



Evidence-based Guidelines on Health
Promotion for Older People:

Social determinants, Inequality and
Sustainability

Overview on health promotion for older people in Italy

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1 Introduction

During the last twenty years or so, the demographic transition has generated economic and political anxieties in our country, as in the other countries of the Western World, creating a negative attitude towards the growing proportion of elderly people in our society. It was of increasing concern that the ageing of the population could create a crisis in the stability of the financial system, in particular with regard to pension schemes, which could weigh disproportionately on the limited resources available to social and health services. These worries could become so alarmist as to provoke drastic solutions to the detriment of the weaker sections of our society. Even though it is true that the elderly are the major consumers of medicines, specialist services, hospital resources and medico-social services, the increase in the expectation of life of the whole population, as a result of the increased wealth and the success of the health strategies in Italy, cannot be overlooked. It is to be emphasised that a longer life is of itself a positive result, because of the opportunities life can still offer to those who have retired from work, who can expect to live a substantial number of years in good health, and also still be a positive resource for society, not only in economic terms but also from a social and humanitarian point of view. Just think of the contribution made by the elderly in voluntary work. However, it is also true that the progress made in the diagnosis of medical conditions, the treatment and rehabilitation of chronic diseases has of necessity increased health expenditure for long or very long treatments. The increase in the number of people who lose self sufficiency because of the interaction of the effects of these pathologies on their individual functional capacity and the weight of the associated social and economic resources, have brought about the need for essential but expensive assistance. Although there are economic problems, it is certainly right and proper to maintain our health system, but it is likewise and maybe even more important to continue to guarantee the necessary care, together with the quality and dignity of life, especially for those such as those who are not self sufficient, to those who have greater need. The existence of information systems which can provide important data about various health indicators of the elderly population presents the opportunity to produce summary reports which can stimulate thought and discussion.

If Europe is ageing, Italy is ageing even more rapidly. This is shown clearly by the data produced by ISTAT in 2005 which gives a snapshot picture of the situation in healthPROelderly – National Report (Italy)

our country. In Italy in 2050, 27% of the citizens will be between 60 and 79 years old and the over-eighties will account for another 14%, whilst only 20% will be under 20. If in 2004, there was another increase in the aging of the population, on the first day of January 2005 the ageing index (the ratio between the over 65 year olds and the those who are under 15) was 137.7% with a constant increase compared with previous years: 133.8% in 2004, 133.8% in 2003, 131.4% in 2002 and 129.3% in 2001. The population is ageing in all the regions of Italy, but at different rates. In the North and Centre the ageing index is 157.9% and 160.7% respectively and in the South and Islands it is 106.6%. The continued ageing of the Italian population can also be seen from the dependency ratio and the mean age of the population which continue to increase year by year. The dependency ratio, which is the ratio of the population aged 65 and over to the population aged 15-64, has increased 0.5% rising from 28.9% to 29.4% between 2004 and 2005. The mean age of the population increased 0.3 years in the same period, from 43.2 to 43.5. In 2002, the expectation of life continued to increase as a result of the reduction in mortality rates at every age. For males, the expectation of life has increased from 77.0 years in 2001 to 77.1 in 2002, while for females it has risen from 82.8 to 83.0. Thus also for 2002, Italy is among the countries with the highest expectation of life. Higher values are found only among Swedish males (77.7) and Spanish females (83.1).

2 Policy initiatives for elderly people / health promotion

The Italian constitution requires the Government to treat health “as a fundamental right of the individual citizen and the community” (art.32). The use and organisation of the National Health Service is therefore the fulfilment of the constitutional obligation, which has been provided for by law n.833 passed in 1978. This law created the National Health Service which had as its cardinal points solidarity, universal coverage of medical assistance and the public nature of the health service. With this model of “health for all”, which is article 32 of the Constitution, the service is available to all and the costs are borne by general taxation. After its first steps, the federal development of the health service was established by law n.112/98 which was reconfirmed by the decree 56/00 which passed the financial burden to the individual regions of Italy. The general reform, with the revision of title V, part II of the

constitution was brought into effect by law n.3 of 18/10/2001, which contains the essential requirements for the approval of the new and distinct regional discipline of Public Health. Also in 2001, there was law n.405, which was entitled “urgent interventions for health expenditure” and set out important regulations, not only about the way services are financed, but also the essential requirements for public hospitals to collaborate with the private sector in the organisation of pharmaceutical treatments. Therefore the process of devolution to the regions gave to the regions the responsibility to legislate in matters of social medicine which in turn, slowed down legislation concerning the elderly at a national level.

The legislation described hereafter involves the elderly (income, taxation, etc.) and some specific indications on the use of funds allocated to the services for the elderly. In addition, regulations regarding prevention and health promotion for the elderly have been included in bylaws passed by the Ministry of Health. The references to national and regional legislation are in the appendix.

3 Health determinants

A logical policy for health planning cannot leave aside the evaluation of the determinants of health and the epidemiological data of prevalence and incidence of the illnesses most frequently suffered by the elderly, ranging from the knowledge of the percentage of the population who are disabled in each age group, to the percentage of persons who become older but remain in good health. This information is essential for the evaluation of the burden of medical assistance and for an efficient use of limited health resources. From the results obtained in various studies, it appears that hypertension has a high prevalence, about 60% in elderly Italians. These results are similar to those found in similar studies (NHANES III) in the United States of America. Hypertension is one of the most important risk factors for cardiovascular diseases which are the most important causes of disability in Western countries. Regular check-ups and the creation of programmes for prevention could lead to a reduction in both the incidence of illness and also the associated costs. Also the prevalence of osteoarthritis is very high, 50.7% for males and 68.7% for females. The prevalence of ischemic heart disease is however, less than that reported in similar studies in other Anglo-Saxon countries and confirms the hypothesis that this disease is less common in Mediterranean countries. Cerebro-vascular disease is the

third cause of death in Western countries after heart disease and cancer, but is the first cause of permanent disability. The incidence reported in various countries is between 120 and 200 cases per 100000 per year, considering only the first stroke, while taking account of repeated attacks, the incidence is between 140 and 260 per 100000 per year. The prevalence rate studies in the general population obtained from various is between 400 and 800 per 100000. In Italy, only two studies have been performed so far, in the regions of Umbria and Val d' Aosta which report incidence rates of 155 and 215 cases per 100000 per year. The only data of prevalence are from the only study done so far on a large scale, obtained from the ILSA study "Progetto Finalizzato Invecchiamento". These data show a high prevalence of this pathology, higher than those reported in similar studies done in other countries on populations of similar age (65-85 years of age). In fact, the foreign data of cerebral ictus show that it has a high prevalence between 3% and 5% for males and between 1.5% and 3.5% for females. The ILSA study found prevalence rates of 7.4% for males and 5.9% for females, with a maximum of about 10% in some age groups. Even if methodological differences could partially explain these differences, the data seem to suggest the prevalence really is higher in Italy and are similar to values obtained from studies done in Japan, the country with the highest prevalence of cerebrovasculaar disease in the world. The prevalence of senile dementia is 5.3% among males and 7.2% for females and rises to about 20% in the oldest age groups. These results are similar to those found in other European studies and indicate a high prevalence, with very high costs both socially and for the health service. They represent a real health and treatment "emergency". All studies, both Italian and foreign agree that the most important risk factor for senile dementia is age. The prevalence increases exponentially from 75 years of age and among persons aged over 85, it affects between 20 and 25% of the population (ILSA study). Senile dementia is among the medical conditions with the highest humanitarian, social and medical costs. Dementia is a serious progressive condition and it is not possible for the patient's family to bear this burden. These patients, from the earliest stages of the disease, need to be continually watched and need increasing help to perform their everyday activities. Pharmaceutical treatment is limited only to psychological and behaviour symptoms. Helpful therapy, even if it could only postpone the loss of self sufficiency for a few years, would also be a great saving economically. There is relatively little epidemiological data about distal neuropathy of

the inferior limbs, which, according to data from ILSA, affects about 6.5% of the elderly with an increase among the very old. This condition, apart from a series of subjective symptoms, is often accompanied by important difficulties in walking, because of the reduction of power, or loss of feeling in the legs and feet. Neuropathologies, in fact, are the main cause of walking problems for the elderly, and may be caused by a fall or fracture of the femur, major causes of disablement in the elderly. The evaluation of functional ability using performance tests, rather than collection of data by interviews, has become an important source of epidemiological data about the ageing of the population and the ability of elderly people to lead autonomous and self sufficient lives in society. Physical performance tests therefore, have become important tools for predicting disabilities, even in subjects who, using the traditional self-evaluation scales, would have been classified as self-sufficient. Disability, once established may progress very rapidly, but at the moment, the causes and the factors which affect the progression are unknown. This gap in our knowledge can only be overcome only by rigorously designed follow-up studies which may be able to lay the foundations for secondary and tertiary prevention in populations of people who are not self-sufficient. According to the ILSA study, the percentage of the population aged 65-84 years who are totally self sufficient (no disability in the ADL) is 70%, while about 23% have slight disability (need assistance in an ADL), and about 3% are not self-sufficient, that is they are disabled in all the ADL. For males aged 65-69, the percentage who are totally self sufficient is 87%, but among those aged 80-84 it is 56.2%. For females, the corresponding percentages are 88% and 54.2%. Slight disability affects 9.6% and 19.8% of males in the same age groups, while for women these percentages are 7.6% and 19.4%. For major disability, the percentages are 3.4% and 24% for males in the respective two age groups and 4.3% and 26.3% for females. These results would imply that the proportion of the population of elderly persons who are not self sufficient, as estimated by the performance tests, is about double that obtained using interviews and implies that performance tests have a greater ability to identify those who are in need of assistance. For the elderly who live at home, it is therefore clear that in order to live autonomously they must also be able to perform more difficult tasks, such as shopping, prepare meals, use public transport, look after their income and expenditure and take their medicines, etc. (IADL) independently. There is a progressive increase in disability in these activities among people in the higher age groups, in which about 50% of males and 73% of

females have difficulty in two or more activities. Another important pathology is cardiovascular disease, which is the leading cause of death among the elderly and one of the major causes of disability. Among the behavioural risk factors, the most important are cigarette smoking, excessive consumption of alcohol and diet, but these associations have not been adequately investigated. Among biological risk factors, obesity, particularly visceral obesity, and hypercholesterolemia are well known, but large scale data relative to the elderly are few. Thus it is particularly important to study the effects of these risk factors to evaluate the morbidity of the elderly. The data from the ILSA study show that about 16% of the females and 77% of the males are or have been smokers. Of these, about 16% of the female smokers and 41% of the male smokers consume or consumed more than 20 cigarettes per day, and over 85% had been smokers for more than 10 years. About 66% of the women and 89% of the men drink wine every day. Among those who drink wine, however, only 3% of the women and 24% of the men state that they drink more than 50grams of alcohol (half a litre of wine) per day. As for diet, so far, only the consumption of fruit and vegetables has been investigated and it is found that only a very low proportion of the elderly, 14% for males and 15% for females, eat two or more portions of fruit and/or vegetables per day. The body mass index (BMI = weight in kg divided by the square of height in metres) is used to measure the prevalence of overweight and obesity. The data show that there is a tendency for the BMI to be over the limits considered normal (20 – 25kg/m²). About 33.6% of the males and 26.9% of the females are overweight and 15% and 28% respectively are obese according to the WHO definition. (BMI between 25 and 29.9 for males and between 23.9 and 28.6 is considered overweight while a BMI>30 for males and BMI>28.6 for females define obesity). There is a statistically significant association between obesity and hypertension.. The prevalence of obesity among hypertensives is 31.6% for males and 18.8% for females, while the percentages are respectively 21.5% and 11.4% for normotensives. This association is constant in all age groups, both for males and females. Also diabetes is strongly associated with obesity. Among those classed as undeweight, the prevalence of diabetes is 4% and 9% respectively for males and females, but among the obese, the percentages are 17% and 19.8 % for males and females. If one considers other biological risk factors, the mean level of total cholesterol in all subjects studied is high, 218mg/dl, even if the variability is high (standard deviation =43.97). However the levels of HDL cholesterol are high, which is

protective for cardiovascular diseases, and predictably, the level is higher among the women than among the men. The data of prevalence presented here describe the characteristics of a population of elderly people measured in a specific time interval. Among males aged 65-84 years, the most frequent cause of death is malignant neoplasms which are significantly more frequent than among females (sex ratio 1.57). Among women, the most common cause of death is circulatory diseases (sex ratio = 0.96), while the fifth cause of death is fractures of the femur. The trend in the mortality for cardio-circulatory diseases and cerebrovascular diseases has shown, in Italy as in other industrialised countries, an important decline in the last 40 years. The causes of this decline are unknown even though, at least in part it has been due to the better control of risk factors such as hypertension and hypercholesterolemia and the longer survival after acute episodes of the diseases. In contrast, there has been a notable increase in mortality from malignant neoplasms, above all, lung cancers which is undoubtedly due to cigarette smoking. In the last 20 years, compared with a decline of 23% in mortality from cancer among persons aged under 55 years, there has been an increase of 17% among those aged over 55 years. Some research workers claim that the predictive value of the presence of comorbidities on the survival of patients with cancer is higher than that of the stage of the disease at the time of diagnosis, but epidemiological data on the effect of comorbidities and their severity on the clinical progress of the cancer in elderly patients are not currently available and this is a major priority for geriatric research. The increase in the incidence of fracture of the femur, and its consequent mortality, above all among women, is one of the major public health problems in Western countries, also because of the important demand for medical assistance and its consequent cost to health services

4 Research strategy

The research strategy that has been adopted has first of all divided the research workers in groups, every one of which is given a specific period of time, generally two years (for example, 1996-97)

The sources that were consulted were:

- § Newspapers
- § Magazines (weekly or monthly)
- § Relevant national legislation
- § Relevant regional legislation
- § Grey literature
- § Interviews with people in various sectors of interest (nurses, doctors social workers, psychologists etc.)
- § Searching sites dedicated to the diffusion of data (ISTAT, CENSIS, ASP, ISFOL etc.)
- § Final reports of research projects and/or research (ASP; ministries, local authorities)
- § The published acts of conventions, congresses, simposia, seminars etc.
- § Sections of books / chapters of books
- § Monographs / books
- § Scientific research journals (periodicals)

One of the major difficulties encountered in this work was the availability of materials. In fact, even though the required information is to be found in different sources, the organisational difficulties that are present in our country have been made evident, which has limited our access to the information (inadequate or insufficient opening hours, catalogues which have not been computerised, etc.). These limitations have

unavoidably lead to delays and an extension of the time necessary to complete the work.

The medical literature is much more easily available, not only because there is much more of it, but also because the university libraries pay particular attention to the problem of the accessibility of information.

Also more recent information, relating to the last five years, is more easily accessible because many data banks can be studied and information extracted only after 2001.

Also, the availability of data in some subject areas was over optimistic since some results are not complete and consequently some of the subject matter requested was not available. (Sustainability, setting, gender, inequality, diversity).

5 Thematic analysis

Inspection of the contents of the literature collected reveals that some themes are over represented in comparison with others.

The majority of the studies start by revealing the social importance of the problems suffered by the elderly and follow by focussing on specific aspects of their living conditions. The medical, epidemiologic and demographic literature are numerous but there are many studies which analyse the quality and lifestyle of the elderly.

The demographic studies show the following:

- ❖ There is an excess of women in comparison with men.

- ❖ There is an increase in the number of elderly people who live alone, especially women. The fact that among the totally disabled women who cannot perform their normal daily activities, 18% live alone and another 9% live with another person aged over 65 years. Among the severely or totally disabled men however, about half live with people younger than themselves and the other half live with a person over 65 years old.

- ❖ Because of their lower level of education in comparison with the rest of the population, the elderly are increasingly vulnerable. Among the elderly, about 30% of the males and 43% of the females have not had more than three years of school education and only about 20% of the men and 10% of the women have a high school diploma or a university degree.

- ❖ The relationship between education and health status is one of the most interesting research areas in geriatrics because it is necessary to identify which factors are associated with an increased risk of illness and disability among less educated people. The Italian Longitudinal Study on Ageing (ILSA) has shown a strong relationship between level of education and physical disability which is twice as common among those with three or less years of schooling as it is in the rest of the population. It is possible that the explanation for this finding is that the disease is more advanced because of later diagnosis among the less well educated. There is also a strong association between education and other specific diseases, for example dementia, stroke and heart failure. Whether this is due to exposure to risk factors or to reduced use of health service facilities, or both is yet to be seen. Health determinants, health promotion and disease prevention are addressed most frequently in the findings of this study. We find studies on longevity often with not very large sample sizes, which consider lifestyle variables such as diet, physical activity and occupation. Particular attention is given to senile dementia and Alzheimer's disease which have high social and health service costs.

In fact, it is disability which is a specific field of study, both for prevention and care.

The projects and the strategies adopted have the objectives to protect the health of the elderly and public health. Usually they are based on three objectives: health information, prevention of diseases and health promotion using health decisions. The objectives are to create social networks with co-ordinated replies and sharing of experiences. Training and the diffusion of information and knowledge can have a synergistic effect so that an equilibrium of integration in matters of protection and health improvement is reached.

The project "Progetto Argento" which involves 11 regions of Italy, is of particular importance. The objectives of the project are to quickly measure the state of the

health of the population, the quality of life and the health needs of the elderly to improve the planning of health services at a regional level. This study is promoted by “Profeta”, a Master of Science in Epidemiology based at the Istituto Superiore di Sanità, the Italian government health research institute, which with the Multipurpose Survey by ISTAT (the Italian government statistics office) and the ILSA study of CNR-Istituto Superiore di Sanità and the Argento network of the Catholic University of the Sacred Heart have identified the health needs of the elderly highlighting the regional differences and the gap between the actual services which are offered and the goal to provide excellent services.

The project makes a quantitative analysis of the state of health of the elderly population taking account of the differences between males and females. It is one of the few studies which takes account of quality, as perceived by the elderly, and the more common diseases. The individual’s perception of his health is a very important correlate of the quality of life and use of health services. Overall, the conclusion of the project is that women live longer than men but their quality of life is less favourable.

There is less information about the promotion of mental health than about the promotion of physical health in general, but some studies have been found that relate to depression and to memory training. An important study, Censis, has deepened the question of the subjective experience of those who are becoming elderly, underlining the course of their individual lives, the question of autonomy, the search for new space and social roles. It has also taken account of new suffering, often hidden or misunderstood which may be associated with, for example, lack of self-sufficiency. The study has paid particular attention to personal relations and social interactions which are decisive for the quality of life.

The studies on empowerment are few and not very representative of the elderly population and show how the elderly are not generally involved personally. However, many studies are about the social promotion of the elderly. Participation in the affairs of society has an important role in relation to the policies adopted at a regional level for the promotion of rehabilitation, recreation and socialisation, particularly for people who are not self-sufficient physically or suffering from pathologies. In some Italian cities, particularly in the North and Central regions of the country, Universities of the “third age” have been established with specific legislation and which contain faculties of Humanities, Art and Entertainment, but

very little is written about it in the Scientific literature. In the discussion of social support, which is part of the Italian socio-health policy, the literature considers above all the use of training courses which are charged to the care-giver , or the so called “badanti” or home-help for an elderly person, or the members of the family of the elderly individual. There are many economic and logistic initiatives which aim to help the families who care for the elderly. Another service for vulnerable elderly people is the provision of accommodation and also there are economic contributions. For example, the local project in the town of Ferrara “Assegno di cura per anziani e disabili” (allowances for treatment for the elderly and disabled) has the objective to provide allowances, to increase the level of medical care and to help to make sure that courses of treatment, for which the allowance was made, once started, continue.

These projects confirm the willingness of local authorities to continue to invest in their citizens, knowing that there can be no development or future for society without an adequate growth in the services dedicated to the elderly.

The initiatives described in the literature tend to guarantee rights to assistance for the elderly population, which in some cities is 30% of the total population, in order to develop their personal abilities and ensure that in old age they will be active and participate in political and social life. The objective is to increase the number of people assisted directly or indirectly, interpret the needs and characteristics of the new requests that are being made, and to re-launch the preventive interventions with the involvement of those on the ground who will make available their local knowledge and experience. These interventions are the social centres, recreation and sports clubs, the universities for the elderly, the cultural centres, the trade union pensioners’ clubs and the Church. One finds that these responsibilities are taken within a social and health framework which encourages self-sufficiency in the elderly and helps them maintain it for as long as possible. The priorities of the projects, other than the quality of the services and hence the quality of life, are medical treatment at home, ensure the continuity of health care, before and after hospital treatment in the hope of reducing unnecessary admissions, projects for family health care, specific qualifications for badanti (home helps), the creation of a social care office which would help the elderly to orient themselves and to be accompanied in the social services network and

finally put the elderly in a privileged position enabling them to avail themselves to the network of associations.

There is an increasing tendency in our country to employ foreigners to help elderly persons. The social policy is therefore to improve the quality of assistance in private dwelling homes. For this reason it is essential to incorporate the help given by immigrants in the programmed and legal community services. Surveys indicate that the private market of home helpers is dividing into two parts, with distinct profiles for home domestic workers and those who offer care.

From the literature examined, there is a very small percentage of articles about the specific methods of social participation such as self-help groups or voluntary work which are also increasing in our country. Further research is needed to evaluate the consistency and the quality of these activities.

Italian data imply that almost all aspects of lifestyle are taken into consideration, above all in relation to the prevention of illnesses. Rarely considered is the use of substances like tobacco, alcohol and drugs by the elderly, while there is a certain number of articles about diet and physical activity (both for prevention and rehabilitation activity).

For example, research carried out by I.U.S.M. on persons aged between 65 and 74 years of age has shown that it really is possible to learn to swim at this age and to enjoy the beneficial effects of swimming on health and above all, the mood of the individual. The real efficacy of this experiment has been shown by the fact that all those who participated in the research continued to maintain their levels of activity, continuing to swim on their own account.

Some studies have investigated sexual activity among the elderly, including the conditions of elderly homosexuals. For example the qualitative research "Omossessualità e terza età" (Homosexuality among the elderly) published in 2000, investigated the psycho-social processes of ageing in this minority and in how homosexual orientation can be an additional stress or a resource for adapting to life in old age. The question of homosexuality among the elderly is not considered in the socio-cultural scene in Italy even if the number of people is not negligible. According to the generally accepted figures, homosexuality involves about 5 to 7 percent of the population, from which it can be deduced that in Italy there are between 600000 and 900000 female and male homosexuals aged over 60years, a considerable number.

It is rare to find articles dealing with the prevention of abuse and violence against elderly people. Abuse of elderly people, even if usually it is not reported, is very common. The three categories of abuse are: domestic abuse, institutional abuse and self inflicted abuse. The measures suggested by WHO are knowledge, education and defence. The family doctor and the geriatrist should play an important role in notification and prevention of subsequent similar events given that they can discover cases of abuse more easily than others.

As regards safety and accessibility, the literature does not reflect what is happening at a regional or local level, where there has been considerable activity. For example, architectural barriers have been abolished, there are specific interventions to help the integration of the disabled and elderly by improving urban access, making use of public buildings and open spaces in the town, introduction of telephonic help and emergency treatment for the elderly and persons at risk. Some studies are concerned with the consequences of accidental falls and other problems related to rehabilitation. The extent of this problem is considerable among persons more than 65 years of age. For example, in Calabria, a project has been designed to reduce the number of domestic accidents over a period of three years, giving incentives for the installation of security measures, initiating programmes for adapting spaces for use by the disabled, starting a publicity campaign and the introduction of an epidemiological surveillance system to monitor the phenomenon. The Public Health Agency of the region Lazio has prepared guidelines for general practitioners in order to contain this dangerous phenomenon. Another initiative from the same agency is the diffusion of the recommendations for the prevention and treatment of bed sores. The treatment of bed sores is not only an economic problem but also difficult to organise and program because very often the clinical condition is not evaluated correctly. These recommendations are the result of the revision of the most important national and international guidelines with the opinions of experts and are an important instrument for health workers.

In other studies, it is found that the perception of old age and the way of life in old age is changing dramatically, changing from the concept of the end of life to a phase of life with new activities and objectives which are different to those in other periods of life.

The stimulus for this social process is connected to the increasing expectation of life and at the same time the possibility, even in old age, to take advantage of a state of health which guarantees sufficient autonomy to participate in activities at will. It is apparent that it is not the intention to make the elderly like those who are younger, or to duplicate the activities that are really appropriate to other phases of the life span, but to search for wellbeing allied to a way of life and behaviour which makes one contented and able to face the problems of old age positively. At a social level, one aspect of extreme importance is the perception of liberty and new opportunities that the majority of the elderly associate with increased life span and living as a pensioner. The increased life span and the end of working life imply in great part the reduction of duties, the loosening of bonds and the freedom to experiment with novelties and unfulfilled ambitions destroying the negative stereotyped image of old age.

One of the most important indications revealed by studies, of well being or alternatively, uneasiness in old age is a network of affectionate relationships, support and care. When the need for care becomes so overwhelming, or continuous because of an illness, or an event for which the physical resources, psychological state or economic resources cannot cope, assistance in the form of a network becomes an especially important resource with which the social and health services can collaborate. Where however, such links do not exist, it becomes much more difficult to maintain the subject in his own usual environment, and in these case it is necessary to transfer him/her from the domestic circumstances to a community based ambient, which in Italy almost always means a nursing home. Within families, in which there is also resident an elderly relative, there are likely to be profound changes in the family circle which are likely to become more acute as the age of the relative becomes greater. If we look only at the relationship in the families we can observe great changes in the family of old people by age. At the brink of old age, the Multiscopo study of ISTAT in 1998 found that between 65 and 69 years of age, about 59% of women and 85% of men live with their spouse and eventually with their children. Between 75 and 79, only 23% of the women and 80% of the men are in this family situation. If these data observed in 1998 were interpreted as if they were a cohort, observed for a period of 10 years, it would represent a profound change in the existence of these elderly people, especially the women, who survive. The substantial

similarity between the interpretation of the cross-sectional data and the cohort can be seen by considering a single cohort. If for example we consider the cohort born between 1919 and 1923, these are considered by the Multiscopo studies of 1989, 1993 and 1998 when they are aged about 65-69, 70-74 and 75-79, respectively. At age 65-69, 56% of the women and 89% of the men live with their partner (and some also with their children), but ten years later when they are ten years older only 23% of women, but still 80% of the men live with their partners even if fewer are with their children. The opposite trend is seen for the percentage who live alone. Between seven and eight percent of the men live alone at ages 65-69, but ten years later the percentage has risen to 13%. Between 25 and 27 percent of the women live alone at ages 65-69, but ten years later the percentage has risen substantially, to 43%.

6 Transversal issues

6.1 Research Methods

The greater part of the research located has used quantitative methods or qualitative with quantitative methods, and the use of structured questionnaires and interviews is more common than the use of unstructured ones.

In particular, the investigations of the illnesses of old people, and there are not too many of these investigations, are often based on interviews in which there is no medical diagnosis of the pathology, but only the self assessment of the interviewee. The use of such interviews has serious limitations above all because the data obtained may be unreliable. In such cases, research using self rated health may be of limited value.

No studies were found which were based on participatory research or action research.

6.2 Strategies of health promotion

The prevention of ill health and the promotion of health are two themes that occur often and studies are conducted both as local interventions and as investigations of the lifestyle of elderly persons. An example of the first of these is the order of

the Ministry of Health “Tutela delle persone anziane” (Protection of the elderly), which consists of programmed interventions by the regions with the objective to reduce the hardship caused by unpredictable extreme climatic conditions. The Ministry has produced and distributed guidelines to achieve these objectives. The Ministry has performed investigations and collected information of the interventions made at a regional and local levels in order to compare and share their well documented experiences.

An example of the second is the studies of the quality of life in the RSA (Residenze Sanitarie Assistenziale, or nursing homes) which admit older people who are not self sufficient. The methods used in these structures is the RUG (Resource utilisation groups) which classifies patients both for admission and for economic support.

One widely used method for the promotion of health is the analysis of the training courses followed by people who work in the health sector. Also some studies adopt a multidisciplinary approach to tackle the questions of persons aged over sixty. Also, interventions for the elderly may have the merit of being not only medico-socio-cultural, but also being concerned with recreation and tourism.

6.3 Settings

The reports studied are concerned with both the ill and the healthy elderly population, but relatively infrequently with the setting in which they live, for example the workplace or the problems faced by the homeless. Generally studies are done in small local areas . Exceptions include studies done on ethnic minorities or the elderly who live in institutions.

6.4 Inequality/Diversity

In recent years, social inequality of health has become a major issue in public health. Briefly, in many countries the phase of observation and measurement of the inequalities has been superseded by research into the causes of this inequality and identification of interventions which may correct it. From the point of view of health, the main indicators show that there are still important

differences in all aspects of health in Italy: self-rated health, physical health, mental health, chronic diseases and disability.

If one considers individual subgroups of the population, one can identify particular weak points from the health indicators. The elderly, who suffer the disadvantage of their frailty also suffer in almost all aspects of health that are studied: lifestyle, perception of their health, poverty in the family circle, cultural conditions and income. The social differences in health among the elderly have particularly strong consequences for disability. It can be hypothesised that the elderly inherit disadvantages in health from their younger adult years, but that in old age the health differentials accelerate towards disability in old age. It is rare in the Italian literature to find the transversal issue of inequality and or diversity discussed. In these cases the research tends to concentrate on poverty in old age or on ethnic minorities, while the general problems are hardly ever taken into consideration.

One very important difference that has been found in a study conducted by the Istituto Superiore di Sanità (the Italian Government's Health Research Institute) which shows an enormous difference between the North and South of the country in both the state of the health of the population aged over 65 and in their health needs. In the North, the elderly state that their health is better, the coverage of vaccination is higher and they suffer fewer cognitive deficits and disturbances. In the South, there is an increase in the incidence of pathologies and hospital admissions and a higher number of elderly persons who are not self sufficient, but to their advantage, they are better integrated in society which, especially for women is a grave problem at this age. For the rest, the elderly population is considered as a whole, in its totality or otherwise the problems of an individual patient, but without further distinction.

6.5 Sustainability

A large part of the research projects, above all those which are very specific, have shown a high degree of sustainability both from the point of view of results and costs. The projects which have short, medium or long term objectives highlight both research methodology and their completion and results in terms of health. An example from which we can all learn, is the project Argento, which has

been active in several regions and which has seen the evaluation of its results which show it to be a highly sustainable project.

Some training projects, which are studies on groups of immigrants even those without permission to stay in Italy, show that they are sustainable and their implementation has been widened to the national scene.

6.6 Cost effectiveness

Even accepting that a posteriori many projects could have had a positive outcome in terms of cost – benefit analysis, there have been no studies that have been evaluated specifically from this point of view. One can only say that some projects, above all at a regional or local level, have led to a partial re-orientation of the socio-health services, giving increased attention to the needs of the elderly. They have a great positive balance in terms of cost-effectiveness in the sense that the elderly population is actively followed with social support and from a health point of view (mammography, pap-test etc.) and in the case of minority groups such as gypsies or immigrants, access to services has been improved.

6.7 Consumer involvement

Although one hears from many quarters, institutional or not, the importance of listening to the voices of the elderly, of considering their subjective experiences, their own opinion about their status and so on, the studies and projects which examine these, rarely take account of them. When the methodology requires the use of instruments such as questionnaires or structured interviews, clearly there is little space for the subjects to express their own opinions.

Thus the involvement of the elderly seems therefore rather infrequent, especially considering the absence of participatory research and action research.

7 Conclusion and Summary

The approach to research on the elderly requires first of all, the identification and understanding of the many interdependent factors which are involved.

The understanding and the care of an elderly person must become analysis and care of the whole person expressed in multidimensional terms like prevention, cure and rehabilitation in a physical, psychological and socio-cultural sense. It is based on differing scientific disciplines, for example biology, nursing, geriatrics, anthropology, sociology, etiology, urban studies and psychology of ageing. The multidisciplinary approach is essential given the variety of factors that are associated with the conditions of the elderly.

The structure of the elderly population is ever more differentiated in relation to biological and socio-cultural variables. This causes different modes of ageing and consequently different types of needs. In this context, the analysis of the needs and the response to them in terms of an increasing diversification of the services offered, is the basic objective of every social-health policy. The services offered must reflect and overtake the difficulties of the aged population, facing up to the question of finding something new to do after retirement and the problem of support at that age.

In the front line are the social and health services, which have acquired an important role in social politics as indicated by the European Union; In the European Social Agenda (Nice 2000), the European Commission in fact noted the double role of the social strategy, that is associated with the factors affecting production and the methods of reducing inequalities and improving social cohesion.

In Italy, the framework of law designed to achieve an integrated system of interventions, social services and the National Social Plan is an important innovation for civil defence. The reform of health care, which unites family welfare, social security and health is not without its problems, both in terms of the resources invested and the critical aspects that are evident in this area of policy, an area which, historically in our country and generally in the Mediterranean countries, has had a residual role and is very fragmented.

One project which can improve the health of the elderly population is the Piani per la Salute (PPS) in which there are two specific elements which are typical of this population.

Firstly, the extreme heterogeneity of the subjects in the elderly population must be remembered. Generally the elderly are considered to be those 65 years of age or over, but within a group thus defined there are many distinct subgroups. To this must be added the variability between individuals, associated with ageing, something that is well known to those who, for research purposes, have tried to define homogeneous groups of elderly persons. The definition of a normal pattern of ageing is still scientifically disputed in Italy.

Secondly, the population itself is ageing. This is a relatively new phenomenon, which is now being faced for the first time with social and biological research methodologies which aim to find working solutions to the problems that it generates.

The demographic transition from high to low fertility and the consequent ageing of the population during the last century has been a feature of all industrialised countries and is now well known. Less cited and less well known is the increase in the “older elderly”, who from 1950 have increased fourfold, and who in 2025 will be one sixth of the population aged over 65. Also, in Italy, the “older elderly” are the major users of the National Health Service. 80% of the persons with functional deficit or are not self sufficient, are elderly. It is not that the single pathology causes elderly person to lose self sufficiency and thus the increased demand for health services, as much as it is the disability which results from co morbidities and the effect of socio-economic factors, among which are poverty, isolation, and change in social role after retirement. The increase in the expectation of life is worldwide and the years of life that are lived with disability and permanent use of health services are the more important indicators that health politicians should use for health services planning.

The National Health Service plan, and consequently the plans for the regions are increasingly directed towards the grass roots, and to ensure that the services become more human and personal. This requires the encouragement of socio-health services which are tailored and delivered, where possible, in a domestic family environment.

Among the many areas of intervention, the following should be noted: to make access to services more simple and improve the relationship between those who provide services and the citizens , the on-going training of health and other specialist professionals, the importance of maintaining cognitive function, frailty, overcoming the aspects of inequality which may dog the life of the elderly (economic difficulties, isolation, physical handicap and lack of family support). Thus to address these needs, the health intervention in isolation is not sufficient; the whole community needs to be intervene, as and where it can, on the specific socio-economic and environmental aspects of the case.

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