CAPTER 2: Marginalized Elderly in Germany

German elder population

The proportion of the elderly in Europe will rise during the next years. In 2000 the rate of persons over 60 years was in Germany 23% of the total population. In 2015 the number of seniors will rise again. Until 2015 the rate of 55 to 64 year old persons will grow by further 3% in Germany. The number of seniors of 65 to 79 years of age will even rise by 28% and that of the elderly over 80 years even by 49% (Statistisches Bundesamt 2011).

Marginalized groups are especially:

Seniors with low income
Seniors with health problems
- physical
- mental

Old persons in the need of care
Lonely seniors
Older migrants (European platform against poverty and social exclusion)

Life situations, which support the development of successful ageing, depend on how basic needs of the elderly are met, e. g. nutrition, housing, social support, etc., all of which are strongly connected to social class or gender. Changes inherent to the ageing process affect the elderly, in consequence, not only at different rates and in different ways, but according to the degree of vulnerability of the elderly themselves and the coping resources and styles available to them. The different effects determine whether the changes may or may not result in a loss of autonomy, independence and quality of life for an elderly person.

The active and regular participation of older people in civil dialogue helps, in particular, to:

- Strengthen their self-confidence and increase their self-esteem;
- Inform and reinforce their awareness of economic, social, institutional or societal issues;
- Better articulate and express their needs and requests which, in turn, are better understood by external actors;
- Mainstream a greater understanding among the public of older people's needs, particularly of those who are most vulnerable and whose perspectives on social inclusion policy are often missing;
- Improve general attitudes towards older people in society and assist in creating and consolidating alliances and links with other age groups;
- Create and further improve solidarity among all population groups and support intergenerational exchange and cooperation (European Year for Active Ageing and Solidarity between Generations http://ec.europa.eu/social/ey2012.jsp?langId=de).

Marginalized groups of the elderly

Vulnerable populations are at higher risk of poor physical, psychological and social health. Poor physical health (e.g. chronic illness) may make an individual more vulnerable to mental health problems (e.g. depression) and/or social deprivation (e.g. few social contacts). Specific vulnerable states which represent risk factors include: poor physical state (dependency or disability), low socio-economic status (poverty), low social capital (isolation) and scarce human capital resources (education). Groups that are of specific vulnerability in old age include: older people living in poverty or at a higher risk of poverty, such as older women those living in isolation and those severe physical restrictions and need of assistance (e.g. at a higher risk for elder abuse) those facing or coping with (critical) life-events and transitions (separation, bereavement and loss (of spouse or of children) and abuse) ethnic minority/migrant groups, homeless older people and prisoners (often experiencing traumatic situations) those who are lesbian, gay, bisexual or transgender those who are ageing with pre-existing mental health problems or disorders

Concerning the question for the cumulation of risks in the higher ages it has to be emphasised that due to their higher life expectancy women are significantly more affected by the problems and challenges of ageing than men. At 100 years of age the proportion of women is approx. 90%. This concernment is intensified by the gender specific marriage behaviour. As women mostly marry men who are older than themselves, often the women who take care for their ill partner. Higher life expectancy and marriage behaviour lead to the fact that women more often become widowed. Among the 80 year old women in Germany 1998 more than 80% were widows, of the men at the same age only 40% (4.Altenbericht der Bundesregierung).

Seniors with low income

Low income and poverty is always a risk factor of marginalization. Especially elder women are affected by this problem, because in the current older generation many women have not worked at all or had part time or badly paid jobs. Consequently they only get a low pension income in old age.

Height and structure of the income of seniors depend mainly on the kind, period and extend of former employment, but also on the ability and willingness to save money during their active life. Also legal regulations play an important role, especially those which determine the claim on the security systems of old age and the taxes and duties which have to be paid. The differing possibilities during the active life to gain income and the legal right to future pension payments largely determine the regular and available income in old age. The accumulative effect of social disparity during the life course causes a high variability of the income levels of seniors, which are moderated only sparsely by the social and fiscal law (Richter-Kornweitz 2010).

In view of the gender specific differences in the distribution of income during working life it does not astonish that the income of elder women often that that of men lies under the threshold of relative poverty.

The legal pension insurance still is the most common system of securing income in old age in Germany. In the western federal countries 91% of he men and 82% of the women with 65 or more years of age get their own income by the legal pension insurance. In the eastern parts of Germany the rate for both men and women is 99% each. Compared with the total net income of the population the economic situation of pensioners has improved in the recent years (4.Altenbericht der Bundesregierung).

Net income of persons 65 years of age and older in Germany per month in EUR						
					Change	
Type of household	**1992**	**1995**	**1999**	**2003**	**95-99**	**99-03**
All	1.207	1.350	1.451	1.610	7,5%	11,0%
Married couples	1.695	1.871	1.958	2.159	4,6%	10,0%
Single living men	1.210	1.330	1.356	1.476	2,0%	8,8%
Single living women	928	1.037	1.100	1.171	6,1%	6,5%

Source: DIA 2005, ASID 2003

In a quarter of the households in which an older women is the main recipient of income the amount was below 50% of the average income. So the rate of relative poverty of the households of elder women is double of the national average of 12,7%. 11% of the households in which men of high age receive the main income can be seen as relatively poor, and of all private households, which receive pensions only 5,7% were poor of income. Furthermore a low income in old age is prevailing in the western parts of Germany more than in the east. A reason may be that in the former DDR nearly all women have been working full time and so get their own pension in old age.

Poverty, dependency, and feelings of shame are everyday aspects of economic dislocation and social marginalization. These experiences affect men and women differently and vary with age. Poverty and economic marginalization have both direct and indirect impacts on people's health (4. Altenbericht der Bundesregierung).

Low income and poverty adds to the risk of marginalization. Seniors with low pensions often are not in a position to visit social and cultural events, they are less mobile because they cannot afford to have a car or to pay the fares of public transport. Thus they are in danger to get isolated and lonely by losing social contacts. This is a risk for physical and mental diseases. Another risk for this is also the fact that they often cannot afford to buy good and healthy food and often life in bad housings. Seniors with higher income also can afford better medical treatment. And persons with low income have less access to social participation and education.

While the number of older persons which receive social welfare is relatively small, there are over proportionally more persons with a high age among the persons with a relative low income (less than 50% of the average income in Germany), and these are especially women.

Even the influence of socio-economic factors on mortality nowadays seems to be clear. For instance in the west European countries an explicit connection between the number of persons living with poor income and the development of life expectancy

has been found. Old men with low income have a greater risk than men with higher pensions. Only at an age of more than 90 years these differences reduce. With women this effect is to be seen from the 80th year of life. But other studies found no reduction of mortality in higher age. Fact seems to be that seniors from disadvantaged groups are a selection of the healthiest elderly while richer but sicker persons reach a higher age because they have better social conditions and are able to pay for a better medical treatment (Büscher 2009).

Seniors with health problems

Physical health problems

Many seniors lead fulfilling lives without significant physical or cognitive changes. They welcome the opportunity to pursue interests and activities that were previously restricted by the responsibilities of work and family.
But for others, the challenges that come with ageing can be debilitating. Physical ailments, mobility issues, chronic pain, cognitive and sensory impairments can affect one's functional ability. Other challenges such as retirement, changes in income, widowhood, the loss of friendships through death, and new caregiving responsibilities can lead to social and emotional isolation.

The average life expectancy in Germany for new born children in 2004 is
For men 75,89 years
For women 81,55 years

20% of the population over 60 years described themselves as ill or injured by an accident. The prevailing part (19.7%) was ill, 0.8% suffered from injuries. This is the result of the additional questioning of the micro census, in which every four years 0,5% of the German population are interviewed for their health status.

With increasing age a growth of health troubles can be observed, as it has to be expected. While the Quota of persons being ill or injured was 14,6% in the group of the 60- to 64-years old persons, it was 27,8% with the persons over 75 years of age (GeroStat 2006).

The findings of the European project „OASIS" confirm the broad approach for an analysis of the ageing process and its relation to the issue of social exclusion. The researchers emphasise the economic situation, the educational background and the health status as decisive for the degree of autonomy in old age and the delay of dependency. The Berlin Ageing Study has proved that the health status is decisive for the performance of daily functions. The maintenance of these functions form a precondition for the involvement in social or leisure activities, whereas the participation in such activities is determined further by the status and income mediated by personality and cognitive competences. Both the performance of daily functions and the participation in leisure and social activities are seen as two basic elements of a „successful ageing process". Strong networks of families, friends and neighbours are regarded as vital for older people and have been revealed to be a significant source of social integration, especially for elderly people living in areas characterised by social deprivation. Both social relations and social activities themselves also correlate positively with the health related quality of life (http://www.oasis-project.eu/).

The right to health of older people is linked to broader issues than the ones strictly linked to health: it encompasses: pensions, housing, access to transport, built environment, full participation to society, etc. These factors have a strong impact on the mental and physical health of older people, on their well-being in general and it is no sense to only ensure access to qualitative and affordable healthcare for older people, if they stay alone at home without any means in their life (Richter-Kornweitz 2010).

Other handicaps

With growing age not only diseases and accidents occur more often. Also losses of function increase sensibly. The physical movability declines, often also vision and hearing get worse.

First of all many seniors have problems with hearing and vision. Although nowadays there are modern hearing aids and means to improve vision especially seniors with low income cannot afford them, because the most modern and effective aids are not paid by the social insurance. So often seniors do not visit social or other events because they have problems especially when many persons are talking in a room. Social contacts reduce and the elderly are in danger of isolation.
The same is the case when the older persons have difficulties with walking. This also hinders them to go outside and meet other people.

Mental health problems

A healthy lifestyle, safe living environment and meaningful, active participation in society and the community are important protective factors for mental well-being in older age. Above all, however, support from families, peers and carers play a key role in promoting the mental health of older people. Prevention of loneliness and isolation is one of the most powerful strategies to promote mental health and well-being in old age. Mental health promotion measures are also important for improving physical health and successful ageing (4. Altenbericht der Bundesregierung 2002).

Older people from certain groups face a higher risk for mental health problems. This includes older women, those living in or at risk of poverty, experiencing chronic illness, suffering abuse and belonging to cultural or ethnic minorities. Measures to build resilience or to reduce their specific vulnerability (for example, through services) can improve living conditions and decrease mental health problems in these groups. These measures can also increase social inclusion and cohesion (6. Altenbericht).

Dementia is one of the most important causes of disability in the elderly; with the increasing proportion of the elderly in many populations, the number of dementia patients will rise also. The most common causes of dementia in EU are Alzheimer's disease (about 50-70% of cases) (http://www.alzheimer-europe.org/, 6. Altenbericht der Bundesregierung 2010).

Participation in education provides a stimulus to behavioural change, whether in employment or in other spheres of everyday life. The relationship between participation in learning and engagement in social and civic activity is largely beneficial. Social networks (the units of social capital) are a basis for social cohesion and reciprocity, which work as protective factors during major life transitions. Hence continuing education or lifelong learning provides the opportunity for new knowledge, skills and

competences, especially for people at risk of social exclusion. However, access and uptake of learning is highly determined by external influences and personal circumstances, such as retirement or ill-health. Barriers include cost, distance, lack of transport, timing, enforced target setting and assessment and bureaucracy. Participation in lifelong learning programs is low among older age groups and needs to be improved (4. Altenbericht der Bundesregierung 2002).

Elderly people with social problems

Many older people may suffer from social exclusion and isolation.
The term *social isolation* describes a lack of social relations. In contrary to the term *living alone* and *being alone* the term social isolation refers to a normative comparison. Isolation is present when he number and duration of social contacts is under a minimum seen - in common - as necessary. Loneliness in contrary is a subjective feeling. Loneliness occurs when a person compares the number and quality of the social relations with the personal wishes (4. Altenbericht der Bundesregierung 2002).

A large proportion of older people report feelings of loneliness (35% in one Swedish study, with 45% showing reduced subjective health) and women report more loneliness than men (Commission of the European Committees 2008). In particular, frail older people may suffer from social isolation and loneliness, often associated with living alone and being impaired in mobility. A decline in health and changes in living situations (e.g. institutionalisation) may lead to a limited social life. Social exclusion and loneliness impact on health negatively. A major predictor of loneliness in older age is poor mental health and depression, psychiatric morbidity, increased physical impairment, small social networks, low life satisfaction and reduced quality of life. In addition, major live events in old age such as separation or bereavement are associated with negative health effects Lang/Resch/Hofer 2009).

Living alone and being alone, the death of the partner, having no children, bad health and limitations of mobility, living in a nursery home are risk factors for the development of feelings of loneliness.

Seniors in long-term care

Long term care resp. living in a nursery home affects many seniors, but is a topic which is sparsely or not discussed in public talks in the area of old age.

Actually there are 2.25 million persons in Germany, who are in the need of care, this is a proportion of 2,7% of the total population. At a closer look this is a substantial amount, which is also rising in the higher age groups and has a quota of 20% in the group of more than 80 year old seniors (Statistisches Bundesamt 2008).

1.54 Mio. are looked after at home, and more than 1 Mio. of them only by informal are by the family. Although 500.000 seniors get help by an ambulant care service it can be assumed that families and relatives take a great part of the care (GeroStat 2007).

Older people living in long term care facilities are also a group of special risk of developing depressive disorders and getting marginalized, a fact that has been linked to more frequently occurring chronic physical illness, social environmental or care-

related factors. Among nursing home patients, prevalence rates range up to 26% for major depression, and up to 50% for minor depression, as measured by symptom rating scales (6. Altenbericht der Bundesregierung 2010).

From a sociological perspective the aspects of stigmatism and social outclassing have been mentioned, which are relevant with regard of need of care. Being in the need of care still often is considered to be an irreversible status, which is on an equality with an exclusion from many areas of the social life. Another factor is that some aspects commonly associated with long term care, like f.i. problems with eating or excretion are seldom subject of socially accepted every day communication.

From a social psychological view long term care is going along with a disorder of relationships and continuity in social networks. Previous living routines and future life planning are tenderly disrupted when in nursery care, often even impossible. For the elderly themselves from an individual psychological perspective also the general loss of autonomy and the threatened individual identity have to be mentioned, which can arise with regard to being in the need of care (4. Altenbericht der Bundesregierung 2002).

Migrants

Migration plays an important role in population dynamics in European countries. More than half (56%) of the non-nationals living on the territory of the EU-27 Member States have European citizenship and around 40% of foreigners in member states come from countries outside Europe (Demography report 2008). In 2008 about 1, 8 Mio. seniors (65 years and older) lived in Germany (6. Altenbericht der Bundesregierung 2010).
Migratory groups are – under certain circumstances – at a higher risk for poor health (stress, trauma) due to unique combination of migration biography and post-migration experiences. Ethnic minorities face particular social disadvantages such as lack of family in proximity, language difficulties, racial and religious discrimination, etc. There is wide variation in standardised mortality ratios for older suicides among different migrant groups. Migrant suicide is related to their country of origin, circumstances and process of migration and the host country. Risk of depression is also higher due to poor family support, loneliness, inadequate access to community services and inability to return home. Family support is the main buffer against depression, but others like religious practices and reliance on peers also seem to afford some “protection” (Hirsch 2005).

In German statistics a person, who has at least one parent born abroad will be counted as a person with immigrant background.

Germany:

Migration and Integration

Population and status of migration

Together	**2007**	**2008** **in 1 000**	**2009**
Population on (Mikrozensus)	82 257	82 135	81 904
Persons with a migration (Mikrozensus)	15 411	15 566	15 703
Foreigners (central register of foreigners)	6 745	6 728	6 695
Naturalizations (Naturalization statistics	113	94	96

Source: Gerostat 2009

More than 16 million people are of foreign/immigrant descent (first and second generation, including mixed heritage and ethnic German repatriates and their descendants). 96,1% of those reside in western Germany and Berlin (Riphahn 2004).

About seven million of them are foreign residents, which is defined as those not having German citizenship. The largest ethnic group of non-German origin are the Turkish. Since the 1960s, West and later reunified Germany has been attracting migrants primarily from Southern and Eastern Europe as well as Turkey, many of whom (or their children) over time acquired German citizenship. While most of these migrations had an economic background, Germany has also been a prime destination for refugees from many developing countries, in part because its constitution long had a clause giving a 'right' to political asylum, but restrictions over the years have since made it less attractive (Yahirun 2008).

Context of immigration and economic circumstance are intertwined in the lives of immigrant elderly living in Germany. For these individuals, economic histories are generally characterised by lower levels of earnings, savings and more frequent spells of unemployment than their native-born counterparts (Hirsch 2005).

The necessity to take elder migrants into account within the district social work arises from the fact that in Germany on the average every 10th person over 55 has immigrated to Germany in the course of his/her life (Yahirun 2008).

Immigrants accounted for 22.3 percent of the social assistance recipients in 2002 even though they made up only 8.9 percent of the German population. Social assistance dependence among households headed by foreign-born individuals has exceeded that of the native population for the last two decades.

The proportion of men is dominating in the group of the elderly migrants. It can be assumed that the number of elderly migrants will double in future years. Although today the group of the „young old" is dominating within this group, in future the demand of support and care will rise significantly (GeroStat 2009)..

Migrants face special risks. The risk of poverty of foreigners is with 32% significantly higher than of Germans with a migration background (22%). The risk of poverty was different according to the time they had lived in Germany. The shorter the time of stay the higher is the risk (European Commission 2011).

Migrants often live in a strained relationship between the images of old age in their region of origin, which they have internalised, and the pattern of old age in their actual environment (Krumme 2003).

In spite of insufficient statistical data experts agree that the health status of older migrants in general can be estimated as bad. This is also due to many burdens they had to take during their life in Germany. First of all there is the mostly hard work, which is offending people physically, as most of them have worked as industrial labourers. Then there is the separation of the family and relatives which makes them sad. There is a German society which ignores them at the best or discriminates them for worst. Such physical and psychological stress is affecting health in the long run. Furthermore there are quite practical problems, like linguistic, cultural and social problems of understanding each other, insufficient information and lacking possibilities of information. Also the separation not only from, the family but also from friends in their home country, social exclusion can contribute to a bad health as well as the lacking access to health services due to linguistic and cultural barriers (Riphahn 2004, Hirsch 2005).
So a suitable possibility to reach elder migrants for offers of prevention or for health services is to see them at a familiar place, which they visit regularly, like Turkish senior's meeting places.

It is known, though, that elderly migrants rather stay in their family than to move into a nursery home when they are in the need of care. Living in such institutions is in the group of the migrants even more stigmatised than in the German population. Additionally only slowly start to adapt to the specific needs of old migrants. Especially linguistic understanding and communication, customs of nutrition, concepts of care, religious needs and the relationship to family members often are barriers, which actually shall be reduced by the approach of the "cultural sensitive care".

There are many prejudices against migrants, often also in regard to the elderly: Lack of understanding with regard to ethnic habits, blaming for not integrating themselves, to strain the health system etc.. If somebody has lived in Germany for a longer time and cannot communicate well in German, there is often the accuse that he does not want to adapt to the guest nation. This may be true, but there are also cases of old migrants, which are partly not allowed to leave their habitation or have contacts to Germans, which is true especially for Turkish women.
So in practice it would be sensible to install mobile interpreter services on a regional level to reduce the language barriers.
An intercultural welfare for old migrants needs differentiated strategies on different levels. Migrants do not need only help and support but also the understanding of the "non migrants" that they can learn and take profit from each other. Furthermore a mutual intercultural understanding supports the quality of life of all citizens (Fuchs 2011).

Here it is f.i. necessary to:
- strengthen the lobby for old migrants,
- securing an intercultural education cutting across the institutions,
- supporting the employment of a staff which speaks the native tongue of the migrants and intercultural teams,
- supporting programs of outreach consultation,
- acquire multipliers in the environment of the migrants,
- providing special resources of infrastructure like rooms or specially developed materials for information and education,
- developing strategical and specialised public relations (Hirsch 2005, Der Berliner Beauftragte für Integration und Migration 2005).

It is known that older migrants do not visit courses when they read an information in the newspaper or get a flyer. They have to be addressed personally, preferably at a group or a place where they normally gather.

Special groups of ethnic German immigrants („Spätaussiedler“)

Since the 1960s, ethnic Germans from the People’s Republic of Poland and Soviet Union (especially from Kazakhstan, Russia, and Ukraine), have come to Germany. During the time of Perestroika, and after the dissolution of the Soviet Union, the number of immigrants increased heavily. Some of these immigrants are of mixed ancestry. During the 10 year period between 1987 and 2001, a total of 1,981,732 ethnic Germans from the FSU immigrated to Germany, along with more than a million of their non-German relatives. The total number of people currently living in Germany having FSU connection is around 4 to 4.5 million (Including Germans, Slavs, Jews and those of mixed origins), out of that more than 50% is of German descent.

The contrast between the two immigrant groups, migrants and ethnic Germans, and the consequences of their varying contexts of reception could not be more obvious. While guest workers were generally expected to return to their countries of origin, *Aussiedler* or *Spätaussiedler* had already returned „home.“ On one hand, guest workers were well integrated into the labour force by virtue of their labour contracts, but their political and social integration was inhibited by expectations of a short-term stay. A lack of clear-cut pathways to citizenship was, and despite reforms in 2000, remains a solid barrier to political and social integration. In contrast, *Aussiedler* and *Spätaussiedler* were not economically or socially well-integrated upon arrival despite automatic citizenship rights, which granted them immediate access to the labour market and other social advantages. In the United States, previous literature has pointed to the importance of context of reception for immigrants’ social and economic integration. An obvious extension of this logic is that context also matters for decisions to return „home.“ (www.Wikipedia.de, 8.10.2011) .

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