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The rights of disabled elderly people

SOMMARIO: 1. The rights of the disabled elderly people in European and international Charters and in the Italian Constitution 2. The realization of the rights of disabled elderly people: the role of the State and the Regions 3. The health care of the elderly disabled people 4. The social care for disabled elderly people 5. The funding of social care.

1. The rights of the disabled elderly people in European and international Charters and in the Italian Constitution

The recognition of specific rights for elderly people and for the disabled elderly is a recent conquest in the juridical realm.

Rights are entitlements that individuals can claim from the State and for which they can demand protection, even in the form of abstention from action, and claim damages when they are violated; or again in exercising a right, a person may even expect that a Public Administration take action towards everyone or only towards some specific well-identified groups.

As can be understood from this statement, rights are a heterogeneous category and their recognition, as can be said for their structure and operation, is the consequence of a slow evolution linked to the emergence of subjectivity.

The parties to the social contract that recognized the authority of the State are the people and the prince, and initially there were no rights. In order to speak about rights the people need to be considered as a group of individuals endowed with direct subjectivity that is qualified as personality recognized by the Law as legal capacity and the ability to act, and it is necessary for the whole legal system to be formed in such a way that conditions are provided for self-determination through the law and for the individual to be a player on the stage of society.

This is ensured by the rights that in successive waves were demanded and obtained by the American revolution and by the French revolution which led to the drafting of the first written constitutions and the first charters. With regard to these rights we speak of first, second, third and fourth generation rights; the first rights to be enshrined in the constitutions were political, freedom and social rights and only later the rights of specific categories of people.

The rights of the elderly and of the disabled belong to the latter two categories and are, as was pointed out earlier, a recent acquisition.

The elderly and the disabled as holders of rights were considered for the first time in the 1948 Declaration of Human Rights, Article 25.1 which states that «Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family (...) and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control».

At the same time, to a more limited extent but with a broader scope, Article 38 of the Italian Constitution states that

Every citizen unable to work and without the necessary means of subsistence is entitled to welfare support.

Workers have the right to be assured adequate means for their needs and necessities in the case of accidents, illness, disability, old age and involuntary unemployment.

Disabled and handicapped persons are entitled to receive education and vocational training.

Responsibilities under this article are entrusted to entities and institutions established by or supported by the State.

Private-sector assistance may be freely provided.

These provisions, that were extremely innovative for the time when they were written, summarize the principles and the evolution of the Welfare State. In the case of the UN Declaration the protection of the elderly is expressed in more universal terms which is typical of the Charters of Rights produced by International Law, whereas in the provision of the Italian Constitution, old age and disability are not considered as personal conditions that in themselves are important and such as to ensure the recognition of rights, but they are linked to the status of worker. Likewise people born with a disability are taken into account as people "unfit for work" .

This stance is due to the weight of labour principles in our Constitution. Indeed, in Article 4, labour is considered to be a "right" and also a "duty" («The Republic recognises the right of all citizens to work and promotes those conditions which render this right effective. Every citizen has the duty, according to personal potential and individual choice, to perform an activity or a function that contributes to the material or spiritual progress of society»), and this is so because the Constituent Fathers considered work not only as a means for enfranchisement, in terms of equality and freedom, but also as something that would ensure conscientious participation «in the political, economic and social organisation of the country» (Article 3).

This hypothesis envisages rights to benefits that are the outcome of the rise of the Welfare State that the Constitution fully endorsed, after the "insurance-based" experiences of the liberal era, and the "social security" experience of the Fascist State. In the democratic organization of the Republican state people's rights are seen as the rights of workers and relevant benefits are a form of social solidarity for the labour world, with the

assistance of the State and with room and freedom for private individuals to carry out charitable activities. Protection against accidents, disease, disability, old age and unemployment for workers is considered to be a form of "social protection" and is considered by the Constitution to be a remedy against any "obstacles of an economic or social nature which constrain the freedom and equality of citizens, thereby impeding the full development of the human person" (Article 3).

As can be noted the economic and social design of the Constitution was particularly advanced, but it did not embody a principle of positive discrimination. To the contrary. Equality and principle of equal social dignity are proclaimed by Article 3 (1), Const. "without distinction of (...) personal and social conditions". The principle of universal assistance to everyone and not only to workers was to be asserted first, then came the awareness of the need to support certain categories of people through active and specific measures, affirmative action, aimed at balancing the negative discriminatory circumstances experienced by some categories of people in our society like the elderly, the disabled, and many others (women, discriminated races, youth, religious groups, etc.).

Now, while as regards health, the universality of rights to health services came with the establishment of the National Health Service in 1978, the rights to social protection for certain categories of people were asserted only in the last decade of last century and took into account mainly disabilities, while for the elderly the recognition of their claims has been more restricted. Undoubtedly if an elderly person also has a disability, even if age-related, his/her condition is considered from the standpoint of his/her disability and not from that of old age, although some disabilities are typical of the elderly, such as Alzheimer's.

From this standpoint the European Social Charter is paradigmatic. In its original 1961 version it already contained – albeit with a vision that was somewhat limited to the health field rather than the social sphere – an article on disability (Art. 15 – The right of physically or mentally disabled persons to vocational training, rehabilitation and social resettlement); on the other hand, the article on the elderly was to appear only in the revisited 1996 version of the Charter: Article 23 – The right of elderly persons to social protection.

The European Social Charter in its last version expresses these "new rights" (or fourth generation rights) quite clearly. And so alongside the rights of the Welfare State (right to a job and to a pension, right to health and right to social security) we also find the rights of the handicapped (Art. 15), the rights of the family (Art. 16), the rights of children and adolescents (Art. 17), the rights of migrant workers (Art. 18), the right to equal opportunities without gender discrimination (Art. 19) and the rights of the elderly to social protection (Art. 23).

How do these new rights compare to the rights of the Welfare State? The rights envisaged in the Welfare State are generally rights to a benefit: unemployment benefit, a bed in a hospital and receiving medicinal products, a disability or old-age pension, etc.

The fourth generation rights are more pervasive, they do not only require benefits, if any, but that it is the whole of society that needs to be organized in such a way that enable the right to be satisfied and protection is seen to be provided as if in a mosaic (suffice it to recall the elimination of architectural barriers to facilitate the mobility of disabled people).

Let us consider the profiles that refer to this case - elderly people with disabilities - and let us examine exactly what is envisaged for them in the European Social Charter.

And with regard to disability, let us consider in particular the text of 1961 as against the 1996 version; in the first text disabled persons are ensured the right to "vocational training, rehabilitation and resettlement" and at the practical level the "provision of training facilities" and the adoption of "measures for the placing of disabled persons in employment" are envisaged; Art. 15 of the 1996 text states "persons with disabilities" are ensured "irrespective of age and the nature and origin of their disabilities, the effective exercise of the right to independence, social integration and participation in the life of the community".

And how is this right to autonomy, integration and participation ensured? Not only through the measures envisaged previously (vocational training and being given a job), but also by promoting "their full social integration and participation in the life of the community in particular through measures, including technical aids, aiming to overcome barriers to communication and mobility and enabling access to transport, housing, cultural activities and leisure".

In the case of elderly persons, the text of Art. 23 of the European Social Charter envisages that "the effective exercise of the right of elderly persons to social protection", be implemented through the adoption of appropriate measures directly by the State or "in co-operation with public or private organisations"; and such measures would be designed in particular:

– to enable elderly persons to remain full members of society for as long as possible, by means of:

a) adequate resources enabling them to lead a decent life and play an active part in public, social and cultural life;

b) provision of information about services and facilities available for elderly persons and their opportunities to make use of them;

– to enable elderly persons to choose their life-style freely and to lead independent lives in their familiar surroundings for as long as they wish and are able, by means of:

a) provision of housing suited to their needs and their state of health or of adequate support for adapting their housing;

b) the health care and the services necessitated by their state;

– to guarantee elderly persons living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution.

As can be noted, the rights of disabled elderly persons do not merely concern the provision of given benefits (health, allowances, pensions, etc.) by the public administrations, but also maintaining conditions of life that enable them to be full members of society for the rest of their lives, freedom as to life-style, active participation in public life and respect for their private life, even when they are no longer autonomous.

The implementation of the rights of disabled elderly persons requires that the State and society be equipped to respect such rights because this not only implies a suitable public organisation, but also a social mind-set that accommodates their presence, and for this reason these social rights may appear to be more evanescent compared to the rights that consist in the provision of benefits.

However, since the rights of elderly disabled persons today are the rights that we, ourselves, shall be entitled to tomorrow, almost as if by magic they are being authentically recognized within society.

Obviously since also new rights require specific investments, this recognition is turning into public services and budget policies for the elderly that help them with their disability problems; however it must be pointed out that the economic crisis has determined austerity policies that have had a negative impact on services for the elderly due to the cut-back in funds available for them.

Before facing this problem of the services for elderly disabled persons, it is necessary to conclude the profile of the recognition of rights, pointing out that the European Social Charter in the 1996 version was signed by Italy on 3rd May 1996, ratified on 5th July 1999 and implemented in the Italian legal system on 1st September 1999.

This is an international treaty that in the internal system corresponds to an ordinary law and that does not require constitutional proclamations even if after the amendment of Article 117 (1) Const., made at the end of 2001, we might say that there is a constitutional guarantee. Indeed, the Constitution envisages that «Legislative powers shall be vested in the State and the Regions in compliance with the Constitution and with the constraints deriving from EU legislation and international obligations» and, from this standpoint there are no doubts that the Charter is a source of «international obligations».

But the rights laid down in the European Social Charter and, in particular, those on the disabled and the elderly, are important for our legal order also through European Union Law, that is binding on the domestic legislator under Article 117 (1) Const., but the efficacy is different, as we are about to see.

It must be recalled that in 2000 when the it was "proclaimed" the Nice Charter (Charter of Fundamental Rights of the European Union [2000/C 364/01]) the European Social Charter was taken as benchmark to give shape to the articles of the new European Charter.

In Title III on Equality, besides equality before the law and the general non-discrimination principle, there are also the rights of the child (Article 24), the rights of the elderly (Article 25) and the principle of Integration of persons with disabilities (Article 26).

In particular, the provision of Art. 25 (The Union recognises and respects the rights of the elderly to lead a life of dignity and independence and to participate in social and cultural life) is more compact than the the provision of the European Social Charter; and the same holds for the provision of Art. 26 (The Union recognises and respects the right of persons with disabilities to benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community). However, it can be stated that the essence of the legal novelties laid down in the Social Charter have been summarized in the new Charter without any loss in substance.

What needs to be pointed out is that the restraints created by these provisions for the national legislator are much more significant.

In order to understand this we need to recall that the Charter of Fundamental Rights of the European Union was again "solemnly proclaimed" by the European Parliament, by the Council and by the Commission in 2007 (2007/C 303/01), in view of the approval of the Lisbon Treaty, that attributed to the Charter a regulatory status similar to the provisions of the Treaties (Article 6.1 - "The Union recognises the rights, freedoms and principles set out in the Charter of Fundamental Rights of the European Union of 7 December 2000, as adapted at Strasbourg, on 12 December 2007, which shall have the same legal value as the Treaties"), that in the European Union corresponds to the first level of the European order, similar to the constitutional status in domestic law.

The rights laid down in the Charter therefore are a primary European law, law of the European Treaties that are binding on Member States; but unlike the other international treaties (like the European Social Charter), the European Treaties do not generate mere international obligations, but a relationship between two legal orders: the European legal order and the domestic order. Not surprisingly Article 117 (1) Const., with reference to this relationships states that "Legislative powers shall be vested in the State and the Regions ... with the constraints deriving from EU legislation", thus recognizing the prevalence of European law.

In conclusion, from the entry into force of the Lisbon Treaty (1st December 2009), in our constitutional order the provisions on the elderly that can be inferred from the Constitution and, in particular, from Article 38, are completed by the provisions of the Charter of Fundamental Rights of the European Union, and by European law, both of which are directly enforceable in our legal order.

As to the European Union, the issue of ageing is already determining a body of acts and initiatives among which Decision no 940/2011/EU of the European Parliament and of the Council, of 14 September 2011 on the European Year for Active Aging and Solidarity between Generations, promoted in 2012.

2. The realization of the rights of disabled elderly people: the role of the State and the Regions

The long path leading up to the recognition of rights in favor of disabled elderly people tells us nothing about the way such rights are implemented in practice within the legal order, especially as regards those rights that depend on the provision of services and benefits that entail public spending and that require a specific type of public organisation.

In order to better understand the rights of disabled elderly persons in a State where the power structure is complex, the first thing we need to do is understand which institutions have the task of regulating the rights and the organisation; and, secondly, we need to check, at the administrative level, what services and benefits are included in such rights and the implementation of the organization that is to deliver such services in order for them to be enjoyed by disabled elderly persons.

Now from the standpoint of the instruments available in the legal order, we need to distinguish the powers that belong to the State and those that belong to the Regions, and within the Regions between those that are concurrent powers and those that are exclusively powers of the Regions.

So, for instance, all the social security measures for disability and unfitness as well as allowances are borne by the State, because social security has to do with the working status of people and for the economic nature of the benefits that constitute such measures.

Welfare measures instead are of competence of the regions even though, as stated by the Constitutional Court in its judgments on the "social card", it is not excluded that in exceptional cases the State may take welfare actions.

However, after the 2001 reform of Title V, welfare measures need to be distinguished into health and social security measures. In the previous division of powers, both types of care came under the only type of power that the Regions are granted, namely the concurrent power which nevertheless always envisages that the State always retains the power to set the general principles of a subject area while the Regions have the task of laying down the specific regulations.

After the constitutional reform, instead, healthcare services continue to be regulated under the principles of concurrent powers since they come under the heading of "health protection", whereas social services are classified as residual competence and hence the Regions have exclusive law-making powers.

This breakdown of powers has generated a number of implementation problems especially because there is a grey area between the two types of services and, especially in the case of care for the disabled elderly, because many services have a mixed nature i.e. come under both the healthcare and social services heading.

This is borne out very clearly by Article 7 paragraph 1 of Act no 104 of 1992 (Framework law for the care, social integration and rights of the handicapped) "Care and rehabilitation of a handicapped person are accomplished through programmes where

healthcare and social services are integrated, where the skills of each handicapped individual are enhanced and that act on the totality of the circumstances in which a handicapped person lives, and where both the family and the community are involved".

On the other hand, the difficulties are emphasized by the fact that the State was supposed to determine "the basic level of benefits relating to civil and social entitlements to be guaranteed throughout the national territory"; instead, while the "essential levels of care" (LEA) in the health field have been defined, the State has not yet taken action to define the "basic levels of social services" (LIVEAS).

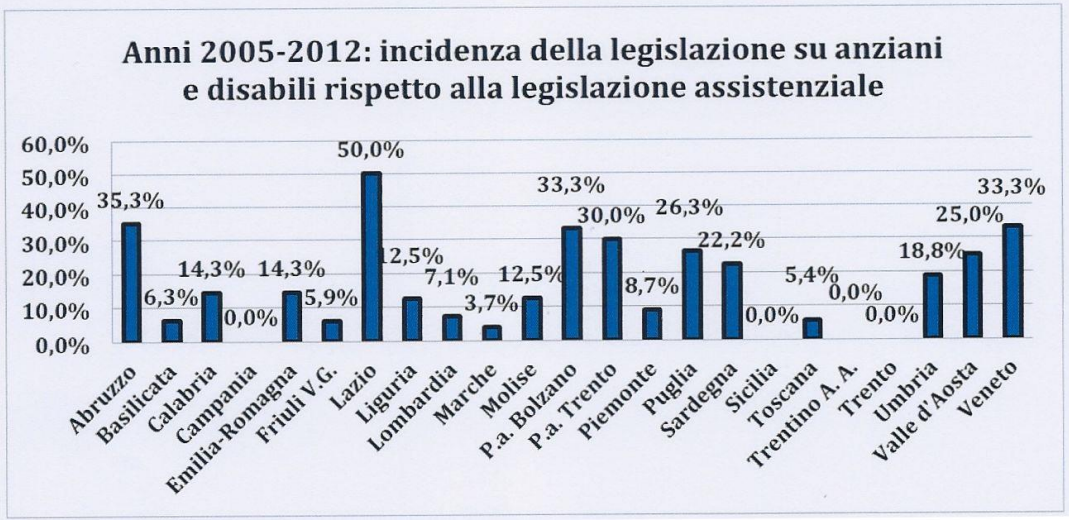
And so, while the levels of care had been defined for patient admission to health facilities, in the more important case of the implementation of the rights of disabled elderly to social services, the failure of the State legislator to define a global framework has deprived such rights of their definition thus producing an uncertain framework that has influenced the behaviour of the Regions.

In addition the lack of a uniform regulatory framework has been compounded with diminished financial means of the State and hence the Regions have had to intervene with their own resources. Consequently, the system of services for the handicapped elderly has been greatly affected by the diversity in the economic and financial conditions of the Regions that, in the Italian case, are characterized by a strong territorial divide.

In spite of this, it has turned out that social policies are a specific field of action for the Regions.

As shown in Figures 1 and 2 that refer to the period from 2005 to 2012, albeit not in a uniform manner across the Country, the Regions have produced a considerable number of laws on this theme, that account for an appreciable proportion of the total number of laws passed by the Regions on social matters.

FIGURE 2



The Regions have, however, sought to make up for this lack of uniformity.

In October 2009 a "Nomenclature of services and social interventions" was approved by the State-Region Conference. The idea arose in early 2006 following an analysis of the results of a "Survey on social services and social interventions in individual municipalities and association of municipalities carried out by ISTAT in co-operation with the Ministry of Labour, the Ministry of Health and Social Policies, the General Accounting Service of the State and with the Regions.

This made it possible to consider the benefits by cluster, start the creation of a shared glossary and develop, albeit in an embryonic form, a shared vision of the (non monetary) benefits to be provided to people in specific conditions of need.

3. The health care of the elderly disabled people

In conclusion, the materialization of rights of disabled elderly persons appears to be founded upon two pillars: the first pillar is represented by the healthcare benefits, arranged according to the LEAs defined by the State and funded by the State, even though the benefits are articulated on a regional basis with the specific facilities (hospitals) and with the territorial services being addressed essentially to rehabilitation for the recovery of undermined functions.

In particular, the latter that do not require hospitalization are implemented through the organizational modalities of delivery of the benefits according to the various regimes: residential, semi-residential, home care and outpatient clinics.

This provision is contained in Article 26 paragraph 1 of Act no. 833 of 1978 (Establishment of the national healthcare service), that states: «The healthcare services aimed at the functional and social recovery of individuals with physical, psychic or sensory handicaps, due to any cause, are delivered by the local healthcare units through their facilities. Where the local healthcare unit is unable to deliver the service itself, the Region shall make provision through agreements with the facilities existing in the Region where the user lives or in other Regions».

The measure adopted together with the possibility of providing the services through agreements with private facilities has entailed the fact that most rehabilitation services are actually delivered through such private facilities (about 90% of residential services).

In particular for non self-sufficient elderly persons, the services may be provided by Residential healthcare services (RSA), or through Integrated home care (ADI).

The former were provided for in Article 20, paragraph 2, letter f of Act no 67 of 1988 with the "creation of 140,000 beds in residential facilities, for elderly persons that cannot receive homecare and in the facilities provided for in letter e) (facilities, non-hospital general clinics and day hospitals) and that require continuous care. These facilities of sizes

that are adequate to the environment according to standards that will be issued in compliance with Article 5 of Act no 833 of 23 December 1978, need to be integrated with health and social services at the district level and with residential institutions that are capable of reinstating healthy conditions. Said facilities, on the basis of size, may be set up in the areas and spaces made available following the reduction in hospital beds".

As regards the ADI, this consists in the integrated and co-ordinated action of healthcare and social workers with the aim of offsetting the patients' disability, improving their wellbeing, reducing hospital admissions and ensuring that patients can be discharged from hospital as soon as possible.

At present in Italy the ADI (Integrated homecare) services are fully active only in some Aziende Unità Sanitarie (Healthcare Units), also because of the lack of precise uniform indications applying to all Regions. In any case, over and above the efficiency with which the services are provided through the ADI, the family goes on being the point of reference for the disabled elderly, while the healthcare services provided through the ADI are an ancillary support.

4. The social care for disabled elderly people

The second pillar through which the rights of disabled elderly persons are implemented is represented by the social services.

As stated above, the actual services envisaged as essential levels of social care (LIVEAS) and of benefits in practice are not organized according to a general principle or a territorial principle, but according to a mixed criterion that concerns the State for some aspects and the Regions for other aspects.

This mix has come about from the application of the previous formulation of Article 117 Const., where the regional (concurrent) power on social care did not exclude interventions by the State; without considering that a part of the social measures envisaged by the law of the State were de factor classified under the heading "social security". All this explains the formulation of social care services as provided by Act no 328 of 2000 (Framework law on the implementation of the integrated system of social interventions and social services).

However, with the 2001 Constitutional reform, the Regional competence of social services has become exclusive, since it is provided for in Article 117 paragraph 4 Const.. This has not entailed major regulatory changes as regards organizational changes that were, however, heavily affected especially throughout the years of the economic crisis.

In practice, healthcare measures that are associated with social security have continued to be borne by the State (invalidity allowances [ordinary cheques, disability pensions and allowances for caregiver], pensions and or social security cheques), also by virtue of Article 117, paragraph 2, letter o Const.; while all the other aspects have de facto been referred to the Regions for them to provide the regulations, in the absence of detailed provisions on

essential levels that the State is required to provide as per Article 117, paragraph 2, letter m, Const.

The result was that, even after the reform of the Constitution, Act no 328 of 2000, was the guide for building up the regional and local social system, so much so that all the subsequent regional reorganisation laws confirmed many of the innovations of that Act such as, for instance, the model of an integrated network system; the municipality as the centre of the services; the "zone plan" (local planning instrument of individual Municipalities or associations of Municipalities); all instruments to be used for programming purposes; the increased role of the "third sector".

The regional legislation framework, therefore, is not very different from that outlined in the framework law, but it does have one major difference, namely the Regions' programming powers and the general power to make laws on social services, and the new financing model that right from the beginning represented a criticality of the system.

In spite of the proclamation made in the State law, the integrated system of interventions and social services is not a universal system.

We speak about co-ordinated policies and benefits comprising the various sectors of social life, integrating services for individuals and families and in some cases allowances. This is an expression that shows that this area embraces a whole range of diverse social conditions from poverty, to drug and alcohol addiction, women in difficulty, care for the mentally ill and minors, and also disabled elderly persons.

In particular, for the latter, essential care levels are determined by interventions to enable the elderly and the disabled to be taken care of in their own homes or be placed with families, persons or in community homes, or in residential and semi-residential facilities for those who being very fragile or with limited autonomy cannot receive home care (Article 22, paragraph 2, letter g).

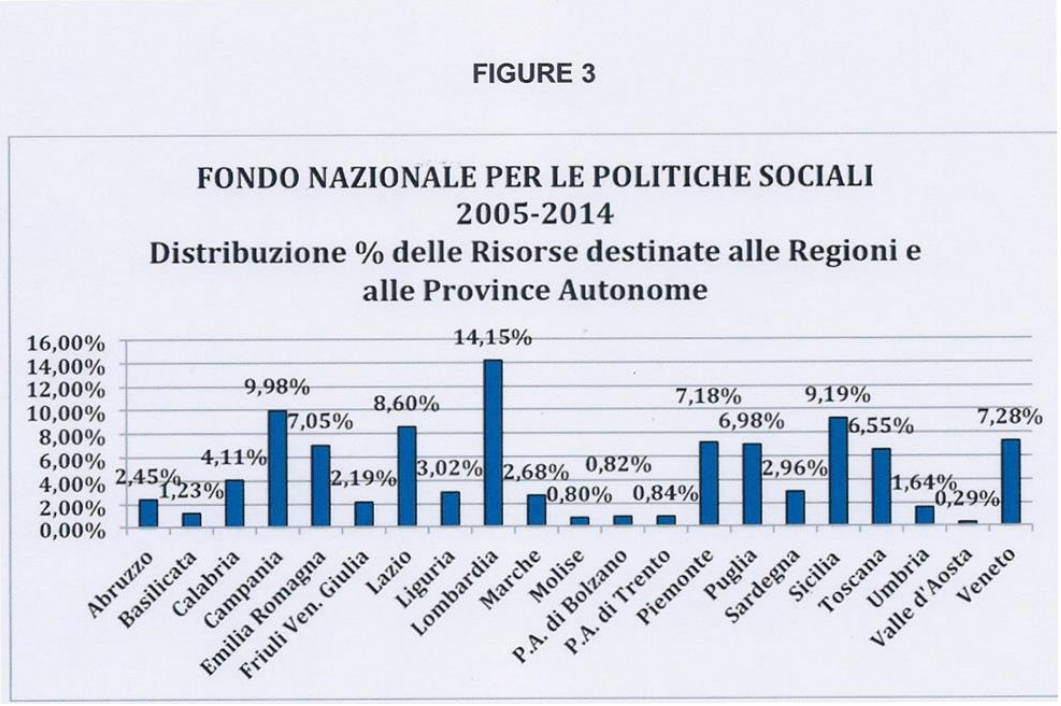
From this standpoint the Regional legislation should make provisions to organize, in general, professional social services and social secretariats for providing information to individuals and households as well as a service for emergency interventions. As regards the specific support for disabled elderly persons, instead, the Regional legislation should define the services that constitute home care, i.e. treatment allowance or indirect care; and, in the case of social fragility, services that can be provided in residential and semi-residential facilities, or in community residential or day-care facilities (Article 22, paragraph 4).

These are measures that the Regions have interpreted in different ways, and have defined the criteria for gaining access to the various services; the healthcare standards of the RSAs; the standards, services and rates of Protected Shelters; day and residential services for patients with dementia.

5. The funding of social care

At this point it is necessary to underscore that, unlike healthcare, the economic restrictions on social care are much more significant. The actions and interventions that constitute the essential levels of social services can be delivered, in the form of goods and services, within the limits of the resources of the National fund for social policies (Article 2), where however account is kept of the ordinary resources already allocated by the local authorities for social spending.

FIGURE 3



The status of the fund and the share distributed to the Regions for funding social services was not uniform over the years and was heavily affected by the economic crisis. In 2011 the National fund for social policies was 218 million Euro, but in 2012 it was cut down to 42 million Euro. The portion that went to the Regions in 2011 was 178.58 million Euro, whereas in 2012 it plummeted to 10.86 million Euro.

FIGURE 4

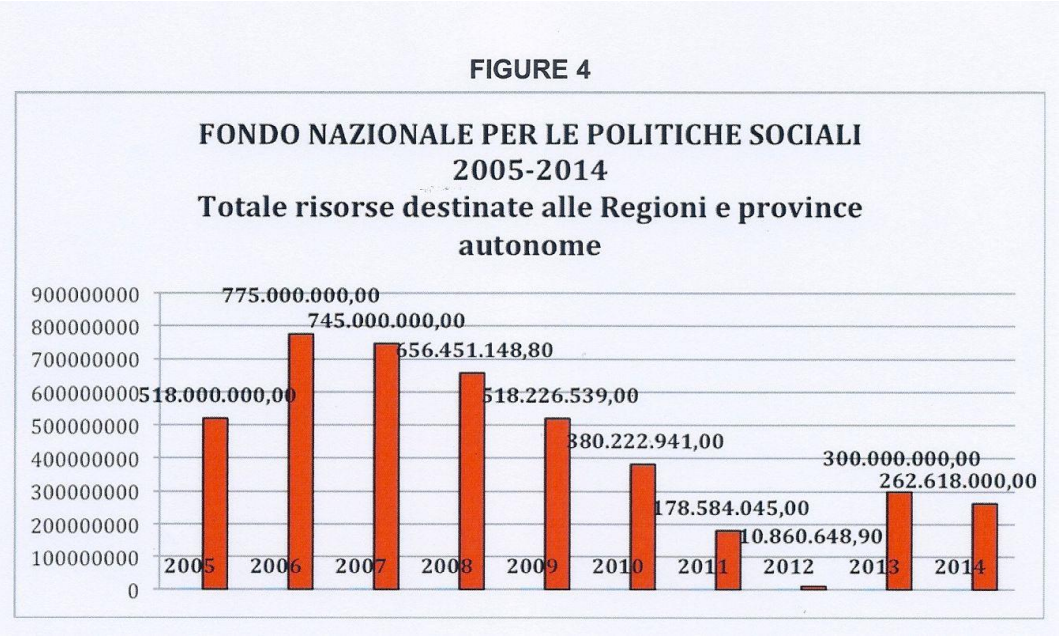


Table n. 1 — FONDO NAZIONALE PER LE POLITICHE SOCIALI 2005-2014
Totale risorse indistinte destinate alle Regioni e Province autonome

%	REGIONI	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
2,45%	Abruzzo	12.697.065	18.996.574	18.261.223	16.090.739	12.702.618	9.319.914	4.377.400	266.213	7.353.513	6.437.216
1,23%	Basilicata	6.373.670	9.535.896	9.166.764	8.077.226	6.376.457	4.678.408	2.197.366	133.634	3.691.315	3.231.352
4,11%	Calabria	21.301.779	31.870.422	30.636.728	26.995.323	21.311.095	15.635.956	7.343.934	446.624	12.336.938	10.799.673
9,98%	Campania	51.711.493	77.367.581	74.372.707	65.532.952	51.734.108	37.957.328	17.827.891	1.084.209	29.948.741	26.216.928
7,05%	Emilia Romagna	36.538.684	54.666.950	52.550.810	46.304.751	36.554.663	26.820.166	12.596.961	766.088	21.161.400	18.524.548
2,19%	Friuli Ven. Giulia	11.362.073	16.999.240	16.341.205	14.398.930	11.367.042	8.340.001	3.917.152	238.223	6.580.351	5.760.395
8,60%	Lazio	44.550.195	66.653.285	64.073.158	56.457.581	44.569.679	32.700.784	15.358.985	934.062	25.801.272	22.586.261
3,02%	Liguria	15.639.425	23.398.753	22.492.995	19.819.534	15.646.265	11.479.668	5.391.799	327.904	9.057.582	7.928.947
14,15%	Lombardia	73.295.508	109.660.268	105.415.354	92.885.947	73.327.563	53.800.451	25.269.128	1.536.751	42.449.136	37.159.691
2,68%	Marche	13.858.666	20.734.491	19.931.865	17.562.813	13.864.727	10.172.554	4.777.870	290.568	8.026.255	7.026.130
0,80%	Molise	4.131.902	6.181.900	5.942.601	5.236.278	4.133.709	3.032.904	1.424.502	86.632	2.392.994	2.094.811
0,82%	P.A. di Bolzano	4.266.480	6.383.247	6.136.153	5.406.825	4.268.346	3.131.686	1.470.898	89.453	2.470.934	2.163.039
0,84%	P.A. di Trento	4.372.844	6.542.382	6.289.129	5.541.619	4.374.756	3.209.760	1.507.568	91.683	2.532.535	2.216.964
7,18%	Piemonte	37.198.411	55.653.993	53.499.645	47.140.810	37.214.679	27.304.419	12.824.407	779.921	21.543.481	18.859.020
6,98%	Puglia	36.140.405	54.071.069	51.977.995	45.800.020	36.156.210	26.527.820	12.459.652	757.738	20.930.736	18.322.627
2,96%	Sardegna	15.334.902	22.943.144	22.055.022	19.433.617	15.341.608	11.256.142	5.286.812	321.519	8.881.217	7.774.558
9,19%	Sicilia	47.580.571	71.187.148	68.431.517	60.297.916	47.601.380	34.925.144	16.403.728	997.598	27.556.315	24.122.615
6,55%	Toscana	33.952.805	50.798.116	48.831.738	43.027.718	33.967.654	24.922.076	11.705.462	711.872	19.663.787	17.213.548
1,64%	Umbria	8.504.062	12.723.259	12.230.745	10.777.029	8.507.781	6.242.161	2.931.834	178.300	4.925.132	4.311.428
0,29%	Valle d'Aosta	1.495.015	2.236.750	2.150.167	1.894.603	1.495.669	1.097.373	515.417	31.345	865.839	757.950
7,28%	Veneto	37.694.045	56.395.531	54.212.478	47.768.918	37.710.530	27.668.225	12.995.280	790.312	21.830.528	19.110.299
100%	TOTALI	518.000.000	775.000.000	745.000.000	656.451.149	518.226.539	380.222.941	178.584.045	10.860.649	300.000.000	262.618.000

State Act no 238 of 2000 envisaged that, as far as the National social policies fund was concerned, the Minister for social solidarity was to determine every year the share to be allocated for services for non self-sufficient elderly persons, to enable them to be autonomous, providing support to families to provide home care to elderly persons who apply for assistance (Article 15).

In allocating the resources for non self-sufficient elderly persons weighted criteria are used on such parameters as population, age brackets and proportion of elderly people in the population, taking into account also the position of the Regions and Autonomous Provinces vis-à-vis the national indicators of non self-sufficiency and income.

A part of the fund is reserved for investments and integrated health and social services projects, implemented as a network with co-ordinated actions and programmes involving public and private entities, aimed at supporting and encouraging the autonomy of elderly people and having them taken care of at home.

By June 30th every year, the Regions that receive these funds are to forward a progress report on interventions made and goals achieved through their activities to the Minister for social solidarity and to the Health Minister; in the report they can also make proposals for innovative interventions.

For the Regions that fail to file their progress report, the funds assigned to them are re-determined and re-allocated.

Subsequently, with the 2007 budget law a distinct social fund was set up called "Fund for non self-sufficient people" (therefore also for the elderly, but not only for them), designed to ensure the implementation of essential levels of social services throughout the Country with special emphasis on non self-sufficient persons. This fund was assigned the sum of 100 million Euro for 2007 and 200 million Euro for 2008 and 2009 (article 1, paragraph 1264).

In the following years the Fund was replenished through the Budget Laws. In 2011 the Fund was reduced to 100 million Euro, allocated entirely for benefits, interventions and healthcare services for people affected by ALS (amyotrophic lateral sclerosis); in 2012 the fund was not replenished because of the economic crisis. The economically viable Regions set up specific funds from their own resources to make up for this cutback on non self-sufficiency.

Table n. 2 — FONDO PER LE NON AUTOSUFFICIENZE 2007-2014

ANNO	LEGGE FINANZIARIA	RISORSE	INTESE CONFERENZA UNIFICATA
2007	Legge n. 296/2006 art.1 comma 1264 – Finanziaria 2007	**€ 100.000.000,00 (quota effettiva destinata alle Regioni e alle P.A.: € 99.000.000,00) € 1.000.000,00: Ministero della Solidarietà Sociale**	20/09/2007 (intesa ai sensi della legge n. 296/2006 – Finanziaria 2007)
2008	Legge n. 244/2007 art. 2 comma 465 – Finanziaria 2008	**€ 300.000.000,00** (200 da finanziaria 2007 + 100 incremento finanziaria 2008 art. 2 Comma 465) **(quota effettiva destinata alle Regioni e alle P.A.: € 299.000.000,00) € 1.000.000,00: Ministero della Solidarietà Sociale**	20/03/2008 (intesa ai sensi della legge n. 296/2006 – Finanziaria 2007)
2009		**€ 400.000.000,00** (200 da finanziaria 2007 + 200 incremento finanziaria 2008 art. 2 comma 465) **(quota effettiva destinata alle Regioni e alle P.A.: € 399.000.000,00) € 1.000.000,00: Ministero della Solidarietà Sociale**	
2010	Legge n. 191/2009 art.2 comma 102 – Finanziaria 2010	**€ 400.000.000,00 (quota effettiva destinata alle Regioni e alle P.A.: € 380.000.000,00) € 20.000.000,00: Ministero del Lavoro e delle Politiche Sociali**	08/07/2010 (intesa ai sensi della legge n. 296/2006 – Finanziaria 2007)
2011	Legge 220/2010 art.1 comma 40	**€ 100.000.000,00 (quota destinata esclusivamente alla realizzazione di prestazioni, interventi e servizi assistenziali in favore di persone affette da SLA)**	27/10/2011 **l'intesa ha previsto anche l'utilizzo per altre disabilità gravi** (intesa ai sensi della legge n. 296/2006 – Finanziaria 2007)
2012	IL FONDO NON E' STATO FINANZIATO		
2013	Legge 228/2012 – Legge di stabilità 2013 – art. 1 comma 272	**€ 275.000.000,00 (*)**	24/1/2013
2014	Legge 147/2013 – Legge di stabilità 2014 art. 1 commi 199 e 200	**€ 350.000.000 (quota effettivamente destinata alle Regioni e alle Province autonome: € 340.000.000) 275 milioni inclusa SLA e 75 milioni per Assistenza domiciliare disabilità grave**	20/2/2014

(*) L'art. 1 comma 109 della Legge 228/2012 stabilisce che "Le eventuali risorse derivanti dall'attuazione del piano straordinario di verifiche nei confronti dei titolari di benefici di invalidità civile, cecità civile, sordità, handicap e disabilità, sono destinate ad incrementare il Fondo per le non auto sufficienze, sino alla concorrenza di **40 milioni di euro annui**. Le predette risorse saranno opportunamente versate all'entrata del bilancio dello Stato per essere riassegnate all'apposito capitolo dello stato di previsione del Ministero del lavoro e delle politiche sociali".
Fonte: Rapporto Conferenza delle Regioni e delle P.A.: LE RISORSE FINANZIARIE PER LE POLITICHE SOCIALI ANNI 2007-2014

The paucity of resources, right from the beginning, entailed the fact that the concrete delivery of social benefits was determined by a form of selectivity based not on the personal situation of the applicant but on the economic conditions of him and of his family.

For these reasons access to benefits was regulated by the Regions through a parameter called ISEE – indicator of equivalent economic conditions.

This mechanism was introduced in the legal order with Legislative Decree no 109 of 1998 (Definition of unified evaluation criteria of the economic situation of individuals requesting social care services in accordance with Article 59, paragraph 51 of Act no 449 of 27 December 1997), but after the 2001 constitutional reform that gave the Regions legislative powers on social services, the Regions were able to reconsider the mechanisms whereby income and assets not only of the applicant, but also of his/her family are taken into account, in order to have access to benefits, and they have consequently established

various degrees of co-payment for such services (see Constitutional Court, Judgment no 296 of 2012).

The State legislator reacted against this heterogeneous situation created by the Regional legislation and which prompted complaints by the users, with Article 5 of Legislative Decree of 2011 (the "Save Italy" Decree), converted into Act no 214 of 2011, which envisaged the "introduction of ISEE for granting tax relief measures and care benefits, and the money saved would be made available to the families".

To correct these provisions, the Constitutional Court, in Judgment no 297 of 2012, received the appeal by the Veneto Region that complained about the lack of a memorandum in the revision procedure of ISEE and because the bodies delivering social service benefits could not modulate in a different manner the indicators concerning the equivalence of the economic situations of the beneficiaries of such benefits.

According to the Constitutional Court, the legitimacy issue is well-founded "because the determination of the ISEE, of the types of services, of the income threshold below which people have access to the benefits and services, and of the LIVEAS has a significant impact on the Regions' power to make laws in the areas of social services and, potentially, on the funds of the Regions, that bear the economic costs of these services", consequently prescribing "a necessary assessment of the local situations, an evaluation of financial sustainability and fair co-operation with the Region in implementing the regulations".

In practice, the determination of the ISEE, that would be binding also on the Regions, was provided for by a decree of the President of the Council of Ministers that in the end was adopted on the 5th of December 2013 (no 159) in 2013.

The ISEE assesses the economic conditions of the person applying for social services and is calculated taking into account the economic conditions of the whole family of the applicant and other information available from the archives of INPS and of the Inland Revenue.

In the light of the regulations adopted, and with a view to calculating the ISEE of non self-sufficient elderly persons applying for residential care services, account will be kept of the offspring who are no longer part of the household of the applicant, whereas for non residential services only the applicant and not his family will be taken into account.

In addition, the calculation of the asset component will be updated to take into account the parameters introduced for establishing the IMU (property tax) and exemptions will be reduced both for real estate and for the financial assets of the applicant.

Finally, new increases have been envisaged in the equivalence scales that have burdened the ISEE for access to benefits, and/or, de facto, expanded the percentage of co-payment paid by the applicant and by his family.

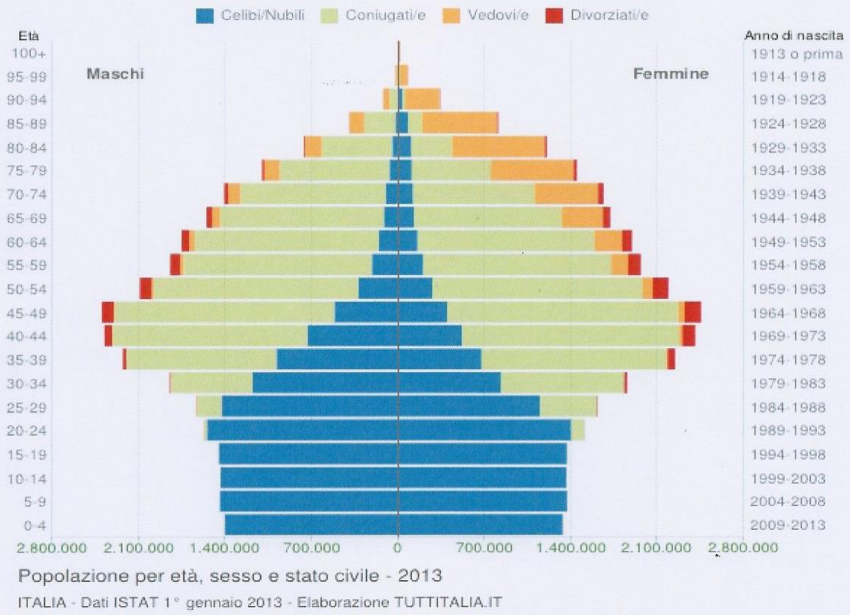
Some recent data: in 2012 the population over sixty-five was 12,370,822, about 21% of the overall population.

In Italy, seven million people, about 13% of the whole population have different degrees of non self-sufficiency; this figure also includes the individuals who need only partial care. While the people needing continuing care are over two and a half million.

Table n. 3

Età	Celibi/Nubili	Coniugati/e	Vedovi/e	Divorziati/e	Maschi	Femmine	Totale	%
65-69	230.855	2.415.450	397.732	88.848	47,40%	52,60%	**3.132.885**	5,30%
70-74	221.670	2.162.596	632.382	63.021	45,80%	54,20%	**3.079.669**	5,20%
75-79	182.311	1.483.753	800.540	35.379	43,00%	57,00%	**2.501.983**	4,20%
80-84	152.511	879.448	891.734	20.099	38,60%	61,40%	**1.943.792**	3,30%
85-89	99.231	353.716	710.564	9.808	32,50%	67,50%	**1.173.319**	2,00%
90-94	35.763	76.126	295.227	2.911	27,10%	72,90%	**410.027**	0,70%
95-99	11.468	11.619	90.434	597	21,40%	78,60%	**114.118**	0,20%
100+	1.718	850	12.392	69	16,30%	83,70%	**15.029**	0
Totale	935.527	7.383.558	3.831.005	220.732	34,01%	65,99%	**12.370.822**	20,90%

Figure 5



Il grafico detto **Piramide delle Età**, rappresenta la distribuzione della popolazione residente in Italia per età, sesso e stato civile al 1° gennaio 2013.
La popolazione è riportata per **classi quinquennali** di età sull'asse Y, mentre sull'asse X sono riportati due grafici a barre a specchio con i maschi (a sinistra) e le femmine (a destra). I diversi colori evidenziano la distribuzione della popolazione per stato civile: celibi e nubili, coniugati, vedovi e divorziati.

In generale, la **forma** di questo tipo di grafico dipende dall'andamento demografico di una popolazione, con variazioni visibili in periodi di forte crescita demografica o di cali delle nascite per guerre o altri eventi.
In Italia ha avuto la forma simile ad una **piramide** fino agli anni '60, cioè fino agli anni del boom demografico. Da notare anche la maggiore longevità femminile degli ultra-sessantenni.

And of course, the funds allocated in Italy to cater to these needs are largely insufficient, especially if compared with the twelve billion Euro spent in Spain in 5 years, or France where, in 2008, additional resources of over 5 billion Euro were added to the fund for non self-sufficient individuals.