Empowering Marginalized Elders Grundtvig Partnership Project 2011-2013

Marginalized Elderly in Germany

Education and Culture
Lifelong learning programme
GRUNDTVIG

VFG e.V.

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Demographical Data: German elder population

Rising proportion of seniors

2000 the rate of persons over 60 years was in Germany **23%** of the total population. 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%.**

German population 50 and more years of age:

Age	Men	Women	Total (2003)
50-54	2 736 279	2 729 718	5 465 996
55-59	2 208 201	2 220 030	4 428 231
60-64	2 735 524	2 834 487	5 570 011
65-69	2 281 310	2 518 429	4 799 739
70-74	1 580 812	1 965 086	3 545 897
75-79	1 069 762	1 827 824	2 897 586
80-84	591 516	1 401 384	1 992 900
More than 85	339 515	1 07 3771	1 413 286

The population of Kassel per 31.12.2010

0 - 2 years	2,5 %
3 - 5 years	2,5 %
6 - 13 years	6,8 %
14 - 17 years	3,6 %
18 - 20 years	3,6 %
21 - 26 years	9,8 %
27 - 64 Years	51,3 %
65 years and older	20,0 %

Life expectancy in Germany

Average life expectancy

Life table			2005/2007	2006/2008	2007/2009	2008/10
Age 0	Male	years	76.89	77.17	77.33	77.51
	Female	years	82.25	82.40	82.53	82.59
Age 20	Male	years	57.49	57.74	57.90	58.05
	Female	years	62.72	62.85	62.97	63.03
Age 40	Male	years	38.20	38.44	38.59	38.73
	Female	years	43.08	43.20	43.32	43.37
Age 60	Male	years	20.75	20.93	21.04	21.16
	Female	years	24.61	24.71	24.81	24.85
Age 65	Male	years	16.93	17.11	17.22	17.33
	Female	years	20.31	20.41	20.52	20.56
Age 80	Male	years	7.56	7.65	7,67	7.71
	Female	years	8.92	8.97	9.04	9.06

Source: destatis (www.destatis.de)

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Vulnerable groups of the elderly

Risk factors for marginalization:

- Low income,
- poor health,
- age and/or gender-based discrimination,
- reduced physical or mental capacity,
- unemployment,
- isolation,
- abuse,
- and limited access to services

can all play a part in increasing the risk of marginalization and social exclusion as people age.

Inequalities in **education, employment** and **health care**, based **on race, ethnicity or gender**, which start early in life are exacerbated by old age. **Poverty** adds to other causes of social exclusion, further reducing **help-seeking capacity, mobility and social capital** in those who have experienced earlier inequalities.

Eldery that are at the brink of marginalization:

1. Seniors with health problems (physical and/or mental)
2. Old persons in the need of care
3. Seniors with low income
4. Lonely seniors
5. Older migrants

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Effects of marginalization

- Exclusion of the individual from meaningful participation in society.
- Relatively little control over their lives, and the resources available to them.
- Handicap in delving contribution to society.
- Risk of some more psychosocial-ideological threats.
- 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).

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Risks of marginalization

Issues :

- pensions,
- housing,
- access to transport,
- built environment,
- full participation to society, etc.

This has a strong impact on

- mental and physical health of older people,
- on their well-being in general,
- access to qualitative and affordable healthcare for older people, if they stay alone at home without any means in their life.

Handicaps...

... can discriminate the elderly and prevent their active participation in society and social life.

Disabilities:

6. Nearly half of disabled people are aged 65 or older. The most common problems: vision and hearing.
7. around 80% of people over 60 have a visual impairment,
8. 75% of people over 60 have a hearing impairment,
9. 22% have both a visual and hearing impairment.
10. Problems with hearing and vision. Seniors with low income cannot afford the most modern and effective aids.
11. Difficulties with walking. This also hinders them to go outside and meet other people.

Result:

6. Handicaps prevent seniors from visiting social or other events.

Consequence:

6. Social contacts reduce and the elderly are in danger of isolation.
7. These disabilities can reduce the ability of older people to look after themselves, resulting in a need for personal care.

Risk factors

Certain groups face a higher risk for mental health problems:

- older women,
- those living in or at risk of poverty,
- experiencing chronic illness,
- suffering abuse
- belonging to cultural or ethnic minorities.

Special risks of living in long term care facilities (nursing homes):

Individual perspective:

⇒ 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)

⇒ rates up to 26% for major depression, and up to 50% for minor depression,

⇒ general loss of autonomy

⇒ threatened individual identity

⇒ even today in spite of the introduction of the care insurance partly high financial burdens for the senior sand their relatives.

Sociological perspective:

⇒ stigmatism and social outclassing

⇒ exclusion from many areas of the social life.

Social psychological view:

⇒ disorder of relationships and continuity in social networks.

⇒ Previous living routines and future life planning are tenderly disrupted:

Long term care

⇒ 2.25 million persons in Germany are in the need of care, (2,7% of the total population).

⇒ The quota is rising in the higher age groups to 20% in the group of more than 80 year old seniors (Statistisches Bundesamt 2008).

⇒ 1.54 Mio. are looked after at home,

⇒ 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.

⇒ Forecasts assume a number of 3 to 4 Million seniors in the need of care between 2030 and 2050.

⇒ The risk to be in the need of care rises after the 82nd year of life to approx. 32%.

Poverty in old age

Relative poverty: Less than 60% of the average available income (1.536,75 EUR per month, poverty level 845,21 EUR)

In Germany: 15% of the population

15% of the elderly over 65 years,

20% of women over 65

14% of men over 65

Source: Mikrozensus 2008

<u>Average pensions in 2006:</u>

Women 519,-- Euro

Men 964,-- Euro

Source: Informationsdienst für Altersfragen 2/2009

Receivers of support for living (social welfare) in Germany 1999

Total 2.811.809:

8. with an age of 80 years and more 42.461

among them:

8. women 37.051 *(87,3 %)*
9. men 5.410 *(12,7 %)*

8. persons over 80 years not living in nursing homes 35.691 *(84,1 %)*
9. persons over 80 years living in nursing homes 6.770 *(15,9 %)*

Sources: Daten in Statistisches Bundesamt 2001, Deutscher Bundestag 2001

More poverty among seniors in future

- Nowadays many persons do not have a continuous working biography.
- Reductions of the pensions because of longer times of unemployment, especially many persons with long-term unemployment.
- Furthermore it is very hard for workless persons even at an age of 50 years to find a new job.
- Also the fact that the retirement age has been raised to 67 years will reduce many pensions, because in many professions people are not able to work until this age and therefore are faced with losses of income in old age.

Morbidity

20% of the population over 60 years described themselves as ill or injured by an accident.

Growth of health troubles with increasing age:

60 - 64 years: 1,46 %

over 75 years: 27,8 %

Women over 60 slightly more suffer from health affections: women 21,2 %, men 19,5%.

Over 65 Years:

women 23,7 %, men 21,6 %.

Mental problems

Depression:

- immediate impact on quality of life,
- risk factor for functional disability
- may predict premature mortality.
- Older people with depression are 2-3 times more likely to have two or more chronic illnesses and 2-6 times more likely to have at least one limitation on their daily life activities compared to younger groups.

Dementia:

- Decline in mental ability,
- usually progresses slowly,
- memory, thinking, and judgement are impaired, and personality may deteriorate,
- affects mainly those aged over 60,
- 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.

Most common cause: Alzheimer's disease (about 50-70% of cases)

Social problems

Isolation: the number and duration of social contacts is under a minimum seen - in common - as necessary.

Loneliness: results as a being alone or being isolated, which is sensed as negative and combined with the unpleasant feeling of abandonment, the lack or loss of contacts.

A large proportion of older people report feelings of loneliness with 45% showing reduced subjective health and women report more loneliness than men. This is often associated with living alone and being impaired in mobility.

Social exclusion and loneliness impact on health negatively.

Risks and consequences of isolation:

- Decline in health,
- changes in living situations (e.g. institutionalisation) may lead to a limited social life.
- poor mental health and depression,
- psychiatric morbidity,
- increased physical impairment,
- small social networks,
- low life satisfaction
- reduced quality of life.
- living alone and being alone,
- the death of the partner,
- having no children, bad health
- limitations of mobility, living in a nursery home

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Vulnerability may lead to marginalization

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, medical care 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.

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Opportunities

Which opportunities do the affected seniors have to improve their situation?

For example:

Promoting healthy lifestyles, active ageing and participation in community life:

- volunteering, intergenerational support, training and life-long learning,
- physical activity of older people through sports and other activities,
- participation in education provides a stimulus to behavioural change, whether in employment or in other spheres of everyday life,
- social networks (the units of social capital) are a basis for social cohesion and reciprocity, which work as protective factors during major life transitions.

- 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,
- from the perspective of older people, the major benefit from participating in policy planning and influencing policy implementation is the improvement in the quality of life for older people in general.

Through civil dialogue on ageing, policy measures can be developed which will better meet older people's concerns and needs.

Continuing education or lifelong learning provides the opportunity for new knowledge, skills and competences, especially for people at risk of social exclusion. (Older) adults with low socioeconomic status (with reduced educational and occupational qualifications) and other often marginal groups (such as migrants, women and people with disabilities) should be especially targeted for integration to lifelong learning.

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Elderly migrants

Population and status of migration 2009

Total population in Germany *(Mikrozensus)*	**81 904 000**
Persons with a migration background *(Mikrozensus)*	**15 703 000**
Foreigners *(central register of foreigners)*	**6 695 000**
Naturalizations *(Naturalization statistics)*	**96 000**

96,1% of them live in western Germany and Berlin. The largest ethnic group of non-German origin are the Turkish.

In Berlin live **105.671** inhabitants with a Turkish passport, in Kassel 8162 (4,4%), but there are many more with a Turkish background, who have become Germans.

Elderly migrants

On the average every **10th person over 55** has immigrated to Germany in the course of his/her life.

Economic histories are generally characterised by **lower levels of earnings**, **savings** and more **frequent spells of unemployment** than their native-born counterparts.

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.

Since 1991 the **proportion of foreign inhabitants** in this group of population has more than doubled from **1.4% to 3,2%.**

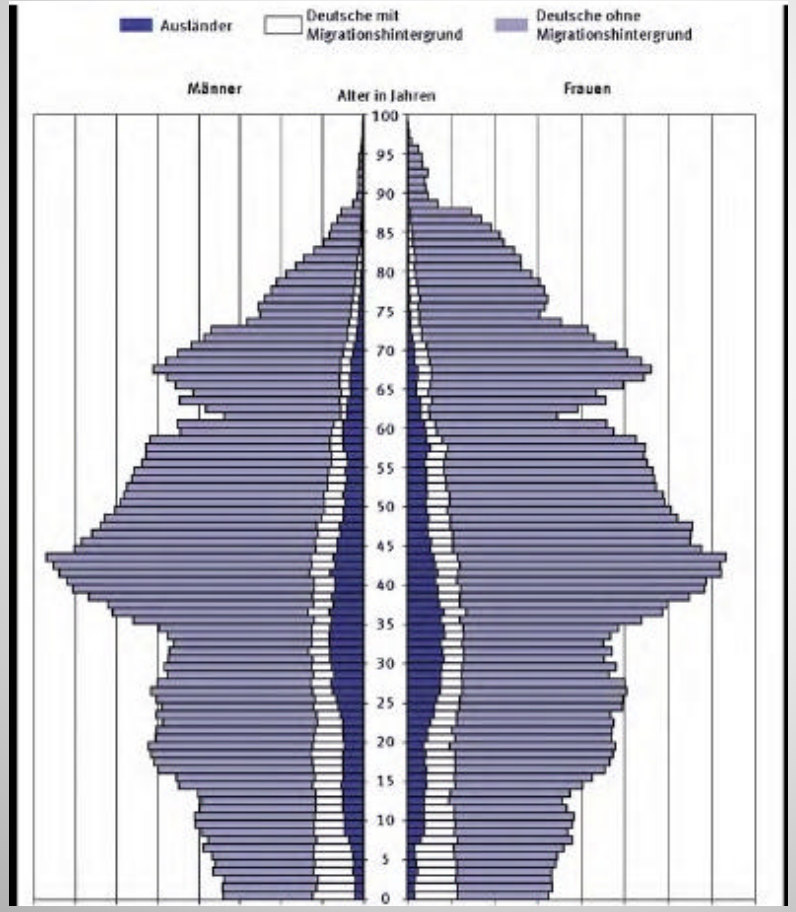
More than on **third of the foreign population** has already lived in Germany for more than **20 years**.

The proportion of **men is dominating** in the group of the elderly migrants. Only in the cohorts of the **70 – 75 years old this is inverting**, and with the 75 to 80 year old migrants the proportion of the women is significantly higher.

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.

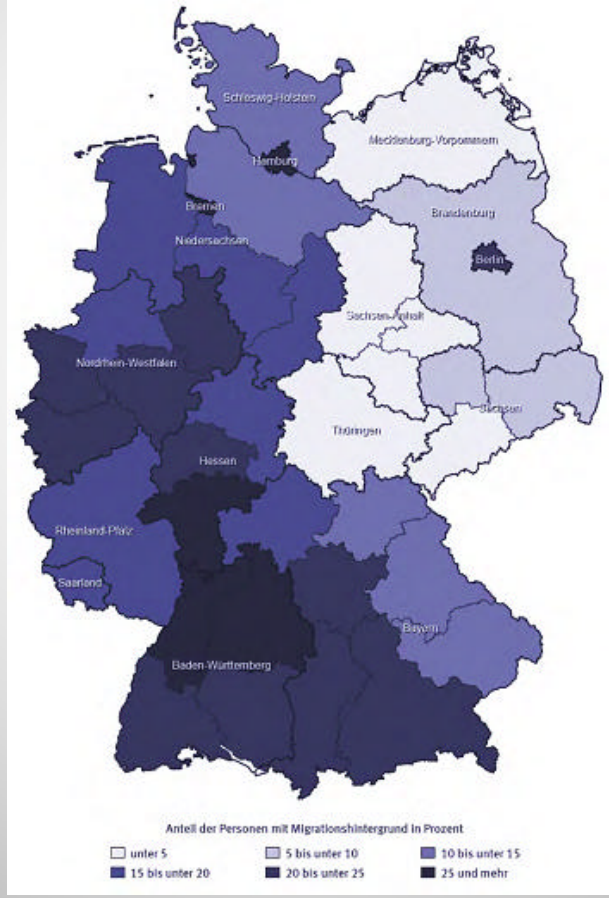
Proportion of persons with a migration background in the age pyramid for the year 2008



Source Statistisches Bundesamt, Mikrozensus 2008

Proportion of the population with a migration background 2008 in the different regions

Source:Statistisches Bundesamt, Mikrozensus 2008



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Risks for elderly migrants

⇒ The **risk of poverty** of foreigners is with 32% significantly higher than of Germans with a migration background (22%).

⇒ The shorter the time of stay the higher is the risk.

The **ethnic roots** are evident and are not neglected. But the Turks in Germany have build an own identity which goes beyond these roots and reflects the life situation in Germany.

On the other hand Germany has become **half of a home country** for them, because many of them have lived and worked here for more than 30 years.

Although there are still close **personal relationships** to Turkey the country at the Bosporus is perceived as a country which has become **strange** to them. But also an exclusive Germany identity does not exist in this group.

Health status of older migrants

The health status of older migrants in general can be estimated as bad.

Reasons:

- Mostly physically hard work, as industrial labourers,
- the separation of the family and relatives, which makes them sad.
- German society which ignores them at the best or discriminates them for worst.

➡ **Impact on health in the long run.**

Practical problems:

- Language,
- culture,
- social problems of understanding each other,
- insufficient information
- lacking possibilities of information.
- the separation also from friends in their home country,
- social exclusion can contribute to a bad health
- lacking access to health services due to linguistic and cultural barriers.

Housing

This can be characterised as follows:

- ⇒ Households of foreign workers obviously more often live in **badly** or **frugally equipped flats**.
- ⇒ The proportion of families **living constricted** generally rises with the number of persons per household. Families of migrants are especially affected.
- ⇒ Households with a “foreign householder” **pay more rent** for apartments with the same equipment than the average of all households.
- ⇒ With **rising duration of stay** the location and the average facilities of the habitation improve.

In the need of care

- Many migrants prefer not to make any final decisions regarding their future, also regarding the question for the kind of care and support
- Elderly migrants rather stay in their family than to move into a nursery home. This is in the group of the migrants even more stigmatised than in the German population.
- Additionally nursery homes 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”.
- Health risks typical for old age occur earlier in the life course with migrants. This is also true for mental diseases like dementia. As also with migrants the proportion of very old persons rises it can be expected that multimorbidity and the need of support and care will increase.

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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 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 fall of the Berlin Wall in November 1989 and the collapse of the Soviet Union prompted a new wave of migration to Germany. This brought dramatic and unexpected increases in the number of Jewish immigrants and ethnic Germans, ***Aussiedler* or *Spätaussiedler***, to Germany. While Jewish immigrants were not granted automatic citizenship upon arrival, *Aussiedler* and *Spätaussiedler*, by far the majority of the new arrivals, were given full political, economic and social rights in the new country.

Differences between the two groups of migrants

The **contrast** between the two immigrant groups is obvious:

- "**Guest workers**" were generally expected to **return to their countries** of origin, *Aussiedler* or *Spätaussiedler* had already returned "**home.**"
- "Guest workers" were **well integrated into the labour force** by contracts, but **their political and social integration** was inhibited by expectations of a short-term stay.
- 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.

Measures...

... to build resilience or to reduce their specific vulnerability (for example, through services) can improve living conditions and decrease physical and mental health problems in these groups. These measures can also increase social inclusion and cohesion.

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Possible measures

- Addressing all dimensions of poverty and social exclusion in old age, such as inadequate pension provisions, severe material deprivation, shrinking access to basic services such as health and long-term care or decent housing.

- Including subgroups of people 65-79 and 80+ in order to secure the adequacy of pension for very old people, a group at higher risk of poverty.

Combat old-age poverty among the most vulnerable groups by:

- Helping the most disadvantaged groups to build sufficient pension rights, such as women suffering from multiple career and pay inequalities; long-term unemployed older workers; workers on low wages or those sent on early retirement as a result of company re-organisation; disabled and/or isolated older persons, older Roma, migrants and ethnic minorities etc.

- Providing those who cannot build an adequate pension for justified reasons with adequate safety nets.

Possible measures of social policy

Promote access for the 50+ to information society, fighting the digital divide and ensure accessibility for all.

Provide adequate resources to live in dignity and support for social participation among the most vulnerable groups.

Look for good practices across the EU on how avoid inequalities in the treatment and care of older patients suffering from Alzheimer/dementia diseases, including measures to support and encourage early diagnosis and appropriate treatment that may impact on the development of the disease.

Possible measures in detail

Infrastructures on a regional level have to be improved, f.i.

- medical and care services,
- transport services, mobile shopping, especiallly in rural areas,
- household services,
- consulting services,
- outreach services,
- urban concepts and concepts for housing
- support of neighbourhood relations and voluntary engagement
- implementation of support structures in the neighourhood
- enable learning in old age by reducing barriers like cost, distance, lack of transport, timing, enforced target setting and assessment and bureaucracy

Different levels of causes and consequences of mental health and well-being in old age as an example for a starting point of measures

Individual level:

- self-esteem,
- coping skills,
- physical health,
- life-styles
- life experiences;

Interpersonal level:

- interactions and relationships with friends and family,
- daily functioning in the community;

Societal level:

- societal policies,
- structures
- resources;

Cultural level:

- equity,
- value,
- tolerance of difference.

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Necessary improvements

In General:

- **Promoting healthy lifestyles**, active ageing and participation in community life: create **opportunities for meaningful roles in society**, the workplace, community and neighbourhoods, such as volunteering, intergenerational support, training and life-long learning introduce flexible retirement schemes.
- Provide **living spaces**, local environments and neighbourhoods that are **safe, convenient and accessible**, and that facilitate older people's **participation, mobility, and autonomy**.
- Provide measures to **promote mental health** and well-being among older people **receiving care** (medical and/or social) in both community and institutionalised settings,
- Respect **identity and personal style of living** of old people in care, promote their autonomy and independent living, increase their involvement in decisions regarding the care services they receive, address physical health problems including pain, visual or hearing impairments, address loneliness and isolation.
- Address **negative stereotypes** about old age, which erode (self-) confidence in the social and mental capital of older people, through media guidelines for non-disparaging reporting, policies and supporting campaigns to combat ageism.

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Special measures for elder migrants

Integration is important. 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**,
- promote learning the German language by **offering specialised courses for elderly migrants**, especially for women,
- develop **translation services**,
- employ **persons with the origin of the migrants** to care services and other institutions.
- increase the number of **volunteers** and community/social service professionals of **different ethnic backgrounds** working in health and social service organizations.
- provide **training to service agencies** to ensure a better understanding of cultural and ethnic differences and how to best serve clients of various backgrounds.

Special measures for elder migrants

- 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.
- 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.
- Ensure that **basic and continuing education of health care providers** include a component that fosters an understanding of the **ethnic and cultural dimensions of health**, the varying beliefs regarding health and health care and how to work with clients and families from different ethnocultural communities.
- Create **mental health services** which are designed specifically for, or respond to, the needs of ethnic minority seniors.
- Develop policies that will lead to the recruitment of **more persons from ethnic minorities** so that health and social service providers better reflect the diverse ethnic population.
- Support **health promotion** and the development and dissemination of other physical and mental health resources, programs and services that are **linguistically and culturally** specific.
- Provide **support to community organizations** to adapt existing resources and programs to meet the needs of their particular ethnic community.
- Create programs to **facilitate transition to long-term care**, in partnership with ethnocultural community organizations.
- Provide resources to ensure the availability of interpretation services within health facilities and institutions.

Thank you for your attention !