros)*

	Work		Pensions		Other public transfers		Public transfers (a)	
	Females	Males	Females	Males	Females	Maales	Females	Males
				2003				
Below 35 years of age	10.677	13.575	4.181	4.404	1.799	2.334	2.078	2.555
35 - 44 years of age	13.675	19.464	5.225	5.082	1.926	2.385	2.434	2.718
45 - 54 years of age	15.146	21.251	7.933	11.768	2.746	3.217	5.281	5.840
55 - 64 years of age	15.153	20.328	9.958	15.847	5.566	2.713	9.979	14.853
65 years of age or over	11.604	17.084	9.177	12.815	1.462	436	9.243	12.924
Total	12.952	17.866	9.137	13.243	2.142	2.181	7.492	9.250
				2004				
Below 35 years of age	11.291	14.285	3.928	4.450	1.843	1.856	2.101	2.144
35 - 44 years of age	14.351	20.486	5.652	5.483	2.308	2.493	2.819	2.870
45 - 54 years of age	15.769	22.612	8.020	10.882	2.526	2.832	5.218	5.141
55 - 64 years of age	15.041	21.037	10.289	16.735	3.550	2.990	10.129	15.567
65 years of age or over	10.384	15.221	9.612	13.681	523	404	9.632	13.784
Total	13.544	18.754	9.517	13.983	2.042	2.055	7.763	9.590
				2005				
Below 35 years of age	11.739	14.700	5.015	4.852	2.117	1.927	2.446	2.217
35 - 44 years of age	14.890	20.489	5.502	5.486	2.414	2.132	2.849	2.545
45 - 54 years of age	16.227	22.750	7.525	8.418	2.471	2.629	4.857	4.240
55 - 64 years of age	14.425	20.511	9.825	15.260	3.033	1.787	9.605	13.912
65 years of age or over	6.124	13.373	9.917	13.918	654	323	9.953	14.012
Total	13.671	18.854	9.637	13.642	2.142	1.753	7.821	9.332
				2006				
Below 35 years of age	11.782	15.192	4.911	4.906	2.218	2.036	2.544	2.332
35 - 44 years of age	15.516	21.303	6.192	5.135	2.464	2.679	2.948	2.961
45 - 54 years of age	16.769	23.664	7.581	8.303	2.806	2.625	4.951	4.287
55 - 64 years of age	15.552	22.639	9.939	15.173	1.683	1.047	9.643	14.061
65 years of age or over	7.552	13.764	10.127	14.136	450	335	10.154	14.227
Total	14.263	19.807	9.810	13.763	2.166	1.846	7.961	9.525

(a) The sum of the perceptors of pension and non-pension transfers income does not coincide with the perceptors of public transfers as there are individuals who receive both these types of income.

Source: elaboration Censis on Istat data, “Income and life conditions”

Table 12 – Old age index by gender ***[composition relationship between the population who has reached 65 years of age and over compared to that between 0 and 14 years of age] (1)*** **- Years 1992-2020** (val. %)

	Males	Females	Total
1992	**80,0**	**121,7**	**100,4**
1993	83,1	126,4	104,3
1994	86,2	131,1	108,1
1995	89,0	135,3	111,6
1996	92,3	140,0	115,5
1997	94,8	143,8	118,7
1998	97,0	147,2	121,5
1999	99,2	150,4	124,1
2000	101,3	153,3	126,6
2001	103,6	156,4	129,3
2002	105,0	159,2	131,4
2003	107,2	161,9	133,8
2004	109,2	164,0	135,9
2005	111,2	166,0	137,8
2006	113,3	168,1	139,9
2007	115,0	170,0	141,7
2008	116,2	170,9	142,8
2009	117,0	171,3	143,4
2010	**118,5**	**172,6**	**144,8**
2011	*119,2*	*172,9*	*145,3*
2012	*121,7*	*175,4*	*147,8*
2013	*124,1*	*177,8*	*150,2*
2014	*126,7*	*180,5*	*152,9*
2015	*128,9*	*183,0*	*155,2*
2016	*131,2*	*185,6*	*157,6*
2017	*133,1*	*187,8*	*159,6*
2018	*134,9*	*190,0*	*161,7*
2019	*137,0*	*192,5*	*163,9*
2020	***139,5***	***195,6***	***166,7***

(1) Data from the 1st of January of each year

Source: elaboration Censis on Istat data

Table 13 – Hope of life for those who are 65 years old (by gender) - Year 1992-2020 *(average age)*

	Males	Females
1992	15,4	19,2
1993	15,4	19,2
1994	15,5	19,4
1995	15,7	19,6
1996	15,8	19,6
1997	16,0	19,8
1998	15,9	19,8
1999	16,2	20,0
2000	16,5	20,4
2001	16,9	20,7
2002	16,9	20,8
2003	16,8	20,6
2004	17,4	21,4
2005	17,5	21,3
2006	17,8	21,6
2007	17,9	21,6
2008	18,0	21,6
2009	18,2	21,7
2010	**18,3**	**22,1**
2011	18,4	22,2
2012	18,5	22,3
2013	18,6	22,5
2014	18,7	22,6
2015	18,8	22,7
2016	18,9	22,8
2017	19,0	23,0
2018	19,2	23,1
2019	19,3	23,2
2020	19,4	23,3

Source: Istat data