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The Elderly between the Needs for Care and Active Ageing

by Tiziana Tesauro* and Luca Pianelli**

1. Introduction

The article starts from the dichotomy that currently characterises the scientific and political debate on ageing. Two opposing, or rather mirrored theses mark the discussion on the "elderly question".

On the one hand it is evident that the progressive ageing of the population brings with it growing costs for the welfare system, given the increase in social security and health expenditure. Indeed in our country the social demand for care on the part of the elderly is on the increase (according to the latest ISTAT data -2007- there are around 2 million non self-sufficient elderly people, and more than 4,800,000 affected by chronic illnesses and pluripathologies). On the other hand it is claimed that, generally speaking, the elderly can be a resource for the whole of society, not only because they live longer, but also because often, even beyond the age of 80, they enjoy good health. On this subject many epidemiological studies have shown that improvements in health without precedent are taking place among the population in general, and the elderly in particular. This is thanks to economic and social progress and to the discovery of new cures and new medical technologies which today can act more effectively on multi chronic conditions, thus slowing down, or at any rate putting off the onset of real and true disability. This confirms what Riley (1979) stated, i.e. that ageing cannot be considered an inexorably degenerative process. Rather, it is the result of the systematic interaction of biological, psychological and social processes. Since these biological, psychological and social processes are in continuous change in time, ageing is a process *in continuous transformation* (author's italics) which never shows itself the same. From this perspective, since every new cohort is born at a particular moment, and faces a unique series of roles and environmental events they have their own personality. Hence individuals belonging to different cohorts tend to age in different ways. Thus the elderly of the third millennium are experiencing ageing in good health.

On this point it is worth underlining that the most recent data disprove the hypothesis suggested by some scholars (Kramer 1980) that there is a directly proportional relationship between the lengthening of life expectancy and the increase in the level of non self-sufficiency. In our country, from 1994 to 2005 the incidence of disability among the elderly went down, despite the fact that in the same decade the population had aged significantly (cf. Figure 1). The health conditions of the Spanish elderly are also improving. According to a recent estimate (cf. Libro Bianco de dependencia) of the approximately twenty years of life left to 65 year old women about 12 of them would be free of disability while of the 16 years left to men 11 would be free of disability. It is interesting to note that in other countries too, such as

*Tiziana Tesauro edited the draft of the article.

France and the United States a progressive decline, not only in serious disabilities but also in minor ones has been recorded (Jacobzone 1999, Manton and others 1993 and 1997; Costa 2000; Cutler). So much is this the case that Combois and Robine (1996) conclude that it is legitimate to expect, as Manton had theorised (1982, 1993 and 1997) that in the future the lengthening of life expectancy, and hence delay in the age of death, would be accompanied, not by an increase in mental illnesses, chronic illnesses and disability (Kramer 1980), but rather by a greater expectation of a life free of disability. In this regard the European Commission has reaffirmed the lengthening of the average life expectancy is increasingly accompanied by the continuous increase in the hope of a healthy life (COM 2005, 94) and that if future increases in life expectancy were attained in basic good health and free from invalidity, the forecast increase in public expenditure on the health of and care for the non self sufficient elderly would be reduced by half (COM 2006, 574). Moreover it is empirically observable that psycho-physical decay and loss of functional self sufficiency are occurring at increasingly older age, and as a consequence there are many elderly who remain active and are organising their lives from the professional and family point of view (Repubblica 16 May 2007)[1].

In view of all the above this article intends to specularly analyse the two aspects of ageing, seeking to maintain together, in a manner of speaking, the two sides of the same coin, discussing on the one hand the factors that determine the social demand for care, and on the other, the many factors that influence the continuation of working activity beyond the age of 65 (a fact generally referred to when active age is discussed in literature and political debate).

In the first paragraph of this article we present the data relating to the ageing of Italians from 1995 to 2005, showing not only the speed and intensity of the phenomenon, but also its territorial differences. In the second paragraph, starting from the theoretical perspective of health determinants (Geddes da Filicaia M. e Macioce G. 2007), which considers health the product of individual and environmental variables, we hypothesise that the different degrees of socio economic development which characterise the North and South of the country (Pugliese 2006) and the territorial imbalance of the system offering socio-welfare services (Caltabiano 2004), constitute environmental variables which can cause inequalities in health in the various macro areas of the country and hence a different territorial articulation of the social demand for care. In the third paragraph, given that some indicators such as the difference in the disability rates, the geographic distribution of poverty, the territorial differences in income, the socio-economic imbalance between the North and South of the country and the shortage of welfare and health care on offer in the South of Italy determine a condition of social disadvantage for the elderly of the South, we consider the possible effects of social unease on active ageing. We put forward two hypotheses:

a) Social hardship negatively influences the quality of life, understood in the broad sense as in Donati (1979) "ability to plan, self mastery, existential vitality and life opportunities", and ends by inhibiting the capacity for self promotion on the part of the elderly, thus compromising the very possibility of living ageing in an active way.

b) contrarily social hardship and economic deprivation are factors that force the elderly to continue working so as to meet their personal and family needs (one thinks of the curse of youth unemployment in Southern Italy).

Finally in the fourth paragraph, starting from a field study carried out in a small town in Southern Italy (Vallo della Lucania) we document the experience of some women in their seventies and eighties who are experiencing their own paths of active ageing.

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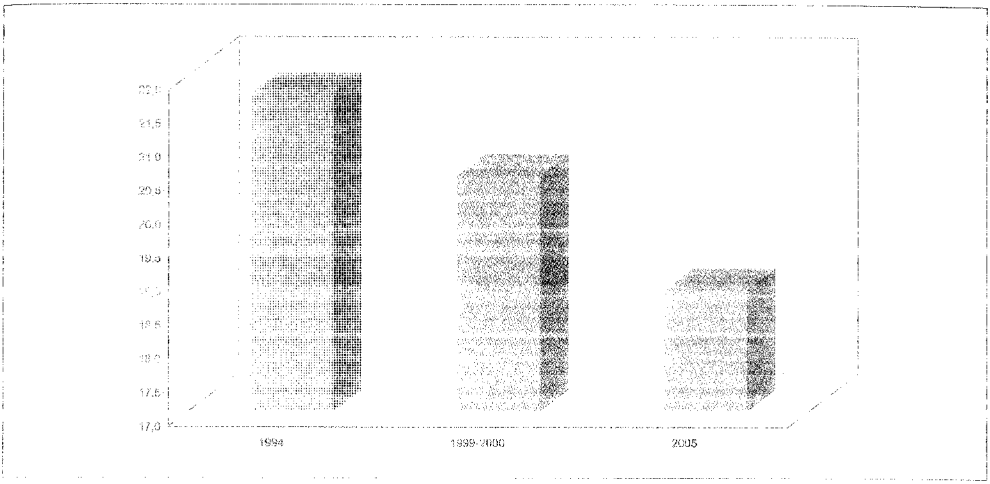
[1] In May 2007 the daily newspaper La Repubblica produced various articles on the subject

Figure 1: People of 65 years and over with disabilities - Comparing the years 1994, 1999-2000, 2005 (standardised rates for ages with data from the 2001 census)

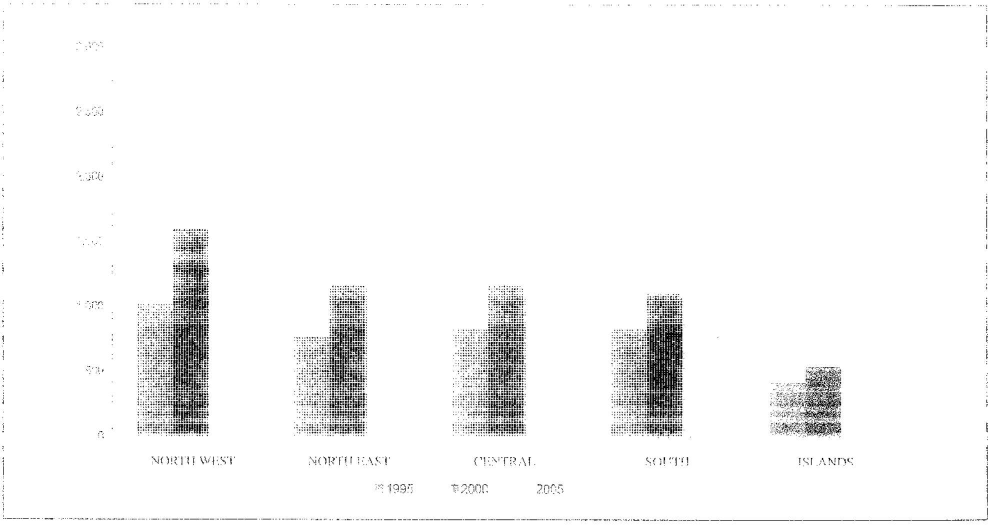


Source Istat 2007.

2. Ageing of the Italian Population

In ten years (from 1995 to 2005) our country has aged significantly. According to Istat (2008) the elderly numbered [illegible] units. From Figure 2 one sees how the over 65 population has grown in the various macro-areas of the country.

Figure 2: People of 65 years and over by geographic area (absolute values in thousands)



At national level the aging index has gone from 16.5% to 19.5%[2], the old age index[3] from 111,6 to 137,8 and the elderly dependence index from 24 to 29.3[4] (see Table 1).

In every Italian region an average increase of 3 percentage points has been recorded in the elderly dependence index (see Figures 3 and 4).[5]

Table 1: Ageing index, Old age and elderly dependence by year, region and geographic spread

	1995			2000			2005		
	Ageing index	Old age index	Elderly dependence index	Ageing index	Old age index	Old age dependence index	Ageing index	Old age index	Old age dependence index
PIEMONTE	18,7	157,3	26,9	20,5	172,0	30,4	22,2	179,7	33,9
VALLE D'AOSTA	17,2	140,2	24,4	18,8	148,2	27,4	19,9	151,0	29,8
LOMBARDIA	15,7	121,5	22,0	17,6	135,0	25,3	18,1	147,5	26,4
LIGURIA	23,0	228,3	34,4	25,0	239,7	38,6	26,5	242,5	42,4
TRENTINO-ALTO ADIGE	15,6	98,7	22,8	16,7	104,4	24,7	17,4	108,0	26,2
VENETO	16,4	124,0	23,3	17,6	133,7	25,8	18,3	137,3	28,1
FRIULI VENEZIA GIULIA	20,2	182,8	28,4	21,1	189,4	31,2	22,2	186,9	33,7
EMILIA ROMAGNA	20,9	192,4	30,5	22,1	196,0	33,2	22,6	184,5	34,8
TOSCANA	[illegible]	180,4	30,6	22,1	[illegible]	33,2	23,0	[illegible]	35,5
UMBRIA	20,7	163,9	31,1	22,4	[illegible]	[illegible]	23,3	[illegible]	[illegible]
MARCHE	19,9	151,4	29,6	21,4	165,8	32,5	22,4	171,6	34,6
LAZIO	15,5	108,3	22,0	17,3	124,3	25,2	18,6	135,0	27,9
ABRUZZO	18,2	120,6	27,3	19,9	139,4	30,2	21,1	155,9	32,2
MOLISE	18,8	119,4	28,7	20,8	140,2	31,9	21,7	[illegible]	33,6
CAMPANIA	12,2	60,8	18,1	13,7	72,3	20,4	15,1	84,8	22,4
PUGLIA	13,5	72,7	19,8	15,3	89,4	22,6	16,9	106,1	25,2
BASILICATA	15,6	87,4	25,2	17,6	110,3	27,0	19,6	132,8	29,9
CALABRIA	14,5	76,0	21,7	16,4	94,0	24,7	18,0	115,7	27,0
SICILIA	14,7	78,2	22,2	16,3	92,3	24,7	17,7	107,8	25,8
SARDEGNA	15,5	82,9	19,3	15,4	107,3	21,9	17,1	130,9	24,6
NORTH WEST	17,4	141,2	24,7	19,2	154,5	28,1	20,8	160,6	31,3
NORTH EAST	[illegible]	[illegible]	25,9	18,7	136,8	28,9	20,5	155,5	31,0
CENTRAL	18,1	138,3	26,4	19,8	153,2	29,4	21,0	160,3	31,6
SOUTH	13,7	73,0	20,4	15,4	88,1	23.1	16,9	103,7	25.3
ISLANDS	14.4	79,2	21,5	16,1	95,5	24,0	17,6	112,6	26,3
ITALIA	16,5	111,6	24,0	18,1	126,6	26,8	19,5	137,8	29,3

Source: Istat 200a, Istat 2006b, our elaboration.

[2] Ageing index: Relationship between the 65 years and over population and the total population.
[3] Old age index: relationship between the 65 years and over population and the population up to 14 years of age.
[4] Elderly dependence index: relationship between the 65 year old population and the active population (between 15 and 64 years).
[5] It was decided to present the level of ageing in the Italian regions in different shades of grey: in many regions they go from pale grey

Figure 3. Italy - Ageing index 1993

Source: Istat, our observations.

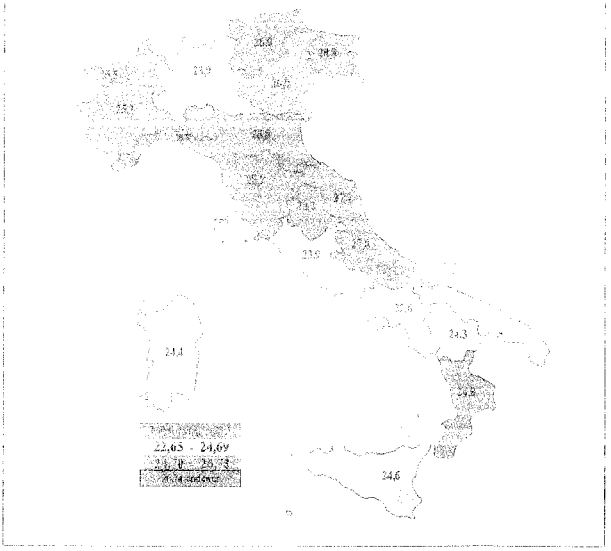
Figure 4. Italy - Ageing index 2003

The increase in the number of over eighties was particularly significant. In 2005 they make up more than a quarter of the elderly population (2,828,204 individuals, in fact 25.5%) (cf. Figure 5 and Figure 6).

Figure 5: The 80 years and over population as a percentage of the total elderly population of the region - Year 2006

Source: Istat 2006a, Istat 2006b, our elaboration.

Figure 6: 80 years and over population as a percentage of the total elderly population by region - Year 2005



Source: Istat 2006a, 2006b, our elaboration.

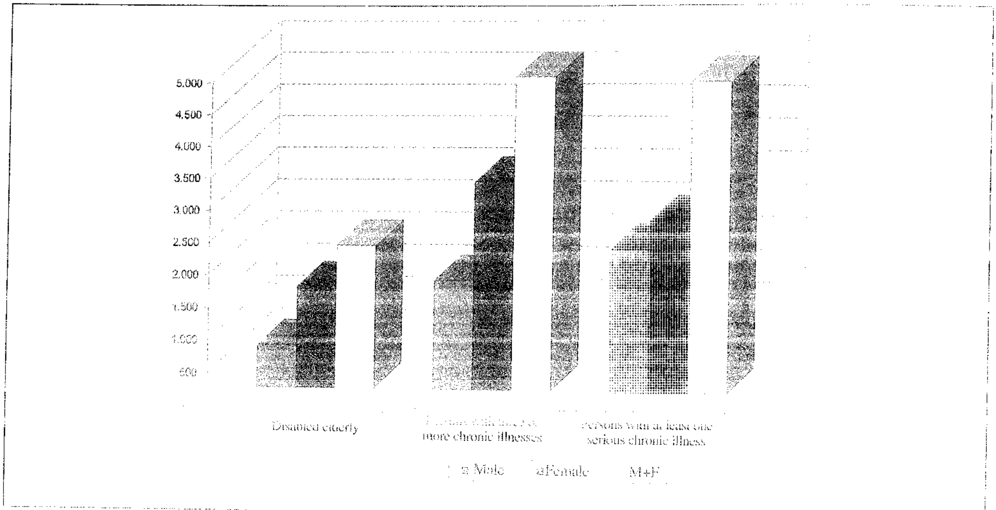
Figure 7: Italy - Variation in ageing index 1995-2005

Source: Istat 2006b, our elaboration.

The data examined attest to the speed and intensity of the ageing phenomenon, but they also show the fact that this phenomenon is not uniform across the country. Indeed, if we consider the percentage distribution of the elderly in the various areas of the country (cf. Figures 3 and 4) it is clear that the Centre-North was, and is, the oldest part of the country. Nevertheless, when we consider the variation in the ageing index (cf. Figure 7), it is revealed that the South is the area of the country where the increase in the elderly population has been the most intense in these ten years. The youngest regions are also those where the ageing phenomenon has seen a surprising acceleration. In some areas of the North, instead, where a consistent incidence of established immigrant family nucleus has been recorded with a consequent increase in foreign minors (Istat 2006a), the growing trend in ageing is beginning to slow down. As is shown from some of our recent elaborations (Tesauro, Pianelli 2007) the North-Eastern Italian ageing index [illegible] those of the Friuli and Romagna provinces.

In any event, given the overall ageing of the population, it is plausible that in the medium to long term perspective the socio-health system will have to sustain increasing costs in order to meet the demand for care coming from this part of the population. In this regard suffice it to say that according to Istat estimates (2007) there are already 2 million non self-sufficient elderly people, and around 4,800,000 affected by chronic and multi-pathology illnesses (cf. Figure 8).

Figure 8: Persons of 65 years and over by disabilities and presence of declared chronic illnesses and sex - 2005



Source: Istat 2007, our elaboration.

3. Health Inequalities Among the Elderly between the North and the South

The most recent studies on inequalities in health (Padovani 2006) confirm that social hardship is the principal non-biological cause of the health differences which occur in the population. And among the various dimensions of social disadvantage, those which most affect the health factor are those linked to education, those relating to material and economic resources, and those relating to life context (where one lives influences one's health more than a little. So much so is this the case that epidemiologic investigations reveal, for example, that people live longer in urban areas than in the provinces). In other words, as Geddes da Felicaia M. and Marlesca C. (2007) confirm, state of health is the product of a multiplicity of variables, interdependent on each other and acting throughout the course of life (not only individual but also environmental variables).

From processing the data of the most recent Istat Multiscope survey (2007)[6] relating to a specific health indicator, i.e. incidence of disability[7] it is inferred that:

1. the incidence of disability increases considerably with the advance of age[8]: from 65 to 69 years it equals 5.5%, from 70 to 74 years it is 9.7%, among those between 75 and 79 years it is 17.8%, and it rises to 44.5% for the over eighties (Cf. Figure 9);
2. there is a connection between gender and disability, since there are more disabled women than disabled men. 11.4% of women between the ages of 70 to 74 are disabled (compared to 7.7% of men of the same age); 20.8% of women aged 75 to 79 are disabled (compared

[6] The Istat Multiscope surveys allow us to set out the data relating to perceived health However, even though, by means of this indicator we cannot know the objective state of health and the various levels of functional dependence of the elderly, perceived health is considered by the international literature to be a methodologically reliable indicator.

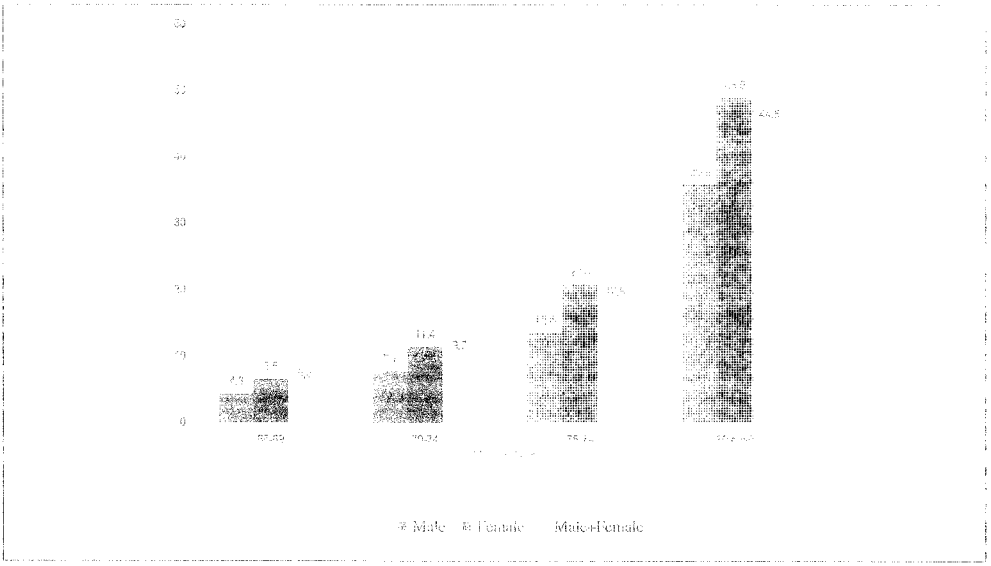
[7] Given the objectives of this article we consider only the incidence of disability related to the elderly population.

[8] The loss of functional autonomy increases with advancing years: among persons of 6 to 44 years it equals 0.9%, from 45 to 54 years it is 1.3%, from 55 to 64 years [illegible]

to 13.4% of men of the same age); fully 48.9% of women over eighty, compared with 35.8% of men, are disabled (Cf. Figure 9),

3. a connection between the level of education and disability also emerges. Indeed it is observed how it is more often people with a lower level of schooling who exhibit worse health conditions. In every age group the number of people who claim to be unwell or very unwell triples or doubles among those who have attained at most an elementary school certificate compared to those with higher educational qualifications (graduates or holders of diplomas): for example among adults aged 45-64, 11.1% of those with degrees or diplomas suffer from a serious chronic pathology, while among those with at best an elementary school certificate the number almost doubles (20.9%; among the elderly aged 65-74 years it goes from 28.4% to 36.5%[9].
4. The disabled elderly are unequally distributed within the country. They form 18.6% of the population, but while 16.2% (2 percentage points less than the average) of the northern elderly are disabled, those of the south are disabled in 22.7% of the cases (4.5 percentage points above the average) (cf. Figure 10). The regions with the highest percentage of disabled are all southern ones: Sicily (26.1%), Puglia (24.2%) and Calabria (22.9%); instead the regions with the lowest percentage of disabled elderly are Trentino Alto Adige (12.9%), Lombardy (15.2%), followed by Friuli Venezia Giulia and Emilia Romagna (15.9%) (cf. Figure 11).

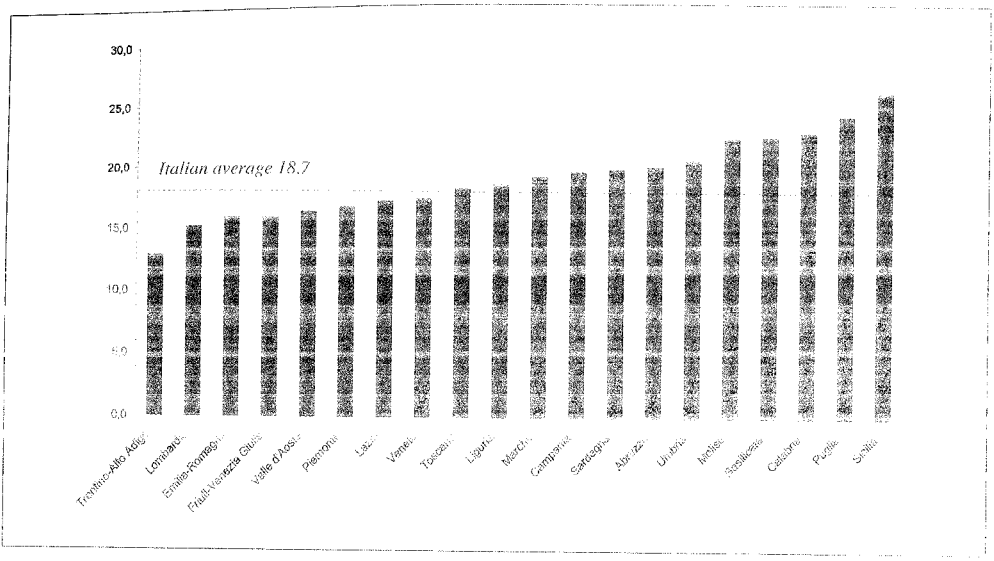
Figure 9: Non self-sufficient individuals of 65 years and over by age group and sex - year 2005



Source: Istat 2007, our elaboration.

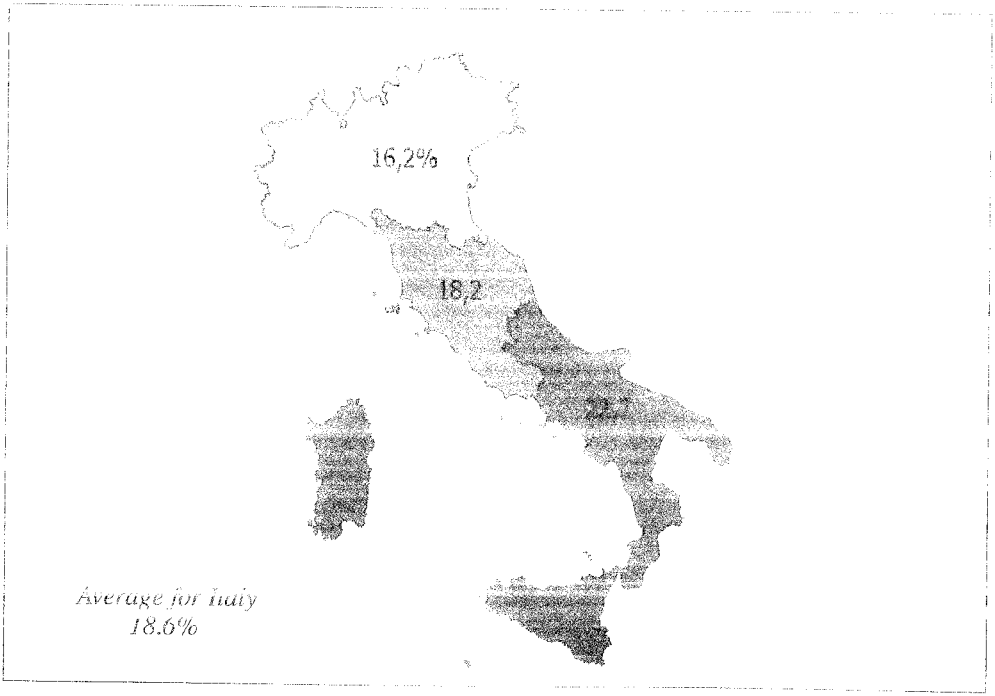
[9] The relationship between schooling and state of health has also been highlighted in the CNR's (National Research Council's) Targeted Programme on Ageing from ILSA (Italian Longitudinal Study on Ageing) which had actually noted a strong association between education level and physical disability, hypothesising, inter alia, that a major seriousness of prevalent pathologies was attributable to a diagnostic delay in the part of the population with a lower level of education. In this regard it is sufficient to consider that, as Istat (2007) shows the practice of preventive medical visits is less widespread among the lower social status population: in all

Figure 10: Percentage of disabled elderly by region — year 2005



Source: Istat 2007, our elaboration.

Figure 11: Percentage of disabled elderly by geographic area — Year 2005



Source: Istat 2007, our elab[illegible]

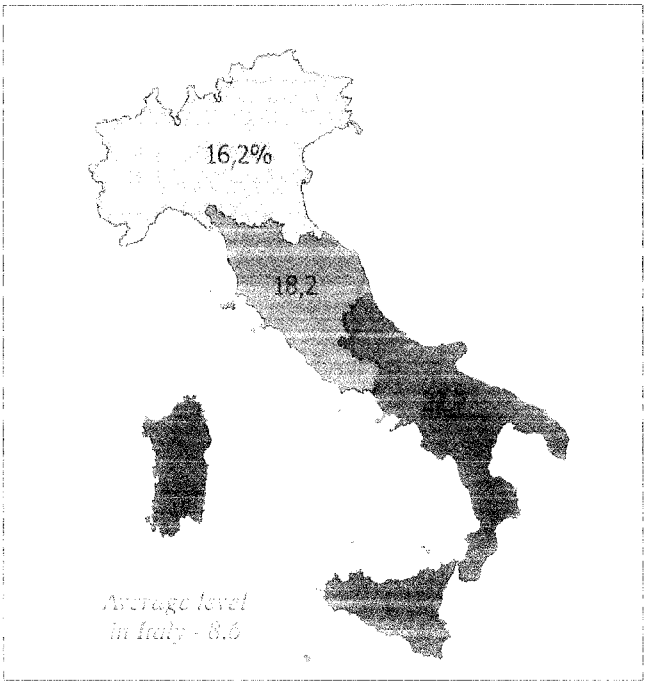
As shown in Figure 12 the incidence of disability among southern women is particularly high, through the "cumulative effect" of the disadvantages of gender and those linked to geographic area. The non self-sufficiency risk, in conclusion, is very unequally distributed among the population since it is influenced by variables such as age, level of education, and the life context in which one ages.

In the light of these results we questioned whether the decrease in the rate of disability too (cf. Figure 1), was harmonious throughout the country, or whether it was spread unevenly in the three macro-areas of the country. As Figure 13 shows the drop in the incidence of disability has involved the elderly of the Centre-North more consistently than those of the South. If one considers, along with Padovani (2008), that the lack of improvement in health, measured over a time span, is another indicator of the social disadvantage of a population or of a group of a given population, then one can, without doubt, conclude that the health disadvantage of the elderly in Southern Italy has its origins in the socio-economic development lacking in this area of the country.

Figure 12: Italy - Percentage of elderly disabled women out of the total of elderly women by region - Year 2005

Source: Istat 2007, our elaboration

Figure 13: Variation in rate of disability among the elderly population between 1994 and 2003 by geographic spread



Source: Istat 1997, Istat 2007, our elaboration

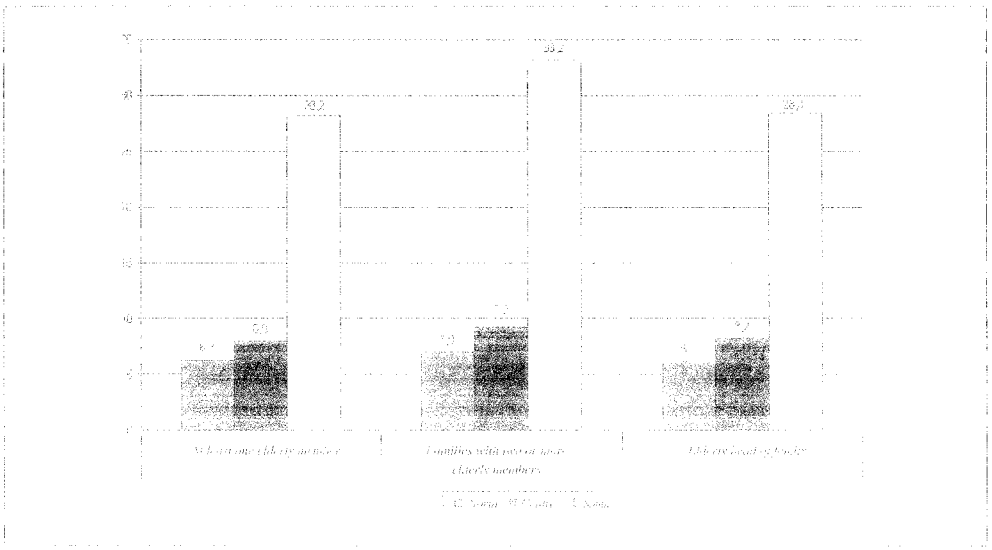
Indeed, epidemiologic studies confirm that health conditions are determined in the first place by socio-economic conditions. In this regard the Manifesto for Fairness published in 2005 through an AIE (Italian Epidemiology Association) initiative (cited in Padovani 2008) states "A large part of the north-south differential in the various health indicators is attributable to the territorial distribution of the socio-economic structure. In other words in southern regions the main variables which determine the socio-economic situation (level of education, average income, employment levels...) have significantly lower indexes than the national average. This means that in this part of the peninsula a series of disadvantages are added together and in many people cause a state of health that is worse than that which prevails elsewhere".

Concerning the socio-economic condition of the elderly, Istat's data on poverty (2006g) reveal a worrying situation in the South:

- 28.2% of families with at least one elderly member are poor (compared with 9.2% for the same family typology in the Centre and 6.3% in the North);
- 33.2% of families with two or more elderly members are poor (compared with 9.2% for the same family typology in the Centre and 7.0% in the North;
- 28.4% of families with a person of 65 years of age at its head is poor (compared with 8.2% in the Centre and 6.2% in the North) cf. Graph 6.
- The incidence of poverty rises from 36.4% (2004) to 42.9% (2005) for families with a greater number of components, in which more generations live together: for families who

- Again according to Istat (2006h) in the South, the incomes of the population in general, and of the elderly in particular, are on average lower than elsewhere.
- Families in which the main earner is aged 65 and over (2004) had an average income equal to 16,911 euro a year, a decidedly lower income, in the same part of the country, than that obtained by a family whose main earner is under 65 (for these families income varies from a minimum of 22,135 to a maximum of 28,119);
- 50% of elderly couples earned less than 16,179 euro a year, i.e. 1,348 euro a month, and 50% of families where there is at least one elderly member earned less than 12,592 a year, i.e. 1,049 euro monthly;
- The situation of lone elderly individuals is particularly disadvantaged. 50% of these elderly earned less than 10,092 euro a year, i.e. 841 euro monthly.

Figure 14. Incidence of poor families with elderly members by geographic spread — Year 2005 / Values %



Source: Istat 2006.

Among the disadvantages linked to a territory without doubt one must also consider the quality of the services system. In the South public socio-health services are often inadequate and inefficient. One fact suffices for all: in the South there are 3.1 beds in socio-welfare centres per thousand inhabitants compared with 5.2 per thousand in the North (Istat 2007).

If one then considers the indices of take-up of care through Integrated Home Care and residential care homes, which are the services which more than any other in our country characterise socio-welfare for the elderly, one sees that the lowest are always those obtained for the southern regions (cf. Table 2 and 3)[10].

[10] Using the Health Ministry's data on the elderly using Integrated Home Care and public and private residential care homes, (as part of an Irpp-cnr (Institute for Population Research — National Research Council) study for the Ministry of Welfare) the take-up indices relating to these two types of service were calculated. Istat defines the take up indicator as the relationship between the users of a specific service and the population of reference, in this case the elderly population. This report indicates how many persons effectively

Table 2: Number of users over 65 who have taken advantage of Integrated Home Care and the take-up index - year 2003

Regions	Users	Population 65+	Take-up index
Piemonte	15.367	916.112	167,7
Valle d'Aosta	64	23.433	27,3
Lombardia	45.292	1.692.906	267,5
Liguria	7.995	409.211	195,4
Trentino-Alto Adige	-	162.323	0,0
Veneto	31.929	847.065	[illegible]
Friuli-Venezia Giulia	20.443	258.283	791,5
Emilia-Romagna	40.365	900.030	[illegible]
Toscana	24.604	[illegible]	[illegible]
Umbria	[illegible]	[illegible]	[illegible]
Marche	9.103	327.113	278,3
Lazio	17.913	946.604	[illegible]
Abruzzo	4.733	264.791	178,7
Molise	6.129	68.568	893,9
Campania	7.810	935.353	[illegible]
Puglia	[illegible]	686.519	[illegible]
Basilicata	[illegible]	[illegible]	[illegible]
Calabria	[illegible]	349.728	[illegible]
Sicilia	[illegible]	[illegible]	[illegible]
Sardegna	[illegible]	[illegible]	[illegible]
NORTH-WEST	[illegible]	[illegible]	[illegible]
NORTH-EAST	[illegible]	[illegible]	[illegible]
CENTRAL	[illegible]	[illegible]	[illegible]
SOUTH	[illegible]	[illegible]	[illegible]
ISLANDS	[illegible]	[illegible]	[illegible]
ITALY	[illegible]	[illegible]	[illegible]

Source: Ministry of Health 2004, Istat 2006a, our elaboration.

Table 3: Users of the public and private residential care homes and take-up indices – year 2003

Regions	Users 65+	Population 65+	Take-up index
Piemonte	11.551	916.112	126
Valle d'Aosta	-	23.433	-
Lombardia	66.420	1.692.906	392
Liguria	4.884	409.211	119
Trentino-Alto Adige	6.424	162.323	396
Veneto	29.218	847.005	345
Friuli Venezia Giulia	11.208	258.283	434
Emilia-Romagna	25.661	908.930	282
Toscana	10.014	801.081	125
Umbria	1.840	192.017	96
Marche	2.578	327.113	79
Lazio	4.851	948.604	51
Abruzzo	914	264.791	35
Molise	-	68.568	-
Campania	243	835.353	3
Puglia	241	656.548	4
Basilicata	85	113.496	7
Calabria	935	349.729	27
Sicilia	967	857.125	11
Sardegna	67	266.701	2
NORTH-WEST	*82.955*	*3.041.662*	*272*
NORTH-EAST	*72.511*	*2.176.341*	*333*
CENTRAL	*19.283*	*2.268.815*	*85*
SOUTH	*2.442*	*2.288.485*	*11*
ISLANDS	*1.034*	*1.125.826*	*9*
ITALY	*178.101*	*10.901.329*	*163*

Source: Ministry of Health 2004, Istat 2006a, our elaboration.

4. Active Ageing

The difference in the disability rates, the lack of health improvements, the geographic distribution of poverty, the territorial differences in income and the scarcity of care and health services on offer in the South, are all indicators which supply a picture of social disadvantages experienced by the southern elderly. All the factors listed have, indeed a significant impact on people's wellbeing (in the widest possible sense of the term).

Can it be hypothesised that there is a relationship between the above indicators of social depravation and active ageing? And what type? In this part we formulate two hypotheses on the question.

a) Social hardship negatively impacts on the quality of life understood in its broad sense, as

life opportunities", and ends in inhibiting capacity for self promotion on the part of the elderly thus jeopardising the very possibility of living ageing in an active manner.

b) Social hardship and economic depravation are factors which, on the other hand, force the elderly to engage in work in order to meet their personal and economic needs (in this regard one thinks of the curse of youth unemployment in the South of Italy).

To check these hypotheses we analyse the distribution of employment rates among the over 65s (from 1993 to 2003) by geographical macro areas. As shown by Table 4 employment rates among the elderly are higher in the South (in the whole decade covered). It is plausible, therefore, as we have hypothesised in point b, that social hardship and economic depravation somehow "push" the elderly to hang on to their jobs. In other words, though in difficult life conditions and in less than the best of health, they "stand firm", they don't give up or retire passively, but on the contrary they take action, remaining in the labour market.

Table 4: Number of users over 65 who have taken advantage of integrated Home Care and the take-up index - year 2003

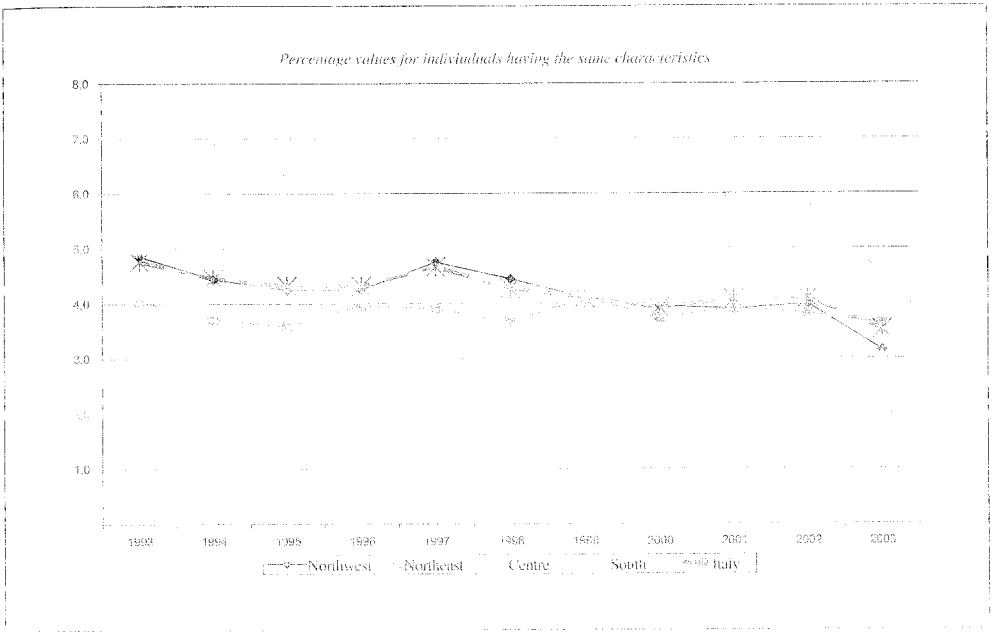
	North			Northwest			Northeast			Centre			South			Italy		
	MF	M	F	MF	M	F	MF	M	F	MF	M	F	MF	M	F	MF	M	F
1993	4,5	8,0	2,0	4,9	8,6	2,0	4,0	7,2	2,0	3,5	7,3	0,7	7,1	12,2	3,4	4,6	8,7	2,1
1994	4,1	7,6	1,9	4,4	8,7	2,1	3,7	6,9	1,6	3,2	6,6	0,7	6,9	11,9	3,3	4,5	8,2	1,9
1995	4,0	7,3	1,9	4,3	8,5	2,2	3,6	7,0	1,5	2,5	7,2	0,8	6,5	11,4	2,9	4,3	8,1	1,8
1996	4,1	7,4	2,1	4,3	8,6	2,2	4,0	7,3	1,8	3,1	6,4	0,7	6,6	11,8	2,8	4,3	8,0	1,8
1997	4,4	8,0	2,1	4,8	8,6	2,3	3,9	7,2	1,8	3,6	7,2	1,0	6,7	12,1	2,9	4,7	8,7	2,0
1998	4,1	7,6	2,0	4,4	8,4	2,1	3,7	6,9	1,5	3,1	6,9	0,8	6,4	11,1	2,9	4,4	8,1	1,7
1999	4,1	7,3	2,0	4,1	8,7	2,0	4,1	7,1	2,1	3,0	6,4	0,7	6,4	10,8	2,9	4,3	7,6	1,7
2000	3,9	7,1	1,7	4,0	8,0	1,9	3,7	7,0	1,5	2,7	6,1	0,6	5,5	10,2	2,2	3,9	7,0	1,5
2001	3,9	7,1	1,8	3,9	8,0	1,8	3,9	7,1	1,8	2,9	6,2	0,6	5,9	10,1	2,3	4,1	7,2	1,6
2002	3,9	7,1	1,8	4,0	8,4	1,7	3,8	7,2	1,6	3,0	6,4	0,7	5,8	10,2	2,2	4,1	7,3	1,6
2003	3,9	6,9	1,9	4,1	8,0	1,9	3,9	6,9	1,9	3,1	6,5	0,8	5,7	9,9	2,3	4,1	7,1	1,8

Source: Istat Workforce survey - Reconstruction of the historical series - IV trim 2003, Istat demographic data - our elaboration.

In an article published in La Repubblica (14 August 2008) there was the following: "In the United States the number of workers aged over sixty five years increased by 101% from 1977 to 2007, and by 2016 another leap of 80% is predicted. Among elderly workers in the last 30 years the number of elderly women has increased by 147% and of men by 75%. The number of workers over 75 years of age has increased by 172% and even if in 2007 they represent 0,8% of the total, the number is destined to rise by 80% by 2016, abetted by good health and economic straits". It appears therefore that the experience of the American elderly is similar to that of the southern elderly: regardless of their state of health, be it good or fair, they remain in the labour market, though more from necessity than from choice. Poor economic resources at a time of life, when there is the fear of illness and care needs, force the elderly to continue working so as to protect themselves independently from ageing linked risks. This happens above all in those territorial contexts such as the South of Italy, where the sparse system of socio-health services forces the elderly to have recourse, more than elsewhere, to private care.

Looking now at the movement of employment rates over the decade (cf. Figure 15) it has emerged that, despite the health improvements in the elderly (cf. Figure 1), from 1992 to

Figure 15: Movement of employment rates among the Italian population at 65 years and over, by geographic spread.

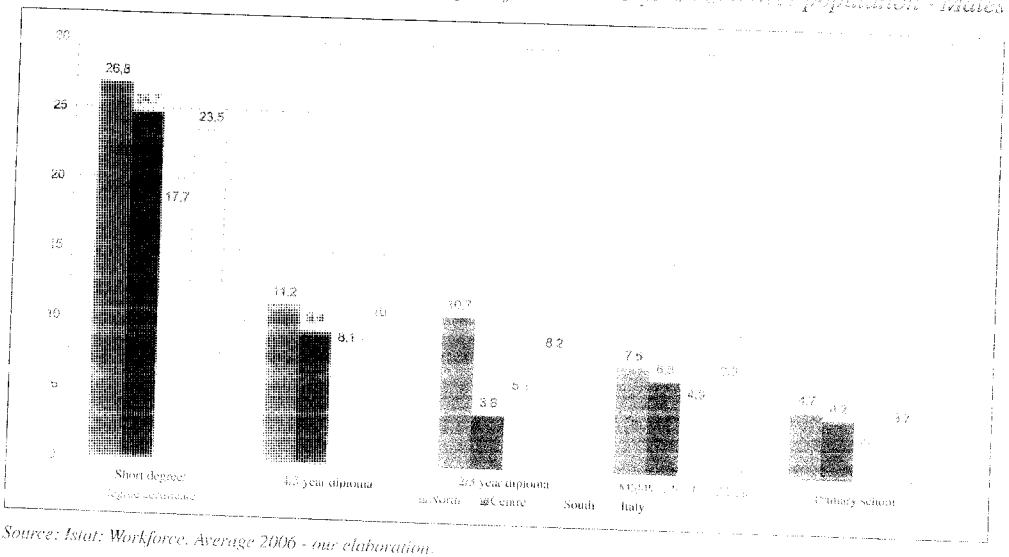


Source: Istat Workforce surveys - Reconstruction of the historical series - Years 1993-2003; Istat demographic data - our elaboration.

These movements lead us to reflect on the fact that in reality the factors which favour continuing to work are many and that good health is only one of them. In a study of a few years ago (Irpps-CNR 2001)(Institute for research on Population and Social Policies-National Research Council) it was shown that the main activities occupying the free time of the over 65s were domestic ones (78%) among which care of grandchildren stands out sharply. The third generations — the grandparents - act as shock absorbers and this role has motivated many adults-elderly to retire. As Livi Bacci stated (La Repubblica 13 April 2008) the further increase in the grandparents-grandchildren relationship in the next twenty years risks accentuating the phenomenon, thus keeping the employment of the third generations (the lowest in Europe) low, and accentuating, besides, the inequalities between those who receive support from strong family ties and those who have none.

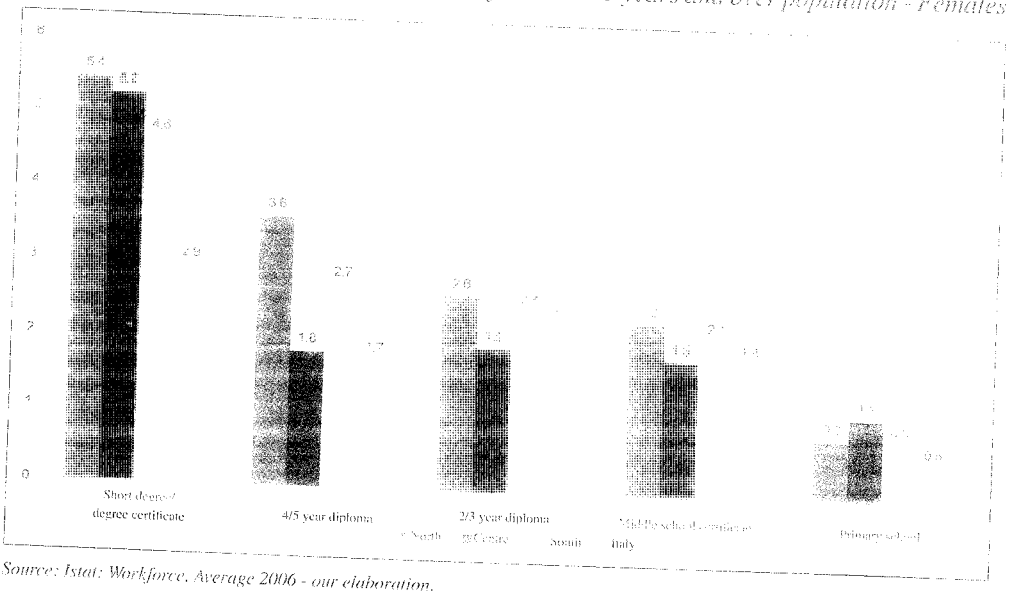
If then the welfare system doesn't support young families in caring for the smallest children through a service system that supports working women, grandparents remain the only and precious resource. Their better health and their time are made available within the family circle and not in wider social contexts, or even less in the labour market.

Figure 16: Activity rates by educational qualification - 65 years and over population - Males



Source: Istat: Workforce, Average 2006 - our elaboration.

Figure 17: Activity rate by educational qualification - 65 years and over population - Females



Source: Istat: Workforce, Average 2006 - our elaboration.

With regard to Table 4 it is not by chance that that the gap between rates of male occupation and those of women is seen to be significant, regardless of geographical area or year of reference. Women, in fact are more involved than men in the work of caring for the family. And this happens, as is shown in Figure 16 and Figure 17 even for women who have higher educational qualifications. It can be seen that education is a factor which has a positive

on active ageing, since it is above all individuals with higher educational qualifications who remain in the labour market at an advanced age (probably because they have better jobs, with better pay). However women, even if well educated and well placed in the labour market, decide to leave the market also, and perhaps mainly, because they are responding to family care needs (children and parents who are very old and so in need of care).

Active old age, ultimately, is the result of various policies, policies which not only promote the right to health, but which support those who work in family care, policies of permanent education, policies which on the whole safeguard the individual's freedom to choose how to live his or her own old age.

5. Active Ageing among the Old Women in Vallo della Lucania

In a field study carried out under the auspices of an IRPPS-CNR project and carried out with a group of colleagues in a small town in southern Italy, Vallo della Lucania (cf. Milione, Nicolaus 2008) we investigated the experience of elderly women and men, all born in the period straddling the twenties and thirties, with the aim of understanding how they lived active ageing, once outside the labour market.

It emerged that the elderly of Vallo have a central role, even in advanced years, in family networks. Good health allowing, they live their old age independently and very industriously. From the many statements gathered, it emerges that these women, so long as they are still self-sufficient, even after the death of their spouses, generally prefer to continue living in their own homes. A sixty year old woman told us: "I don't want to go and live with my daughter, I prefer to stay in my home". Another: "I live (only in winter) with my daughter because she needs help, she is a gynaecologist and is always very busy. In summer I go to my home, with my sister [....] and, to tell the truth,, I prefer it when I'm alone, I can go out with her, go to my cousins' for a coffee meet the group. When I live alone I feel freer [...] I can cook, do what I want, go out and come back when I want. Without answering to anyone". Another, eighty-seven years old, states: "I am alone, my son lives next to me, but I stay home and do everything by myself. I need nothing, and then what do I need? A little cleaning [...] but do you clean every day?" From their words there emerges a determined defence of their own self-sufficiency, regardless of age.

And while their strength permits it is they who offer help and support to their children, as emerges from another statement: "I get up at seven because I look after my daughter's children and in seven and one fourteen I must get there early. I have to get them ready for school and cook. I deal with everything. Then I go home to my house, I've been living alone since my husband died". Now grandmothers, these elderly women often take on the role of [illegible] women, and particularly for those living in the [illegible] contexts, indeed, there is a chronic shortage of services capable of relieving the burden of double work. Consequently it is down to grandmothers to take the place of agencies.

The commitment and availability of grandmothers is essential to their daughters and therefore, as emerges from the statements we collected, grandmothers have a far from marginal position in family networks.

It is not by chance that their role is basically centred on caring. In old age, indeed, there [illegible] routines and habits are developed which it often appears obvious to reproduce in old age. Therefore for women who have spent a large part of their life taking care of the family and the home it is "taken for granted" that they will continue to do domestic chores and carry out care tasks, supporting their daughters who often work and therefore need help.

Precisely by carrying out care tasks, indeed, they remain active longer. From our research it emerges that the active role, carried out within family circles, further reinforces the independence of these elderly women who, physically effective and active in the family, manage to maintain a wide circle of both family and extra-family relationships. However the commitment to the family circle does not take up all their time or energy. The time "free" from the needs of their children and grandchildren becomes all their own to invest in other relationships [illegible] themselves. Living as active elderly women for these women also means exploring avenues of independence in extra-familiar contexts.

They are all women who appear attentive to self care, lucid and capable of talking about themselves. They have as Micheli (2004) says the ability to re-plan their self autonomy in line with events in their lives both within the family circle and beyond in wider contexts. Listening to their stories it would almost seem as if autonomy is a personal resource capable of reproducing itself through activity: the more active they are the more they remain autonomous, and the more autonomous they are the [illegible] different environments.

[illegible] within the family circle, [illegible] they have left [illegible]

[illegible] that women express a greater wellbeing than men of the same age [illegible] participation. They continue to feel [illegible] in their lives and in the family [illegible] in a marginalised role, both within and outside the family. They describe their daily life as a time of [illegible] resource.

6 Conclusion

As has been seen the differences in mortality rates, the lack of improvement in health, the geographic distribution of poverty, the territorial differences in income and the lack of welfare and health services on offer in the South are all indicators demonstrating how ageing in the South is a process influenced by the concentration of many disadvantages linked to the area. Thus the elderly in the South of the country are bound by a series of bonds that condition

their wellbeing. Yet their very state of socio-economic hardship forces them to keep their jobs. They don't give in to passivity, nor do they give up, but rather they act, remaining in the labour market. To all intents and purposes they are active elderly in accordance with the concept of active age as used in political debate and literature when referring precisely to the experience of those who choose to continue their work in the labour market.

However the concept of active age probably defines a more complex and varied reality. As indeed emerged from the field study carried out in Vallo della Lucania, it appears an oversimplification to relate the above concept exclusively to the continuation of work within the labour market. The elderly, above all elderly women are a necessary and precious resource since they make their energy, their time and their "know how" available to their family circle. How can we conceptualise the experience of these women if not as "active ageing"? And how many other ways do the elderly have or will they have to live their old age as players, trying out paths of self re-invention? What possible life opportunities are there for making active ageing the practice instead of only a possibility?

Open questions on the future which lead us to agree with what is written in the Green Book on Welfare: "The challenge to which we are called is not only economic, but first of all one of culture and planning". That is to say it is a matter of reconfiguring, with a good dose of imagination and against the still widespread stereotypes on ageing, the role of the elderly, not only in the world of work but in every other sphere of social life. To do this perhaps it would be necessary to start from the interested parties, to listen to their stories to discover what they still have to give to society.

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