

QUALITATIVE-QUANTITATIVE APPROACHES ON THE MATTER OF DISABILITY

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ABSTRACT

The idea of the first qualitative-quantitative approach within the definition of the phenomenon of disability stems from the fact that it assumes a remarkable importance for everything that arises from the care system and its respective costs. In order to do that, it was necessary to start from the data available in the ISTAT¹ data bases. The availability of statistical information on disability is a fundamental prerequisite for the proper implementation of rules and the allocation of adequate recourses. However, in Italy, as in most other countries, we haven't yet come to an organic and complete data on the various aspects of disability. It results that it is neither possible to say precisely how many disabled persons there are in Italy, which disabilities they have, what is the level of their social integration, nor which needs of disabled persons and their families are met and which are not.

Before proceeding into more details related to the estimation of disabled persons in Italy, immediately stating that ISTAT report and the content of Rocco Di Santo's volume was deliberately in use.

Key Words: Methodology/Social Policy; Disability/Perception of Disability; Overall Picture Italy/Abruzzo.

1. INTRODUCTION

In order to write this paper, I had to refer to what was reported in the projects of statistical survey done by ISTAT, and in recent sociological literature, which seem to be the best tool to try to trace the mapping of the problematic. Preliminarily, for the strictly methodological part, I have to add that in general the processes of the sociological research follow the same model of other sciences. Besides a pure fact (analyzed through elaboration programs such as for example Statistical Package for the Social Sciences, in the work of putting in practice a research with its various phases, there is also a work on interpretation and reviewing the collected material. As much as the data can be precise and complete, their value remains incomprehensive; they will come to full light only being observed through descriptive lenses.

It means giving them meaning and from time to time, place them in a conceptual framework within which they make sense. Resuming what Piergiorgio Corbetta states, the distinction between the methodology and the technique can be compared to the one between the reflection on a certain matter and the matter itself. It is implicit in the same term structure. To summarize: the methodology signifies the study of the method, the rules, formal

However, in Italy, as in most other countries, we still don't have an organic and complete data on various aspects of disability.

As a result, it is neither possible to state precisely how many disabled persons there are in Italy, which disabilities they have, what is the level of their social integration, nor which needs of disabled persons and their families are met or not.

Before proceeding into more details related to the estimation of disabled persons in Italy, immediately stating that ISTAT report and the content of Rocco Di Santo's volume was deliberately in use, it will be appropriate to clarify certain aspects:

- 1) *The definition of disability is not universal.* In fact, it changes depending on statistical survey/detection and by whom it is carried out; terms such as disabled, handicapped, invalid, unfit are often inaccurately used. For example, disability and invalidism are two different concepts: the first refers to the person's ability to perform independently (although with aids) the basic activities of daily life as stated in the **Law 104/1992**, while the second refers to

conditions which are the basis of each and every scientific research; the technique (or techniques, as Corbetta always says), the operating procedures that allow us to learn about a certain reality. To evaluate it well, however, we must also consider that there is no clear difference between methodology and technique (at least there is no clear split between the two terms); it appears as a deep continuity between the philosophical speculations about the method and the operational actions of the techniques. We should add that, we can do that without methodology, but the methodology itself cannot do it without techniques. I insist, the intent of this report will be to come to a secondary analysis with data, not direct ones, difficult to be retrieved due to rigidity of the regional structures in charge and the need to be able provide thru secondary analysis; therefore, initial mapping of the current situation help decision makers to make their choice, when we want to start developing a fact-finding investigation of social reality which should result in an action-research and implementation of social policies or action research with a goal of improving the quality of life.

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the right to receive an economic benefit as a result of a physical injury regardless of the overall evaluation of self-sufficiency, and refers to the **Law 118/1971**. Combining data from different sources in order to provide an overall estimate of the number of persons with disability means to consider that people are identified with diverse parameters.

- 2) *The accuracy of survey/detection depends on the type of disability.* It is much more difficult to detect mental disabilities than the physical ones, because of resistance and cultural prejudices that drive people, directly involved or their family members, not to come into contact with public services or not to respond appropriately to questions in research and surveys. To be added to these are the major difficulties in identifying the appropriate means to detect mental disabilities compared to other types of disabilities.
- 3) *Estimation of the number of disabled children requires sources of information not currently available.* The institutional source of the number of school certifications does not fully solve the problem either because it does not include

the pre-school children or because registration to kindergarten is not required, therefore the real number of children with certified disabilities from age 3 to 5 is definitely underestimated.

- 4) *In order to count the disabled, both the disabled people living with their families, as well as disabled people in residences should be taken into consideration.* In the first case there have been specific investigations since long time, in the second case reliable data are available and complete only for a few years.
- 5) *The current system of disability certification.* An invaluable source of data to estimate the number of disabled people in Italy might be set up by certification, in fact every ASL² established special committees which issue various types of certification to ascertain the invalidism and state of handicap. Unfortunately, for such certifications, there have not yet been adopted neither criteria for recognition nor uniform recording devices; moreover, they are almost never transferred to computer, not even a statistical survey is foreseen on the national level. **However, as already mentioned above, there has been insufficient cooperation at the local level for gathering the data updated up to 2012. Therefore we had to use the latest available data (2004-2005).**

WHO disability classifications

Among the purposes set by WHO, there is also the identification and classification of diseases. Inherited statistical tradition, created in France and subsequently used in the USA and later on in the rest of Europe, has classified the main pathologies cause of death. In fact, among these "methods" we find the ICD (International Classification of Disease) as a tool for classification in which the diseases and injuries are sorted, for statistical purposes, in groups correlated and so far have ten versions. The family of international classifications, by which we try to read and understand the disease/health both in a strictly bio-psychic and social sense, also consists of ICIDH (International Classification of Impairment, Disabilities and Handicap) and, in its latest version, the ICF (International Classification of Functioning, Disability and Health). For our purpose, we will refer to the latter classification.

The disability according to the ICF

In 2001, a new classification of disability was accomplished. The new International Classification

of Functioning, Disability and Health-ICF as a *standard of measurement and classification of health and disability*. The purpose of the ICF is to offer the standardization of a reference model for the description of the components of health and related states from body perspective, the individual and social in two main lists:

- 1) Body Functions and Structures,
- 2) Activities and Participation.

The classification also lists environmental factors that interact to determine a disability. It is defined as the consequence or result of a complex relationship between the health condition of an individual, personal factors and environmental factors that represent the circumstances in which the individual lives.

The ICF can be used in different disciplines and sectors (clinical, statistical, research, welfare policies) as far as:

- it provides a scientific basis for understanding and studying of health, conditions, consequences and its determining reasons;
- it establishes a common language in order to improve communication between different users, among others health professionals, researchers, politicians and the population, including people with disabilities;
- it allows comparison between data collected in countries, health care disciplines, services and different periods;
- it provides a systematic coding scheme for health information systems.

ICF

The International Classification of Functioning, Disability and Health (ICF) is one of the international classifications, developed by **World Health Organization (WHO)** that allows us to encode a wide range of health-related information (e.g. diagnosis, functioning and disability, access to services). Such information using a standardized common language, support communication in the field of health and health care, among operators worldwide and between various sciences and disciplines.

The ICF also provides *environmental factors*, the characteristics that make individuals less skilled. By measuring health condition and disability, we will be able to quantify the loss of productivity and its impact on the lives of people in any society.

We can assess changes in time and get a picture of how healthy people lose in functionality, where the real problems are and where we can make progress. In other words, the ICF can be used to measure the results of health and it seems as a simple classification of health, but it can be used for many

purposes, among which the most important is a programming tool for those who must take political decisions.

For the then Secretary of the Ministry of Health, Antonio Guidi, the ICF is an overturning of views; as he says, "by inverting the perspective, we do not want to normalize anyone, but to propose models to lead to higher levels of life quality and of health as well as of a growing number of people with disabilities".

The ICF, therefore, is not a classification of "consequences of disease" but of "components of health". The first type of classification focuses on the "consequences" that is, the impact of disease or other health conditions that may result, while in the second type constituent elements of health are being identified. In this sense, ICF is not concerned only about people with disabilities, but about all people, especially because it provides information describing human functioning and its restrictions and uses terminology in which Body Functions and Structures, Activities and Participation substitute the terms of impairment, disability and handicap. the implementation of activities that allows identification the obstacles to be removed or interventions to be made so the individuals can reach the maximum of their self-realization:

Body functions: the physiological functions of body systems, including psychological functions.

Body structures: the structural or anatomical parts of the body (organs, limbs and their components) classified according to body systems.

Impairment: a loss or abnormality in body structure or physiological function (including mental functions).

Activity: is the execution of a task or action of an individual; it represents the individual perspective of functioning.

Limitation of activities: the difficulties that an individual may have in executing activities. An activity limitation may deviate from mild to severe, in quantitative or qualitative terms, while executing activities compared to the way and measure expected by people without health condition. Participation: involvement in a life situation; it is a social prospect of functioning.

Restrictions of participation: problems that an individual may experience involved in life situations. The presence of a participation restriction is determined by comparing the individual's participation to that which is expected of an individual without disability in that culture or society.

Environmental factors: all aspects of the outside and extrinsic world that form the context of an

The ICF classification proposed by WHO integrates the ICIDH (see in the following comparative table), in an approach in which health is assessed altogether according to three dimensions: biological, individual and social, medical and social conception of disability.

It is essential the passage from an individual approach to a socio- relational in the study of disability as for disability is seen as the consequence or the result of a complex relationship between the health condition of an individual, personal factors and environmental factors representing the circumstances in which a person with disability lives.

It means that all the individuals, regardless of their own health condition, can find themselves in an environment with characteristics that may limit or restrict their functional abilities and social participation.

The ICF associates the health condition with the environment, and thus promotes a method of measuring the health, capacity and difficulties in

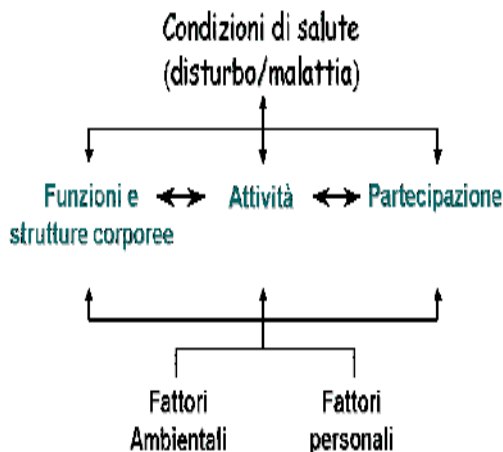
individual's life and as such have an impact on the functioning of the person (e.g. physical environment and its characteristics, attitudes, values, policies, social systems and services etc).

Personal factors: contextual factors related to the individual such as age, sex, social class, life experiences, general behaviour patterns and character styles that can play a role, despite their extreme variability in disability at any level.

Functioning: includes all body functions, activities and participation. It indicates the positive aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors).

Disability: general term for impairments, relational activity limitations. It indicates the negative aspects of the interaction of the individual (with a health condition) and that individual's contextual factors (environmental and personal factors).

The conceptual model on the basis of ICF is presented in the following format (see source ISTAT):



Health conditions
(disorder/disease)

Body functions and structures ↔
Activity ↔ Participation

Environmental factors Personal factors

Therefore, impairment/disability/handicap contrast with of relations between dimensions held as constituents of the health of a person at a given time of his life.

An argument considering disability as a linear consequence of impairment and disability is supported by the fact that functions and body characteristics fall into category of impairment, while activities and participation in the social life of a person fall into category of disability and handicap.

If the Functions and Structures of the body include the physiological functions and structural and anatomy parts and of the human body, WHO considers *Activity* as performing a task and action by the individual. Instead, the term *Participation* considers involvement in a life situation.

Therefore, as Limitations of activity are considered difficulties that an individual may have in performing activities; on the other hand, Restriction of participation includes problems that an individual may experience in involvement in life situations. The domains of the Activities and Participation component include two qualifiers: Performance and Capacity.

The first of these describes what an individual does in his current environment while the second qualifier describes the ability of an individual to perform a task or action.

It is clear that both Activity and Participation are closely linked and influenced by environmental factors, which include the physical, social

environment, and by attitudes in which people live and conduct their lives. These factors are external to individuals and can have a positive or negative impact on the participation of the individual to execute actions or tasks, or the functioning or structure of the body.

These factors may therefore constitute either a barrier or a facilitating factor for the individual himself.

The ICF consists of two main parts:

Part 1 - Functioning and Disability:

- *Body functions and structures* includes two classifications, one for functions of body systems, and other for body structures
- *Activity and Participation* includes the complete range of domains indicating the aspects of functioning from the perspective of both individual and social.

Part 2- Contextual Factors:

- *Environmental factors*, including the physical environment, social and attitudes in which people live, may have an influence on the individual's capacity to execute actions or tasks, or on its functioning or structure of the body.
- *Personal factors* are the personal background of life and the existence of an individual that can play a role in disability.
- The components of Functioning and Disability can be expressed in two ways. On one hand they can be used to indicate problems (e.g. impairment, activity limitation or participation restriction, grouped under the general term *disability*); on the other hand they can indicate non-problematic (neutral) health aspects and

related states, grouped under the general term of *functioning*.

The following table presents an overview of the ICF (see **ISTAT source**):

**4.1 TABLE
ICF OVERVIEW**

Components	Part 1: Functioning and Disability		Part 2: Contextual Factors:	
	Body functions and structures	Activity and Participation	Environmental factors	Personal factors
Domains	Body functions Body structures	Fields of life (tasks, actions)	External influences on functioning and disability	Internal influences on functioning and disability
Construed	Change in body functions (physiological) Change in body structures (anatomic)	Capacities Performing tasks in standard environment Performance Performing tasks in actual environmental	Easing or obstructive impact of the characteristics of the physical, social world and attitudes	Impact of the characteristics of the person
Positive aspect	Functional and structural integrity	Activity Participation	Facilitators	not applicable
	Functioning			
Negative aspect	Impairment	Limitation of activity Restriction of participation	Barriers/obstacles	not applicable

		ation		
	Disability			

The person is defined as disabled, excluding conditions referring to temporary limitations, if declares the highest degree of difficulty in at least one of the functions identified with each question, even taking into account the possible use of assistive devices (prosthesis, sticks, glasses, etc.). Depending on the compromised functional autonomy, four types of disabilities were being built: **confinement**, **difficulty in movement**, **difficulty in the functions of everyday life**, **the difficulties of communication**.

Confinement means permanent constriction in bed, on a chair, or at home for physical or psychological reasons; those who are confined only respond to questions on motor activity compatible with the relative type of confinement.

People with **difficulty in movement** have trouble walking (they can only take a few steps without having to make stops), are not able to get up or down from just a flight of stairs without stopping, they cannot bend down to pick objects from the ground.

The **difficulties in daily life functions** concern the complete absence of autonomy in carrying out essential daily activities or personal care, such as getting into bed or sit by themselves, dress themselves, wash or take a bath or shower alone, eating alone even cutting up food.

The difficulties of communication include hearing restrictions (not being able to follow a TV program even when the volume is high and despite the use of hearing aids); limitations in seeing (not recognizing a friend at one meter distance); difficulties in speech (not being able to speak without difficulty). In other words, it can happen that a person being a motor invalid due to lack or ankylosis of a limb, but resorting to the support of a prosthesis or other device, results not to be dependent and cannot be declared motor disabled.

On the contrary, a person who has no impairments in the limbs, but for example, due to the advanced age, cannot move a step without the help of other people, has a motor disability while not declaring motor invalid.

We can try to schematize the differences in the following way:

ICIDH	ICF	ICF
IMPAIRMENTS	<i>BODY FUNCTIONS</i>	<i>BODY STRUCTURES</i>
<ol style="list-style-type: none"> 1. Impairment of intellectual capacity; 2. Other psychological impairments; 3. Language and word impairments; 4. Hearing impairments; 5. Visual impairments; 6. Visceral impairments; 7. Skeletal impairments; 8. Generalized sensory impairments and other types, 	<ol style="list-style-type: none"> 1. Mental functions; 2. Sensory functions and pain; 3. Voice and speech functions; 4. Functions of cardiovascular systems, haematological, immunological and breathing apparatus; 5. Functions of digestive, metabolic and endocrinal systems; 6. Genitourinary functions; 7. Neuromusculoskeletal functions related to moving; 8. Functions of skin and related structures 	<ol style="list-style-type: none"> 1. Nerve system structures; 2. Eye, ear and related structures correlate; 3. Structures involved in voice and speech; 4. Structures of cardiovascular systems, haematological, immunological and breathing apparatus; 5. Structures related to digestive, metabolic and endocrinal systems; 6. Structures related to genitourinary and reproductive systems; 7. Structures related to movement; 8. Skin and related structures
ICDIH	ICIDH	ICF
DISABILITY	HANDICAP	<i>ACTIVITY AND PARTICIPATION</i>
<ol style="list-style-type: none"> 1. BEHAVIOUR DISABILITY 2. COMMUNICATION DISABILITY 3. HAUSHOLD CARE DISABILITY 4. LOCOMOTIVE DISABILITIES 5. BODY STRUCTURE DISABILITY 6. DEXTERITY DISABILITY 7. CIRCUMSTENCIAL DISABILITA' 8. DISABILITY PARTICULAR ACTIVITIES' IN 9. OTHER RESTRICTIONS OF ACTIVITY 	<ol style="list-style-type: none"> 1. HANDICAP IN ORIENTATION 2. HANDICAP IN PHYSICAL INDEPENDENCE 3. HANDICAP IN MOBILITY 4. OCCUPATIONAL HANDICAP 5. HANDICAP IN SOCIAL INTEGRATION 6. HANDICAP IN ECONOMIC SELFSUFFICIENCY 7. OTHER HANDICAP 	<ol style="list-style-type: none"> 1. LEARNING AND APPLICATION OF KNOWLEDGE; 2. GENERAL TASKS AND REQUESTS; 3. COMMUNICATION; 4. MOBILITY; 5. CARE ABOUT ONESELF; 6. DOMESTIC LIFE; 7. INTERPERSONAL INTERACTIONS AND RELATIONS; 8. MAIN FIELDS OF LIFE; 9. SOCIAL, CIVIL LIFE, COMMUNITY.

Disability in Italy...

Between 2004 and 2005, about 2 million and 600 thousand disabled people, with disabilities over the age of six (4.8% of the Italian population) were noted.

Taking into account 190.134 people living in social and health care residences an **estimated total** of less than 2 million 800 thousand persons with disabilities is reached, equal to 4.8% of the population aged 6 and over living in a family. The estimate is based on a very restrictive criterion of disability, according to which people with disabilities are considered only those that during the interview reported a total lack of autonomy in at least one essential function of everyday life. If we consider generally people who have experienced a significant difficulty in performing these functions, the **estimate** exceeds to 6 million 606 thousand people, equal to 12% of the population, living in a family, older than 6 years. This figure is in line with the one seen in the major industrialized countries. However, the figure doesn't comprise people who suffer from some form of disability, not physical but mental, but are able to carry out these essential activities. Regarding the **estimate** of persons with disabilities who do not live with their families but in the social and health care residences, we can refer to the data from the survey conducted on these structures, which indicate in 2003 (latest year available), the presence of 190.134 people with disabilities or not self-sufficient elderly people.

The presence of disabilities is of course related to age: among persons aged 65 or more the share of people with disabilities is 18,7%, and it reaches 44,5% (35,8% for men and 48,9% for women) among people of 80 and older.

The disability rates show a gender difference to the detriment of the female: in relation to the total population, women have a disability rate of 6,1% and men 3,3%. This phenomenon is determined largely by the demographic evolution, which caused a remarkable aging of the population, characterized by an increase in life expectancy at birth for the whole population, but more so for women.

In the analysis of the territorial distribution emerges a difference between northern, southern and insular Italy (the islands). In particular, there has been a disability rate of 5,7% in insular and 5,2% in southern Italy, while this rate falls to 4,2% in the North-East and 4,3% in North-West Italy. The central Italy has a disability rate of 4,9%. The same geographic structure is observed for men and for women.

... And in Abruzzo

Based on these estimates the expected number of disabled patients in Abruzzo is 59.700 (the estimate of the frequency in the population aged 6 and over is equal to 5,41%), out of which 50.000 elderly (84% of disabled people, equal to a rate of 19,5% among the over sixty). The estimate of elderly patients with severe/complete disability is 2-3%.

Among the elderly estimate of dementia cases is about 15.000 (6%), of which more than 2.500 serious (1-2%). The number of pensions recorded in 2003 stood at 47.560.

Preliminary results obtained from samples of the elderly population of Abruzzo - on the basis of data collected by general practitioners - are described below. Of a total of 102.802 cards, sampled for the period 2002-2004, the number of patients is 49.808. The analysis was conducted on the last survey per patient carried out during the reporting period.

The analysis on the Index of Katz (ADL)³, numerical expression of sedimentation of red blood cells, shows that 17% of seniors have at least one condition of disability/dependence among the eight functions investigated. The increase of Katz's index is an indicator of disease activity, without even taking on a precise and specific meaning in diagnostic scope.

The frequency of the elderly with dependence in all aspects (class G) is 3,9% (males 3,3% , females: 4,4%). Such a total dependence ranges from 2,1% of the elderly < 70 years to 15,9% of the over nineties. 38% of the sample is positive to mental state testing: severe mental deterioration is present in 5,7% , with variable frequency from 3,0% of the elderly < 70 years to 23,3% of the over nineties. Estimates of frequency do not seem to vary between coastal areas and inland/mountain.

Estimates analyzed in General Medicine are consistent with ASSR/ISTAT estimates. The analysis is a basis for in-depth territorial plan by the Study Group for Epidemiology in General Medicine (OER - General Medicine - ASL)

What emerges from the data?

It is evident that the representation of the phenomenon shows that we are dealing with a complexity and variety that often is confused with the general phenomenon of the disease.

We have tried to highlight, in the epigraph, that the terms of illness and disability are often used interchangeably; it is also persistent vision that disability is contiguous to the state of pathological chronicity. On the contrary, even from the information on the comparative difference between

³ Katz Index of Independence in Activities of Daily Living

ICIDH and ICF, the real difference between sickness and disability emerges with all its strength whenever the focus shifts to a level of micro sociological observation reported to the experience of the person with disability.

It would not be difficult, in fact, to say that a possible collection of stories of lives would detect situations in which there are emerging barriers to the mental and physical dysfunction and structural alterations preventing the limitations of activities and restrictions of relationships filled by environmental facilitators, allowing a harmonious relationship Person/environment regardless of the assigned pathology.

It should be also put in evidence that what is lacking is an institutional approach empirically dedicated to data collection in order to facilitate local decision makers; the latest known survey is from years 2004/2005 and is stated on the online

publication, Disability in Italy, often cited as dated in 2009.

According to the data, it is clear that the range of greater effect concerns those from 65 to 80 years and more. Just to give voice to this segment of the population, that from initial analysis, would be particularly affected by functional difficulties similar to what is reported in the ICF as *Neuromusculoskeletal functions and related to the movement*, and in order to give meaning to the entire projection/experimentation, which is believed to hit the target included among the age group 65/80 years on, with the hope that we can start a serious season of experimentation.

The appendix shows the statistical tables with national and regional data (Abruzzo region) and related rework.

STATISTICAL ANNEXES

Persons with disability aged 6 and more living in family.
Absolute values and rates on 100 persons. Year 2004-2005

	6-14	15-24	25-34	35-44	45-54	55-64	65-69	70-74	75-79	80 on	Total
Absolute values (data in thousands)											
Men	41	19	28	46	51	76	64	99	131	328	882
Women	39	17	23	41	50	98	111	180	289	879	1.727
Men and women	80	36	52	86	101	174	174	279	420	1.207	2.609
Rates on 100 person											
Men	1,6	0,6	0,7	1,0	1,4	2,2	4,3	7,7	13,4	35,8	3,3
Women	1,6	0,6	0,6	0,9	1,3	2,7	6,5	11,4	20,8	48,9	6,1
Men and women	1,6	0,6	0,6	0,9	1,3	2,5	5,5	9,7	17,8	44,5	4,8
Source: ISTAT, Investigation on health conditions and use of health services, 2004-2005.											

Persons with disabilities and non self-sufficient seniors, hosted in residential social care according to the sex. Year 2005.								
Men	Persons with disabilities aged less than 18 years	882	Persons with disabilities aged 18-64 years	18489	Non self-sufficient elderly people	35.970	Total	55.341
Women	Persons with disabilities aged less than 18 years	569	Persons with disabilities aged 18-64 years	14950	Non self-sufficient elderly people	125.358	Total	140.877
Men and women	Persons with disabilities aged less than 18 years	1441	Persons with disabilities aged 18-64 years	33439	Non self-sufficient elderly people	161.328	Total	196.218

Source: ISTAT, Investigation on residential social care. Year 2005

People with disabilities aged 6 and over, who live in family by region. Absolute values, crude and standardized rates on 100 people. 2004-2005.

Abruzzo	Absolute values	66	Crude rates	5,4	Standardized rates	4,9
ITALY	Absolute values	2.609	Crude rates	4,8	Standardized rates	4,8

Source: ISTAT, Investigation on health conditions and use of health services, 2004-2005.

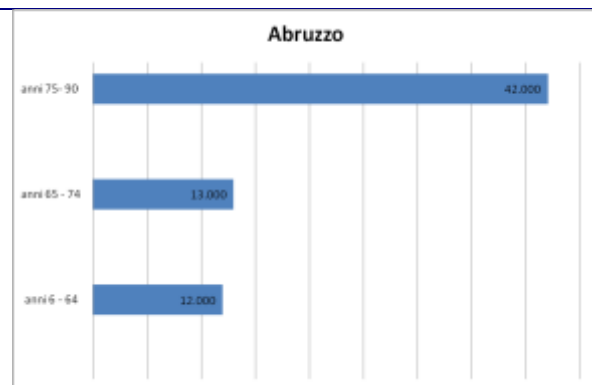
**in family per region and age group. 2004-2005.
(Data in thousands)**

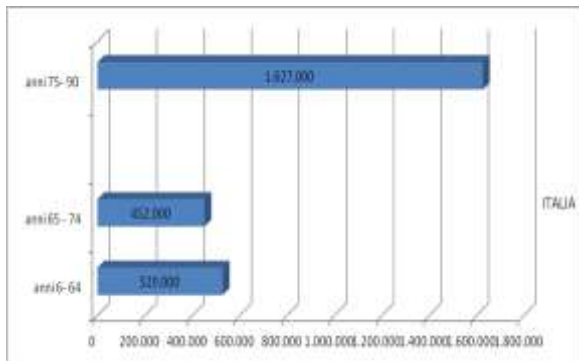
People with disabilities aged 6 and over, who live

Abruzzo	From 6 to 64 years	12	From 65 to 74 years	13	From 75 years on	42	Total	66
ITALY	From 6 to 64 years	529	From 65 to 74 years	452	From 75 years on	1.627	Total	2.609

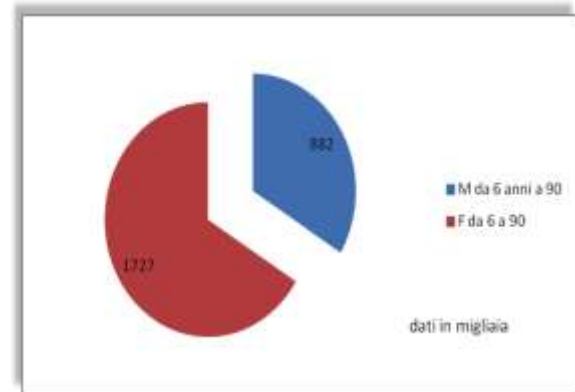
Source: ISTAT, Investigation on health conditions and use of health services, 2004-2005.

People with disabilities aged 6 and over living in family. Data Abruzzo Region. 2004-2005. (Data in thousands). Reprocessing.



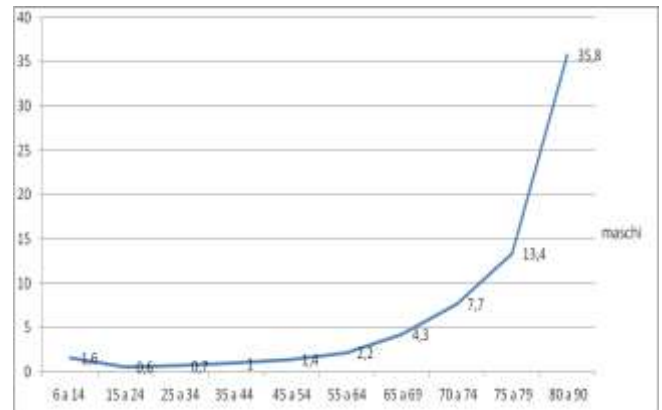
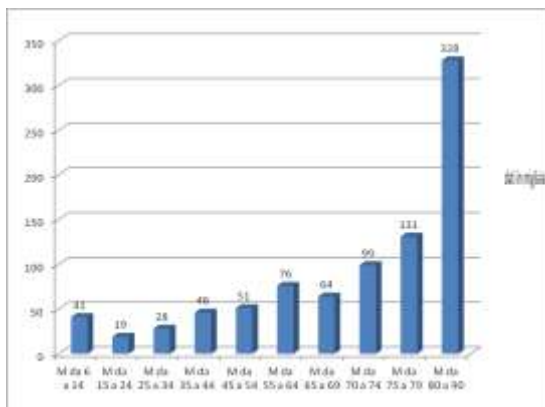


People with disabilities aged 6 and over living in the family. Data Italy. Year 2004-2005. (Data in thousands). Reprocessing.

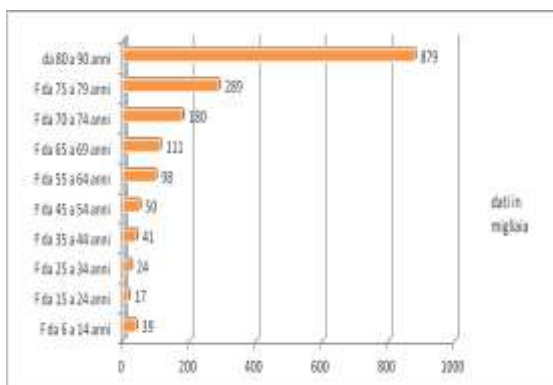


Total Population M + F with disabilities living in the family. Reprocessing.

Disabled male population by age living in the family. Reprocessing.

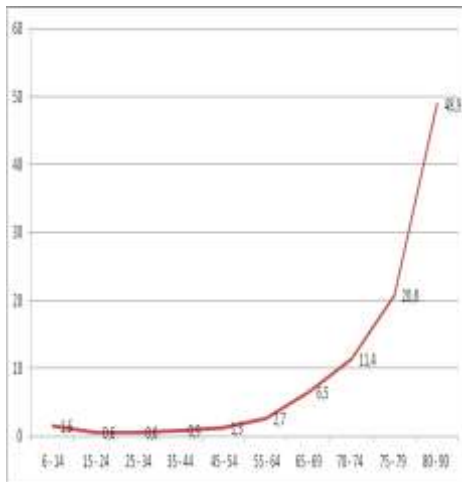


Disability rate per 100 males living in the family. Reprocessing.

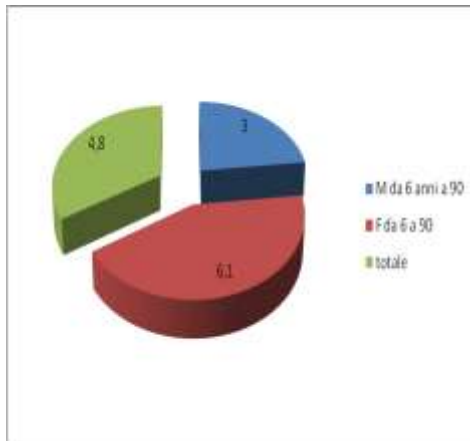


Disabled female population by age living in the family. Reprocessing.

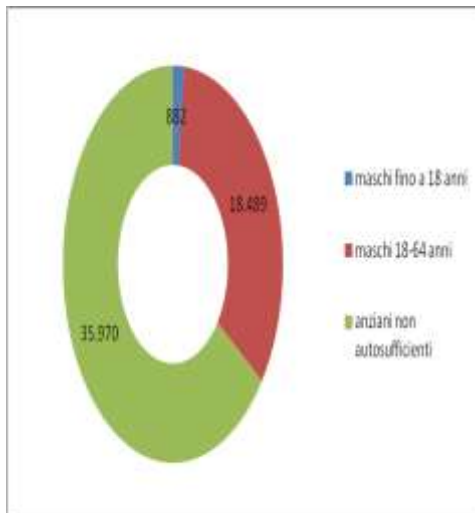
From 80 to 90 years Female from 75 to 79 years



Disability rate per 100 females living in the family. Reprocessing.

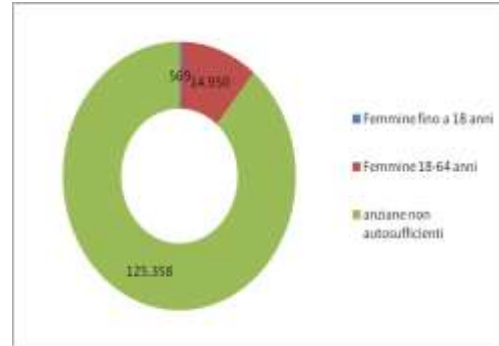


Disability Rate per 100 males and females living in the family. Reprocessing.

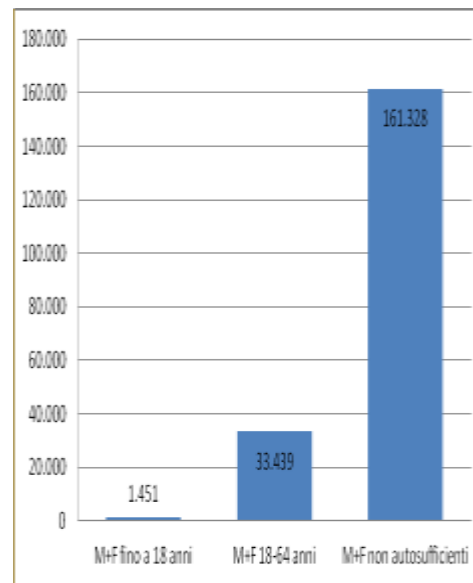


People with disabilities and non self-sufficient elderly guests in the residential social care.

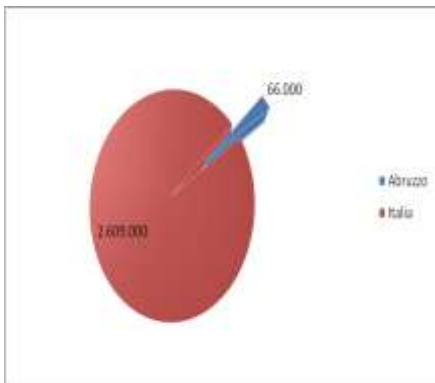
Males 2005. Reprocessing.



People with disabilities and non self-sufficient elderly guests in the residential social care. Females. 2005. Reprocessing.



People with disabilities and non self-sufficient elderly guests in the residential social care. Males + females, 2005. Reprocessing.



People with disabilities aged 6 and over living in the family. Data Abruzzo Region and Italy. Reprocessing.

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