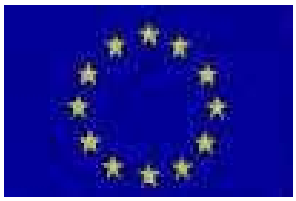

SEEM Final Report (Phase I)

Personal Social Services for Elders from Black and Minority Ethnic Groups in Leeds (Great Britain), Lille (France), Dortmund (Germany) and Gothenburg (Sweden): Backgrounds, Local Strategies for Delivery, Examples of Good Practice and Recommendations for further Strategies of Action

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Disclaimer

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I Background and Introduction of the Project SEEM

In many European countries the development and delivery of adequate personal social services for people from ethnic minority groups who are growing old have become important social and socio-political issues. This is due to the fact that in the context of migration triggered by poverty, flight and job search the formerly 'national' European countries of the 1950s have changed to migration societies whose economic, cultural and social spheres are increasingly being influenced by population groups who have immigrated. (Filtzinger 1995) Even though the total numbers of elders from those ethnic minority groups are still small today, they will increase rapidly within the next decades. Apart from general questions concerning the form and the extent of social, cultural and political integration of minority groups within the host society, there are special challenges for the prevailing systems of community care. Providers face the task of opening up their services for elders from black and ethnic minority groups with their different cultural, ethnic, religious and linguistic backgrounds.

The European countries are characterised by clear differences in their migration history, demographic features and specific socio-political and cultural developments. Looked at from a perspective of migration, the United Kingdom and France are strongly influenced by their colonial past which has put a stamp on their current population mix and migration policy. Sweden, which also has a history of emigration, was the first Nordic country to become a country of net immigration. During the 1950s and the 1960s the migration flow consisted mainly of migrant workers but from the end of 1980s on, the influx of migrants was dominated by refugees and asylum seekers. (ILO 1998) Germany has found itself as importer of 'guest workers' from south-eastern Europe after World War II. These different backgrounds are also reflected in the respective collective perceptions of 'migration' and the people behind this phenomenon (meaning in what ways migration and migrants are viewed by countries), as well as in the scope and the basic focus of migration research. (Fernández de la Hoz 2002: 29)

Elders from black and ethnic minority (BME) communities are identified by numerous sources as being particularly at risk from social exclusion and poverty. Across Europe, older people from BME groups are more likely to be socially excluded than indigenous elders and also face additional discrimination. (Pro Senectute 1999; Patel 2003). To combat this risk,

BME elders require a range of appropriate, good quality services to keep them integrated in the broader community. Within the last ten years some European countries began opening and developing and providing social services for BME elders and thus - mainly at local level where personal social services are delivered to elders - there begins to be experience in this field. However, up to now there has hardly been any exchange of good practice between different European countries in this field. Concerning the twin cities Dortmund and Leeds, comparing research exists comparing local strategies for opening up and developing personal social services for BME elders. (Gerling 2001, 2002).

Against this background and led by the Leeds City Council, the project *Services for Elders from Ethnic Minorities* (SEEM) was set up. It is a European funded project[1] for four cities to exchange good practice in promoting social inclusion for elders from black and minority ethnic communities. The project comprises seven partner organisations which are Leeds City Council, (United Kingdom), Leeds Older People's Forum (United Kingdom), Ville de Lille (France), Stadt Dortmund (Germany), Forschungsgesellschaft fuer Gerontologie e.V. (Dortmund, Germany), Verein fuer Internationale Freundschaften (Dortmund, Germany) and SDF Gunnared – Elderly Services (Gothenburg, Sweden).

SEEM aims mainly to build up good partnerships, to involve BME elders and their organisations, to exchange good practice, to produce and disseminate policy recommendations and to apply for further European funding for phase II of the European programme. Within the project two partnership meetings took place in Dortmund (March 5th-7th) and Leeds (April 30th – May 2nd) where the partners presented and exchanged relevant background information and visited and discussed existing models of good practice. Additionally, each city wrote a background and a recommendation report and held a dissemination seminar at the end of the project. The city of Leeds produced a webpage (www.leeds.gov.uk/seem) and a flyer for the project which is available in English, German, Swedish and French. Furthermore, the project was presented at the fifth European Congress on Geriatrics and Gerontology in Barcelona, Spain (July 2003).

This final report gives an overview of the groups and migration histories of BME elders in all four cities, their life circumstances and important social political and legal aspects. It draws

[1] The project has received funding from the European Commission from December 31st 02 to September 30th 03 within the framework of programmes and actions in the social and employment sectors.

together existing experiences in the field of personal social services for BME elders, identifies models of good practice, analyses the conclusions of the different local projects and gives recommendations for further strategies of action on different political levels.

II Preamble / Remarks on Terminology

Within the context of different national histories, diverging integration concepts and different models of welfare state the topic 'Services for BME Elders' is addressed and implemented differently in the four countries. The difference also has a clear impact on the prevailing terminology. Unfortunately it is not possible to find and use a terminology that suits the views of all the countries involved in the project. This problem cannot be discussed here completely but a few remarks should be made to illustrate the problem and to define certain terms used.

1. Personal Social Services

This is a widely accepted term within the field of social policy and social work. It is commonly applied in international and comparative studies. Within this report, the term personal social services is defined as comprising services in the fields of advice, support, care and medical treatment. Thus, personal social services mainly react to immaterial social needs and are therefore problem-orientated. In general, personal social services are provided by the informal care system such as families, neighbours, friends and acquaintances or by the professional care system such as organised services. (Naegele 1999: 435)

It is worth noting however that in Great Britain the term 'social services' also refers to local Social Services Departments (SSD) that provide social services for children and adults.

When speaking of (personal) social services in this report and not explicitly referring to the services of SSDs, the broader definition is meant.

2. Integration / Assimilation

Within the discourses in migration sociology different concepts are used to describe the relationship between members of the host society and immigrated people, focusing on the latter. The way and intensity with which they are included within the host society is described with terms such as assimilation, absorption, integration, acculturation etc. Until the end of the 1980s it was mostly assumed that assimilation (in the sense that immigrated people totally adopt the culture of the host society) was something that inevitably had to happen. Only from

then on did some concepts develop that were not based on the model of final assimilation. However, multicultural approaches are more often found on the level of political ideologies than on a theoretical sociological level. The UK especially views itself as a multicultural and multiracial society and its approach of anti-discrimination legislation also has a clear impact on the delivery of social services for BME elders themselves: In contrast to Germany, specific and separate services for elders from black and ethnic minority communities are more widespread and not regarded as an obstacle to integration. (Gerling 2002)

France also has an anti-discrimination legislation and the legal basis for immigration used to be the so called principle 'ius soli', which is friendly to immigrating people in the sense that people who are born on French territory automatically gain French citizenship. In the 1990s, the principal of the 'ius soli' was changed and amplified by elements of the principle of 'ius sanguinis' which relates to the origin of people. Although the Republican tradition emphasises the idea of a society of citizens ('citoyens') in which equal citizens are obligated to the French nation, no matter what their real origin or the colour of their skins , there has always been a monoistic, one-sided pressure that immigrants have to assimilate (Mintzel 1997: 414f.)

In Germany the term integration is more widespread than assimilation, but integration is often viewed as a one-sided integration of immigrated people to the German culture and thus is very close to the concept of assimilation.

The Swedish general and official approach is that diversity is most important for the society. The outcomes of this statement are still difficult to see. Just like in Germany the term integration is used rather than assimilation, since assimilation is a one-sided concept.

From these short introductions into underlying national approaches and views of the interaction between members of the host society and immigrated people it becomes clear how difficult it is to find a term that is accepted by the different partners.

In this report the term 'integration' is not used as one-sided assimilation but as a two-sided process both by immigrated people and by members of the host society. Furthermore it is more used in the sense of social inclusion, meaning integration in social and societal and not cultural contexts.

3. Black and Ethnic Minority Groups

This term is mainly used in the UK to describe people who are not of white British origin. A lot of the Commonwealth migration to Great Britain occurred from the West Indies, Asia and Africa and most of those people are visibly not 'white' and thus are called 'black'. Although the skin of people from Asia is not black, they are in general subsumed as 'black'. Also, the

term ‘black’ is often used as a political term trying to emphasise a group cohesion of all black people.

Because the term ‘black and minority ethnic groups’ seems to be more neutral than the term ‘migrant’ / ‘immigrant’ (see below) it is in general used in this report to describe those people who are not indigenous in the respective country. However, when speaking of a certain country, the respective ‘national’ terms are used.

4. Migration

In this report migration is described as a process of leaving one’s home country to resettle in a new country on a long-term basis. The reasons for migration can differ but comprise mainly of economic, political and social (for instance family reunification) reasons. Short-term migration such as seasonal work migration is not considered here.

5. Migrant / Immigrant

These terms are widely used in Germany, France and Sweden and usually try to describe people with a migration background in a neutral way. In general, the term is not being used as a legal one, but as a socio-demographic one. In Germany, both within the socio-scientific and the political / public sphere the term ‘migrant’ is increasingly used and often replaces the official term ‘foreigner’ in order to avoid the negative (hostile) associations of the latter. In general the term ‘(im)migrant’ refers to a bigger group than the legal term ‘foreigners’ which is especially the case for Germany and France. For instance in Germany, most migrants do not have the German citizenship, although some immigrated groups are statistically counted as German people such as (late) emigrants of people with German origin[2].

Yet in Great Britain the term ‘migrant’ or – even more so – ‘immigrant’ is more connected to the political far right and thus also has a (different) connotation and is mainly used in a negative, ‘racist’ sense. Against the background of the specific migration history of Great Britain which is linked to migration from the Commonwealth to the ‘mother country’ there is another reason why the term ‘migrant’ or ‘immigrant’ is not liked: it implies a process of migration that is not yet finished, meaning that people have not fully settled. Since a lot of people in the UK with a non white British background have been living in the UK for several decades and most of them do have British citizenship the term ‘black and minority ethnic groups’ is widely accepted.

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[2] ‘Late emigrants’ are people of German origin who used to live in the former Soviet Union and came back to Germany after the fall of ‘iron curtain’.

6. Race

This is a term that is accepted and widely used within the UK to describe people of a certain origin. However, in Germany, France and Sweden the term is not used at all. In Germany this is due to the national-socialist past in which belonging to a Jewish 'race' was interpreted as being inferior with all its horrible implications and consequences. In France, there is also a tendency to avoid the term 'race' and 'racism' and instead much of the discourse is framed in terms of 'culture' which again links to the greater importance of uniformity and assimilation in France. (Lloyd 1991: 67)

From a sociological perspective, the term 'race' is not a concept with a clear content and thus in sociological theory the term is not being used.

When the term 'race' is used in this report, it does not refer to the existence of different races on earth but in the context of the British usage.

7. Self Help

Within the field of social policy, social work and the delivery of social services, self help has always been an important issue. However, depending on the particular welfare state system, those principles have a different meaning and play a different role in different countries. For instance due to stronger principles of political and economic liberalism, self help and self responsibility play a more crucial role in Anglo-American countries than in Germany or Sweden. In Great Britain, from the 1980s on, the voluntary sector has been strengthened by neo-conservative reforms of the welfare state (Gerling 2001: 18f.) which is characterised as a two-edged sword because it also means cutting back elements of the welfare state. On the other hand, due to this political tradition, the voluntary sector is strongly developed. This is also true for the so called 'black and minority ethnic' voluntary sector (i.e. the organisations of minority ethnic groups) which is, compared to France, Germany and Sweden, most developed in Great Britain.

Sweden, as the prototype of the modern (social-democratic) welfare state, with its universalistic approach of social security and a dominance of the public sector (Schmid 2002: 206), hardly knows self help organisations in the way they are known in Great Britain, France or Germany.

When using the term 'self help' in this report is it not used in a normative way but simply as a way of, for instance, delivering social services. Supporting self help in this sense does not imply (further) cutting down elements of the welfare state, but implies supporting self help abilities for instance by structural or organisational measures.

III Elders from Black and Minority Ethnic Groups in Leeds (UK / England), Lille (France), Dortmund (Germany) and Gothenburg (Sweden)

The following chapters give an overview on the groups, migration histories and the life circumstances of BME elders in the four countries and cities. It then shows relevant socio-political and legal aspects as to the situation of BME elders in the respective country and finally summarises the similarities and differences of the four countries covered.

1. Groups and Migration History

This chapter gives an overview on the varying BME groups on national and regional level and the respective migration history in each country / city involved in the project.

1.1 United Kingdom / England/ Leeds

The United Kingdom is made up of England, Scotland, Wales and Northern Ireland. 'Great Britain' includes the first three. Statistics and numbers tend to be gathered at all the different levels. For the purposes of this report and for simplicity of definitions (there are issues of 'ethnicity' language, and culture between the different constituents of the UK), the 2001 Census information has been gathered for England. The legal and structural frameworks apply sometimes to England, sometimes to Great Britain, and sometimes to the UK. In England, the biggest BME groups originate from the New Commonwealth (Caribbean islands, India, Pakistan, Bangladesh) and also from Ireland. (Coleman 1996) Against the background of Great Britain's history as a colonial power, a distinction is made between immigrants from the Commonwealth and the so-called 'foreign' immigrants who come from countries that do not belong to the Commonwealth and thus do not have British nationality.

Just like the other countries involved in the project SEEM, Great Britain experienced an increased immigration after World War II. Up until the 1970s, the strongest immigration took place from the New Commonwealth.

The different statistics aiming at categorising ethnic minority groups concentrate on criteria such as skin colour and national / ethnic origin. Because - until 1962 - most immigrants from the Commonwealth automatically gained British citizenship when entering the country, they

are called minority ethnic groups. To distinguish them from the predominant white indigenous population, they are also subsumed under the term ‘black’. (Gerling 2002)

The total population of England is 49,139,000. In 2001, there were 10,199,830 people aged 60 and over in England, 20.8% of the total population. By 2016, the number of people aged 60 and over is expected to rise to 12,844,000 (24.8% of the total population). The estimated size of the black and minority ethnic population of England in 2001 was 6,392,000 which is 13% of the total population.

The number of people in black and minority ethnic communities who are aged over 60 will increase over the next 15 years from around 748,000 today to nearly 1.8 million in 2016 (from 0.35% to 3.5% of the total population).

The groups identified under the 2001 Census headings were:

Group	Population
Black Caribbean	561,000
Black African	476,000
Black ‘other’	95,000
Indian	1,029,000
Irish	624,000
Pakistani	707,000
Bangladeshi	275,000
‘Other Asian’	238,000
Chinese	221,000
‘Mixed’	643,000
‘Other’	215,000
‘White Other’	1,308,000

Britain’s minority ethnic population in 2000 was mainly concentrated in large urban areas. 11% of local authority districts accounted for 70% of the overall minority ethnic population. The first large scale migration to the UK in the last 50 years was of people from the Caribbean, shortly after the Second World War, and during the 1950s. Those from the Caribbean generally came as families, compared with the second main group of migrants

from India and Pakistan, who tended to arrive as male adults with their wives and children following later.

Many immigrants from these groups arrived before the 1971 Immigration Act came into effect. This means that they arrived as UK citizens. Thus, the vast majority of BME elders in the UK are UK citizens.

Most Chinese people migrated to Britain in the 1980s and many of the Black Africans in Britain came during the 1980s and 1990s. The 'white' majority group also includes other minority ethnic communities, for example Irish, East European and Jewish communities.

The average age of people from all minority ethnic groups in 1995 was nearly 27, compared with 38 for the white population. Because of this relatively young age structure, minority ethnic groups are also the fastest ageing groups within the population. Now, just over 8.8% of the total minority ethnic population is aged 65 years and over. This will increase as those who are presently 'middle-aged' (45-65) become pensioners.

The age-sex profiles and the proportions of each ethnic group born in the UK are greatly influenced by the timing of the various waves of immigration into this country, as migrants are mainly young adults (with or without families). In London, for example, South Asian and black older age groups include higher proportions of men than white and other groups; and more Black Caribbean and African men live alone than do men from other BME groups.

Virtually all (97%) people from black minority ethnic communities who are aged 45 and over were born outside of the UK. This proportion will change over time because between 1997 and 1999, 90% of the total minority ethnic population aged 0-14 years were born in the UK. (Leeds Background Report 2003)

1.1.1 BME Elders in Leeds

Leeds is the third largest manufacturing centre in Britain and its varied and diverse industry mix supports over 55 000 jobs. Leeds is a major centre for engineering, chemicals, toiletries, textiles, glass, furniture and food processing, and is the largest printing centre outside London. The city also has a very diverse and strong voluntary and community sector with over 8000 organisations and groups.

Leeds has some 715,400 inhabitants (2001 Census). At least 77,530 (10.8%) of its citizens come from black and minority ethnic communities. The general history of migration patterns to Leeds is similar to the national one outlined earlier. In the Yorkshire and Humberside

region: "…before the growth of the woollen and textile trades from the late 18th Century, there had been little foreign immigration into the region in the modern era. But for the past 200 years immigrants and their descendants have made a significant contribution to the region's economic and cultural life. German manufacturers and merchants and Irish factory hands helped build the textile and garment industries…; and Jewish entrepreneurs, by developing Marks and Spencer and the Burton tailoring chain, put Leeds at the forefront of retailing. The presence of older people from ethnic minorities is not therefore unprecedented…." (Age Concern in Yorkshire 2002)

In Leeds, 142,735 people are aged 60 years and over. Of these, it is estimated that 9,167 (6.4%) are BME elders. As with the national projections, this figure is likely to rise gradually over the next 10-15 years.

Leeds is characterised by a wide diversity of BME groups, from, for example, other parts of Europe, the Caribbean, and South and East Asia. Some communities are quite small in numbers but have their own distinctive needs. It is difficult to get a meaningful projection from the information currently available. Some of the breakdowns of numbers may not be very accurate; they may understate the true figures. Also, information from the 2001 Census does not always correspond with actual communities. For example, in Leeds there is a sizeable Kashmiri population, which does not show up in the Census information. Some of these difficulties may be reduced when a more detailed analysis from the 2001 Census is available – for example, there will be more information on religious groupings which will increase the knowledge of the volume and location of cultural needs and access issues. However, there may still remain a problem in gaining precise enough numerical information for feeding into service planning.

It should be noted that the definition of 'elder' in many local BME communities includes people of 50+ years. This fact is taken into account, for example, in the planning and provision of neighbourhood support services for BME elders in Leeds.

The main groups of BME elders in Leeds are:

⇒ *Black-Caribbean and 'Black Other' Elders:* The 1999 Census update estimates there to be 1490 people aged 60 years and above defining themselves as either Black Caribbean, or Black Other. The majority live in the North Leeds inner areas, and are likely to be living on a low income. Elders mainly originate from St Kitts and Nevis, Jamaica and Barbados. Many older people feel most comfortable speaking in Patois.

⇒ *Arab Elders:* Arab communities tend to be spread across the city and the North West part of the city. No Census population estimates are available yet, but it is thought that in Leeds at present there tend to be mainly younger Arab people, living in family groups.

⇒ *Black African Elders:* The Census estimates 120 Black African elders, with at least half living in the North West of the city, possibly due to previous connections with Leeds University. Little is known about nationalities, cultures or needs.

⇒ *Chinese Elders:* From the 2001 Census information there were 230 Chinese elders (60+). From this we also learn that older Chinese people live across the whole city, not concentrated mostly in inner area wards as is the case with most other BME communities.

⇒ *Gypsies and Travellers:* Little information is available on the specific numbers and needs of elders. Community leaders are at present focusing on the needs of the communities and families as a whole.

⇒ *Irish Elders*: The population of Irish elders aged 60+ is estimated as 2,800 (2001 Census), distributed across the city, with the largest numbers in the inner areas and in East Leeds, (and likely to be on a low income).

⇒ *Jewish Elders:* from religious classifications in the 2001 Census, there are 2680 elders (60+) of the Jewish faith.. Most Jewish elders live in the North East of the city.

⇒ *Bangladeshi Elders:* The Bangladeshi community first established itself with the arrival of younger male workers from the 1960s onwards (Bangladesh was then part of Pakistan). Families followed much later – from the 1970s and 1980s. Because of this migration pattern, there tend to be a bigger proportion of men elders than in the general population. From the 1999 estimates, there are 180 Bangladeshi elders aged 60+, with nearly everyone living in the inner areas of the city on a low income. Elders first language is likely to be Bengali, (Sylheti dialect), and some older men speak Urdu.

⇒ *Kashmiri Elders*: Kashmiris are considered to be particularly disadvantaged and marginalised in terms of accessing services. There is no separate Census information for Kashmiri people. They may for example be counted under ‘ Pakistani’ or ‘Asian other’. In

2001, as part of a national pilot scheme, a small sample area in inner Leeds counted 81 families defining themselves as Kashmiri. It is estimated that possibly 75-80% of people counted as Pakistani, both nationally and locally, are of Kashmiri origin. In 2000, Leeds City Council, and subsequently the health services, adopted 'Kashmiri' as a separate ethnic category for the purposes of monitoring employment and service delivery. Kashmiri elders speak Pahari or Mirpuri.

⇒ *Pakistani Elders:* according to the 2001 Census, there were 880 Pakistani elders aged 60+. As outlined above, 75-80% may be of Kashmiri origin. Although Pakistani and Kashmiri people may share many cultural values and traditions, and share the Muslim religion, the language is different. In planning services, elders are likely to respond to provision in their own language which reflects their own culture and heritage. Pakistani (as opposed to Kashmiri) elders are likely to have Urdu or Punjabi as their first language. Based on an assumption of under-reporting for the 1991 Census, there are likely to be at least 2,500 Bangladeshi, Kashmiri and Pakistani elders living in Leeds. Services for elders need to provide Halal food and take account of other religious and cultural requirements. Services need to be provided for men and women separately.

⇒ *Indian Elders:* There are estimated to be 1120 Indian people aged 60+. Again, this is likely to be an underestimate. Although there remain some concentrations of elders in the inner areas, a large number of Indian elders live in two of the more affluent wards in the North East of the city. Indian languages in Leeds include Punjabi, Hindi and Gujerati; the main religions are Sikh (705 Sikhs aged 60+), Muslim or Hindu (360 people aged 60+)..

⇒ *Vietnamese Elders:* It is hard to estimate the numbers of Vietnamese elders. Population estimates are included under 'other ethnic groups' in the 2001 Census. Current estimates are up to 800 people (in 100 families). Vietnamese people settled in Leeds in the early 1980s. Most people are thought to be living in North Leeds. It is thought that about 80% understand or speak Chinese or Vietnamese, 20% just Vietnamese. (Leeds Background Report 2003)

1.2 Germany / Dortmund

Germany has a total population of about 82,260,000 people (21.12.00) of which about 7,300,000 belong to the group of so called foreigners (defined as people who do not have the German citizenship), which is a share of about 9 %. (Statistisches Jahrbuch 2002)

However, those numbers reflect only one group of people with a migration background living in Germany. This is due to the fact that official German statistics merely differentiate between people with German citizenship and people without (foreigners). Some other immigrated groups are not counted as foreigners but as German people. Those groups comprise the following: so-called (late) emigrants of people with German origin who used to live in the eastern parts of Europe and came 'back' to Germany after the fall of the wall (they make up about 3.8 million) and people with double citizenship. People seeking asylum who are not yet accepted do not occur in the official statistics either.

It also has to be mentioned that almost 20% of the foreign population groups were born and raised in Germany; those younger people are often called 'indigenous foreigners'. (Deutscher Bundestag 1998) Due to their legal status, foreigners are not allowed to vote (only foreigners from EU member states are allowed to vote on local level) and thus have very limited political influence.

In 1998, the biggest groups of foreigners stem from the following countries: Turkey (about 2 million), Yugoslavia (Serbia and Montenegro) (about 757 000), Italy (about 600,000), Greece (about 363,000), Bosnia (about 341,000), Poland (about 283,000), Croatia (about 200,000), Austria (about 185,000), Spain (about 132,000) and Portugal (131,000). (Deutscher Bundestag 1998)

In Germany, from a historic point of view, emigration used to be stronger than immigration. However, at the beginning of the 19th century, the dimensions of immigration outnumbered those of emigration and especially after World War II there was a big increase in immigration. Until the beginning of the 1950s about 12 million refugees migrated to Germany. They came mostly from former Eastern parts of the German Reich and the so called 'Sudetenland'. At the same time, people immigrated from the Russian occupation zone as well as from the later-built German Democratic Republic but this was stopped in 1961 when the wall was set up. From the mid 1950s on, due to shortcomings in the labour force, Germany recruited so called 'Gastarbeiter' (guest workers) from Southeast Europe, North Africa and Turkey. Thus, the share of foreigners increased from about 1% in the beginning of the 1950s to about 5,7% at the beginning of the 1970s. In 1973, the German government officially stopped the

recruitment of guest workers but due to family reunion and further immigration by other groups (mainly asylum seekers and refugees), the share of foreigners increasingly grew to about 9% today. However, the composition of the groups changed over time. (Gerling 2001)

Because of the comparatively young age structure of the foreign population, the numbers of foreign elders in Germany are still relatively small: At the end of 1995 there where about 430,000 foreign elders in the age group 60 and above. Since the last census in 1987, the numbers have doubled and the share of foreign senior citizens in relation to the total population has increased from 1.3% (1987) to 2.5% (1995). Prognoses estimate an increase of this share up to 11.3% in 2030. This means, in total numbers, that there will be about 1.3 million (2010) and almost 2.9 million (2020) foreign elders aged 60 years and above living in Germany. (DZA, Dietzel-Papakyriakou & Olbermann 1998) Thus, "foreign seniors are expected to be the most rapidly increasing population group in Germany" (Bundesregierung 1993). Apart from the statistically registered foreign elders, there are also about 420,000 so-called resettled senior citizens (aged 60 years and more) from the Eastern parts of Europe and Russia. Statistically they are treated as Germans but obviously they also have experienced migration and different cultural socialisations. (Dronia 2000)
The biggest groups of foreign elders stem from former Yugoslavia (almost 80,000), Turkey (almost 76,000), Italy (almost 45,000), Greece (almost 33,000), the Netherlands (almost 22,000), Austria (about 22,000), Spain (almost 20,000) and Poland (almost 20,000). Foreign elders from former recruitment countries (except Tunisia) add up to about 262,000 persons and make up about 60% of all foreign senior citizens aged 60 years and above. (DZA, Dietzel-Papakyriakou & Olbermann 1998)

Compared to the shares of indigenous elders those of BME elders are smaller: from the group of all foreigners the share of senior citizens aged 60 years and above is about 6 % (in 1998). For German elders the same share is about 23%. (Gerling 2001)

In contrast to indigenous population groups, the gender relations of immigrant seniors are dominated by male seniors, although clear distinctions exist between different ethnic / national groups. In Germany, elders from Morocco (83%) and from Tunisia (80%) have the highest shares of men. (DZA, Dietzel-Papakyriakou & Olbermann 1998)
Due to work migration, the highest concentrations are in the northern parts of old industrial conurbations. In Germany, the regions with the highest number of foreigners are Frankfurt am

Main (29%), Offenbach (28%), Stuttgart (24%), München (23%), Mannheim (21%), Köln and Düsseldorf (both 19%), and Duisburg (17%). Almost 70% of all elders from ethnic minorities live in urban conurbations, which is a lot more compared to indigenous elders (53%). (Gerling 2001: 255) However, on the local level, the composition of ethnic minority groups differs significantly. (Deutscher Bundestag 1998)

In general, households of BME elders are bigger than those of indigenous elders although there are big differences between ethnic groups and there is also a tendency for convergence. In average, one person households are the most common size but more BME elders than indigenous elders live together with their children and grand children. For Turkish elders, this is even the predominant household form. The share of single living BME elders is lower than that of indigenous elders but nevertheless comprises 25%. Differentiated between ethnic groups, these amounts are highest for Italian elders and elders from former Yugoslavia and lowest for those from Turkey. (Gerling 2001)

1.2.1 BME Elders in Dortmund

Dortmund has about 600 000 inhabitants and is Germany's seventh largest city. Its industry used to focus for a long time on steel, coal and beer and from the 1960s on, it was heavily hit by arising crises in these industries. Meanwhile, the economy in Dortmund has changed from a dominance of the primary (producing economy) to the tertiary sector (services).

Dortmund, just like the whole Ruhr region, has always been affected by processes of work migration. Towards the end of the 19th and at the beginning of the 20th century, the coal and steel industries expanded and caused heavy immigration from the Eastern parts of Europe by the so called Ruhr Polish people ('Ruhrpolen'). From the 1950s to the 1960s most immigration took place from Southeast Europe, Northern Africa and Turkey as guest workers had been recruited from those countries. A big amount of guest workers of the first generation has been living for more than 30 years in Dortmund. From the 1990s on, there has been an increased immigration to Dortmund, for instance by people from Eastern Europe. (Vollmer, Langenhoff, Skorvanek, Rosendahl & Becke 1995). Thus, the share of foreign people has risen from less than 1% in the early 1950s to about 13% in the late 1990s which is higher than the federal state share (9%) and that of the Bundesland North Rhine Westphalia (10,2%). In total, about 78 000 foreign people are living in Dortmund. At the end of 2002, there were about 10 300 so called foreigners aged 55 years and above.

About 70% of all foreign people in Dortmund stem from former recruitment countries (Turkey, former Yugoslavia, Italy, Spain, Greece, Morocco, Tunisia and Portugal). The biggest groups stem from Turkey, followed by former Yugoslavia, Greece, former Soviet Union, Italy, Morocco, Poland, Portugal and Spain (figures from 1998). About half of the immigrants from Turkey were raised in rural areas. (Gerling 2001)

From the total foreign population group, the share of BME elders aged 60 years and above amounts only to about 7% which reflects the still young age structure of that group. For indigenous elders the comparable share is about 26%. From the total group of all elders people living in Dortmund aged 60 years and more, the share of foreign elders is less than 4%. Within the different nationalities, Turkish people have the highest numbers of elders, followed by elders from former Yugoslavia, former Soviet Union, Greece, Italy, Spain, Poland, Morocco and Portugal.
If one takes a look at the regional distribution of immigrant elders in Dortmund it becomes obvious that over half of their entire population lives in the three downtown districts North, West and East. Although many people criticise the spatial concentration of immigrants as an obstacle to integration, the elders especially profit from it in many ways. Social contact with members of the same ethnic groups are facilitated and the usage of the ethnic infrastructure as for instance shops and mosques is guaranteed. (Gerling 2001)

1.3 France / Lille

France has 58,520,688 inhabitants. In 2050, Metropolitan France will have between 58 and 70 million inhabitants. By this time, more than a third of the population will be older than 60 years old, as opposed to one in five in the year 2000. Whatever happens, the slice of those older than 60 years old will be bigger than that of those less than 20 years old.

It was at the end of the 19th century that France became a country characterised by immigration. Between 1850 and 1900, whilst the population of the rest of Europe tripled, France's population had stopped rising. This was the first reason for the migrant influx at the start of the century: workers were in short supply all over France, from the countryside to the towns; and neighbouring countries were the main providers of labour (miners were mainly recruited from Italy, Belgium, Spain, Switzerland, and Poland).

Immigration in the 1960s saw a marked diversification in the sources of recruitment: there was a progressive decline in Italian immigration in favour of Spanish immigration, especially after the Franco-Spanish agreement of 1961; Portuguese immigration exploded after the Franco-Portuguese agreement of 1963; there was a significant renewal of Moroccan immigration, and development of Tunisian immigration, after the 1963 agreement; after the end of the Algerian War (1954-1962), there was a very marked increase in Algerian immigration; and immigration from Sub-Saharan Africa began from 1964 onwards.

The economic crisis was accompanied by a fundamental re-examination of migration policies in Europe. And then, France 'closed its doors'.

Figure 1: Foreign Population in France

		Men	Women	Total
Total	%	53.1 %	46.9 %	100 %
Number		1,732,288	1,530,898	3,263,186

Source: Lille Background Report 2003

A true picture of immigration can be seized through two different facts: the number of foreigners, which is a measure of a shifting legal reality (given that a foreigner can acquire French nationality), and the number of immigrants, which, on the other hand, reflects a particular population as defined by an objective given (that is, those people who were born abroad and who did not have French nationality at birth). At the time of the census discussed here, a significant number of these immigrants were French.

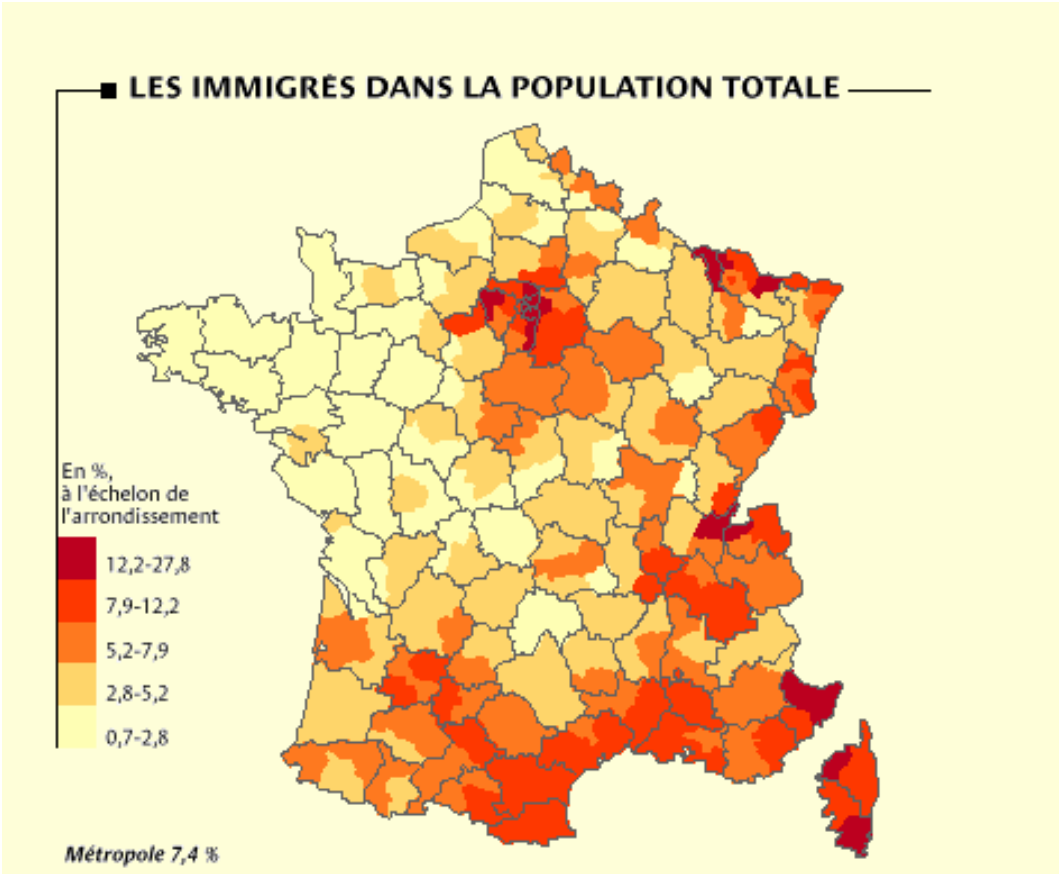
In March 1999, there were 3,260,000 foreign people living in Metropolitan France, that is 5.6% of the total population. As far as immigrants are concerned, there were 4,310,000 living in Metropolitan France in March 1999 which is 7.4 % of the population. This level has remained constant since 1975. In 1999, there were 1.56 million immigrants of French nationality. The number of foreign immigrants had reached 2.75 million. More than one immigrant in three (36 %) is French.

Between 1990 and 1999, there was a diversification in the geographical origins of immigrants. In 1999, the number of immigrants coming from an E.U. country was 1.6 million, that is 9.3% less than in 1990. This fall can be explained in terms of those populations which had traditionally been the biggest, dating back to old waves of immigration (from Spain, Italy, and Portugal). In contrast to this, the number of immigrants coming from other E.U. countries is

increasing. The proportion of immigrants coming from Europe as a whole is in constant decline (57% in 1975, 49% in 1990 and 45% in 1999). The number of immigrants born in North Africa was 1.3 million, that is 6% more than in 1990. People coming from Morocco represent three quarters of the reason for this increase.

In the context of immigrant population, those people coming from the rest of the world are increasing both in number and in proportion. In 1999, they numbered 1.11 million; whereas in 1990 they numbered only 850,000. Constituting 15% in 1982, they went up to 20% in 1990, and 25% in 1999. In the main, they were born in Turkey (16%), other Asian countries (35%), and Sub-Saharan Africa (37%). The number of immigrants coming from a country in Sub-Saharan Africa is 400,000, which is an increase of 43% in relation to 1990. Amongst immigrants from the rest of the world, people coming from Turkey are the only ones who represent more than 2% of the immigrant population resident in Metropolitan France. (Lille Background Report 2003)

Figure 2: Immigrants in the total Population in France



In % according to region (arrondissement) Capital 7.4%

Source: Lille Background Report 2003

A large share (37 %) of the immigrant population lives in the Ile-de-France district of Paris. More than one person in six living in Paris is an immigrant.

The increase in the immigrant population can be explained entirely in terms of women (up 7.2%). The increase in the number of women immigrating had begun in the mid-1970s, with the development of measures facilitating the reuniting of families. The number of men remained stable. And so, whilst the majority of the immigrant population had always been male, it was then that the balance of men and women was reached.

The structure of the immigrant population, in terms of age, differs from that of the population as a whole. There are less youngsters given that immigrants, by definition, are not born in France. Those less than 20 years-old make up a quarter of the population as a whole, and only 8 % of the immigrant population. Half of immigrants are between 30 and 55 years-old, as compared with a third in the population as a whole. A quarter of the immigrant population is more than 60 years old. This age group, in contrast, is only a fifth of the population as whole. Between 1990 and 1999, the immigrant population aged markedly. The number of those less than 20 years-old decreased a lot (22 %). The proportion of people aged 40 or above increased more than the others (up 15 %). This increase is clear in immigrant men aged 60 or above (up 17 %), who came from the labour-related immigration of the 50s and 60s.

Figure 3: The Elders Immigrant Population

Age	Total	E.U.	Spa-nish	Italian	Portu-guese	Alge-rian	Moro-ccan	Tuni-sian	From African countries formerly governed by France	Tur-kish	Vietna-mese, Laotian, & Cambo-dian	Other
50-59	483 380	205 608	26 007	31 640	108 246	104 316	69 274	22 471	17 419	19 535	5 729	39 028
60 +	536 757	300 241	74 094	101 2249	68 559	105 598	38 796	13 772	6 472	6 761	9 493	55 624

Source: Lille Background Report 2002

50.7% of foreign people aged 60 or above come from the European Union (Italy, Portugal, Spain); 36.8 % come from North Africa. The French population is ageing and foreign populations do not constitute an exception to the general trend, even if conditions vary noticeably according to where people are from.

Statistics give only an imperfect view of ageing in the immigrant population. Other things being equal, in those age groups approaching retirement age today, the number of people coming from the E.U. is tending towards being static, whereas the number of foreign people coming from North Africa (Algeria, Tunisia, Morocco), particularly Algeria, is increasing considerably. This immigration group is characterised by being strongly linked to France's colonial past, and by the particular way in which it was managed by the State. It is predominantly male, given that men make up 68 % of foreign people aged 65 or above coming from North Africa. The number of men even rises to 78 % in the group of North Africans aged between 55 and 64. More than two thirds of ageing North-African populations are therefore presumably living as single people in France. This isolation is all the more problematic because in France it is mainly the family which takes responsibility and care of ageing people, with its accompanying disabilities; ageing immigrant people from North Africa are not party to this way of doing things.

1.3.1 Native and Non-Native Foreign People in Lille

If what is known of the foreign population of Lille and its suburbs is poor, knowledge of the population of French people issuing from immigration is even poorer. The integration policy followed in France, with the idea of assimilation, means that people coming from immigration do not presently constitute a separate category that can be identified and measured.

The individual questionnaire used at the census (which is the only near-exhaustive source of information) bears no question regarding the nationality of one's parents. Even defining that group of people issuing from immigration is problematic, as it is difficult to decide how far back should one go, for instance to the parents' generation or the grandparents' generation.

1.3.2 BME Elders in Lille

Given how difficult it is to gather data, most of the research has been carried out at the level of the northern administrative area (*département du Nord*) from the 1990 census. Foreign populations benefit (sometimes to a lesser degree) from increased life expectancy in France. But they are characterised in particular by the very history of immigrations into France. The following table illustrates this clearly.

Figure 4: Foreign Elders in Lille by Origin

	Total population	Foreign people from the E.U.	Foreign people from North Africa
Aged 60 & above	17 %	22.6%	5.6%

Source: Lille Background Report 2003

It can be seen that the situation of older foreign people differs markedly according to their origins. The explanation to this is historic: foreign people coming from the E.U. migrated earlier and are therefore characterised more by ageing. Foreign people coming from North Africa are only now beginning to reach the age of 60 and above. The number of the latter should continue to rise, as the following table illustrates.

Figure 5: Foreign Elders in Lille by Age Group, Sex and Origin

	Total	Foreign people	Foreign people from the E.U.	Foreign people from North Africa
Total 40-59	30 675 (17.8 %)	3 849 (23.1 %)	713 (26.5%)	2 674 (24.8 %)
Total 60 & above	27 885 (16.2 %)	1 232 (7.4 %)	512 (19 %)	428 (4 %)
Men 40-59	15 141 (18.6 %)	2 713 (28.2 %)	421 (28.7 %)	1 988 (32 %)
Men 60 & above	9 899 (12.2 %)	740 (7.7 %)	284 (19.3 %)	328 (5.3 %)
Women 40-59	15 534 (17.1 %)	1 136 (16.2 %)	292 (23.9 %)	684 (15.1 %)
Women 60 & above	17 986 (19.8 %)	492 (7 %)	228 (18.7 %)	100 (2.2 %)

Source: Lille Background Report 2003

In general, the number of foreign people aged 60 and above is, in percentage terms, a lot lower than that of the reference population of Lille (7.4 % as opposed to 16.2 %). This figure falls to 4 % for foreign people coming from North Africa and as low as 2.2 % for women coming from North Africa.

This can be explained by the fact that the people in question came to France to work, and many of them still have some or all of their family in their country of origin. And those foreign people who have reached retirement age and returned to their country of origin also serve to explain why these figures are so low. The 40 - 59 age group illustrates a complete reversal of this trend.

The situation of elders coming from North Africa is worthy of more detailed study because it is different in two remarkable ways. Whereas the gap in the total number of people living in Lille, between the number of 40 - 59 year-olds and the number of people aged 60 and above (30,675 as opposed to 27,885) is not great, the same cannot be said for foreign people coming from North Africa. Indeed, there are 428 people aged 60 and above as opposed to 2,674 people between 40 and 59, that is, a ratio of 1 : 6.

This illustrates that the ageing of this population is a very present reality. It should be remembered that the figures date from 1990. Departures and deaths aside, it can be estimated that the number of foreign people coming from North Africa who are aged 60 or above has been multiplied by 2.5 or 3 since 1990, and that this trend will continue over the coming years.

The second remarkable point is that women are under-represented. Women represent 23.3 % of foreign people coming from North Africa aged 60 and above. By way of comparison, women in the total population of Lille who are aged 60 and above represent 64.5 % of this age range. A complete reversal in the usual percentages is therefore in evidence. And this is not without consequences in terms of how these groups are cared for.

Elder migrants share the same concerns affecting all ageing populations: insecurity, isolation, health problems, and having to depend on others because of their physical condition.
Foreign people in Lille make up nearly 8 % of the total population. Data provided by the elders migrant watchdog (source: *I.N.S.E.E.*, 1999) makes it apparent that, in Lille, there are twice as many people aged between 60 and 74 as there are people aged 75 and above. This marked increase is going to continue over the next 10 or 15 years. Indeed, this increase reflects the fact that people living in Lille who came to France at the time of the significant influxes of migration in the 1960s and 70s, mostly coming from North Africa (more than 60 % of the population presently concerned), are now entering old age.

Figure 6: Foreign Elders in Lille by Nationality and Age Group

Foreign elders in Lille	**60 – 74**	**75 & above**	**Total**	**%**
Total	1 390	365	1 755	100
French by birth	0	0	0	0.00
Spanish	43	19	62	3.53
Italian	105	46	151	8.60

Portuguese	71	5	76	4.33
Other nationalities of the European Union	70	75	145	8.26
Other European nationalities	53	87	140	7.98
Algerian	573	75	648	36.92
Moroccan	393	31	424	24.16
Tunisian	18	3	21	1.20
Other African nationalities	22	2	24	1.37
Turkish	7	2	9	0.51
Cambodian	5	5	10	0.57
Laotian	5	2	7	0.40
Vietnamese	3	2	5	0.28
Other Asian nationalities	18	9	27	1.54
American and Oceanic nationalities	4	2	6	0.34

Source: *I.N.S.E.E.*, 1999

Figure 7: Elders in Lille who Acquired French Nationality by Age Group and Country of Origin

Elders in Lille who acquired French nationality	60 – 74	75 & above	Total	%
Total	667	576	1755	100.00
French by birth	0	0	0	0.00
Spanish	16	9	25	2.01
Italian	68	51	119	9.67
Portuguese	15	8	23	1.86
Other nationalities of the European Union (Austrian, Finnish, Swedish)	131	203	334	26.87
Other European nationalities	207	233	440	36.40
Algerian	87	27	114	9.17
Moroccan	55	12	67	5.39
Tunisian	8	4	12	0.97
Other African nationalities	19	7	26	2.09
Turkish	5	0	5	0.40
Cambodian	7	0	7	0.66
Laotian	4	0	4	0.32
Vietnamese	12	10	22	1.77
Other Asian nationalities	22	7	29	2.33
American and Oceanic nationalities	11	5	16	1.29

Source: *I.N.S.E.E.*, 1999

The myth of return: Originally the immigration plan estimated that after working in France for a number of years, people would return to their countries of origin.

This 'returning home' is a myth which has been replaced by another reality: the coming and going between the two countries, the welcoming of other family members, the sending back of money to help the development of the village. In other words, the perspective is now one of growing old and maybe dying in France, but without breaking the strong ties with the country of origin. (Lille Background Report 2003)

1.4 Sweden / Gothenburg (Gunnared)

"Sweden was the first Nordic country to become a country of net immigration and, in 1993, the share of the foreign population in the country was 5.8 per cent of the total population. During the 1950s and the 1960s the migration flow consisted mainly of migrant workers and the migrant's situation in the labour market was similar to the rest of the population" (ILO 1998: 2). From the end of the 1980s on, the influx of migrants was dominated by refugees and asylum seekers. Another important immigration group is due to family reunification.

Altogether, immigrants come from a relatively large number of countries. Finns accounts for about 25 per cent and other Nordic nationals for another 14 per cent of all foreigners. During the 1990s those of European origin became proportionately less than those from countries outside of Europe. This was reversed in 1993 when large numbers of refugees came from former Yugoslavia. (ILO 1998: 2)

1.4.1 BME Elders in Gothenburg

At the beginning of 1999 there were 130,000 elders living in Sweden who were born outside of the country. From the Swedes aged 65 years and above this is a share of 8,6%. Altogether, elders born outside of Sweden represent 146 nationalities.

Almost half of the elders born outside Sweden are born in a Scandinavian country. Nine out of ten are born in a European country. More than every tenth person in the age of 65+ was born in a country outside Europe. The most common countries of birth are Chile, Iran, Iraq, Turkey, China, Syria, Lebanon and India. This following figure is for the whole of Gothenburg.

Figure 8: Older People from Ethnic Minorities in Gothenburg 2000

Country	55-64 years	65-older	Total 55-w
Finland	2147	1490	3637
Former Yugoslavia	1874	1087	2961
Germany	562	714	1273
Poland	384	505	889
Estonia	217	466	683

Iran	443	398	841
Hungary	445	271	716
Turkey	237	208	445
Other countries	3447	4558	8005*
Total	9756	9697	19453

From Denmark and Norway 3076

Source: Gothenburg Background Report 2003

The group per se does not have or risk more problems in its contact with the system of social or medical care for elders. But within this group there are sub groups and individuals that need to be recognised in order to create reasonable living conditions.

1.4.2 Elders in Gunnared

The city of Gothenburg is divided into 21 districts. Gunnared[3] is a suburb district in the outskirt, with 21 000 inhabitants and 8000 households. The buildings inGunnared were built between 1960-70, most blocks are flats. About 50% of the inhabitants have immigrant backgrounds. Many are refugees. More than 30% of the households receive allowances. People aged 65 years and above make up 9 % of the total population and comprise about 1800 people. About 44% of these have a different ethnic background than Swedish. (Gothenburg Background Report 2003)

Figure 9: People Aged 65 Years and Above in Gunnared by Non-Swedish Nationality in 2000

Country	%
Finland	5,4
Denmark & Norway	1,7
Former Yugoslavia	8,2
East Europe	5,0
Iraq	5,5
Iran	4,5
Turkey	0,3
Lebanon	1,5
Other Asian Countries	4,4
Somalia	1,8
Other African Countries	2,4
Latin America	2,3

Source: Gothenburg Background Report 2003

[3] The following data and also the description of services for BME elders refer to Gunnared and not to Gothenburg as a whole.

BME elders in Gunnared are currently mainly from Iraq, Iran, former Yugoslavia, Finland, Poland, South and Central America and Somalia.

2. Social-Political and Legal Aspects

As mentioned before, the four countries involved in the project SEEM are characterised by different socio-political, historical and legal circumstances that indirectly influence the way the respective welfare system treats BME elders and develops benefits. In how far BME groups are excluded or included in the prevailing social security system is largely dependent on their legal status. In general, when they are citizens, meaning they do have the prevailing citizenship, they have full political and social rights and are entitled to the whole spectrum of welfare services.

The following chapter gives an overview of the diverging frameworks in each country.

2.1 United Kingdom

2.1.1 Type of Welfare State

Compared with other welfare systems, the system of social security in Great Britain is of special interest as it can be characterised as a hybrid form of different welfare state types[4]. It combines: 1. elements of the conservative welfare state type, as social security benefits are of more relevance than welfare benefits, 2. elements of the liberal welfare state as the extent in which social security benefits compensates income is very low and 3. elements of the social-democratic state as the social security system has an universalistic approach (in covering the whole population) and welfare benefits are predominantly provided by the public sector. (Schmid 2002: 164) The hybrid character of the British welfare state is reflected by the typology 'liberal-collectivist'. It means on the one side that the institutions 'market' and 'family' are still providing important welfare functions and the system of social security only compensate these when they fail (individualistic welfare approach). On the other side the system of social security is characterised by direct public provision of welfare, universality and national unity and thus has collectivist features. According to the 'liberal-collectivist' approach, social security benefits only cover a 'social minimum', further risks have to be dealt with through private precautions.

The three basic principles of the British welfare state go back to Beveridge and include universality, comprehensiveness and appropriateness of benefits. These principles are based

[4] In 1990, Gösta Esping-Andersen has developed three different models of welfare states: the liberal, the conservative and the social democratic type. (Schmid 2002: 83ff.)

on the idea of ‘citizenship’. Analogous to political rights, individual citizens have social rights which means that regardless of income or profession they are entitled to appropriate welfare benefits. (Schmid 2002: 164f.)

2.1.2 Old Age / Services for Elders

Within the National Insurance older people in the UK are provided with a basic state pension and an additional pension (SERPS) based on income. To receive a full state pension the insured person must have paid insurance contributions for at least 90% of his or her working life in a minimum amount. In cases where the number of years of insurance contributions is lower, the state pension is reduced. The full state pension is relatively low and approximately equals a third of the average income of an industrial worker.

In 1978 an additional pension based on income was introduced which is paid in full amount when insurance contributions have been paid for at least 20 years. Altogether, the highest rate fora pensioner which includes both the full state pension and the SERPS approximately equals 50 per cent of the average income of an industrial worker.

Parallel to these state pension schemes voluntary pension insurance schemes of companies have gained weight. There are also voluntary private pension insurance schemes. (Schmid 2002: 167f.)

In the UK, social services for elders comprise a broad spectrum. Community care for elders aims at securing an independent and self-determined life in freedom and dignity. Outpatient services (services at home) enjoy priority in comparison with services in institutions.

Community care in a broader sense comprises the whole spectrum of services and care that can be chosen by different groups to get the right level of intervention and support but in a closer sense it focuses on outpatient care and services. (Means & Smith 1998)

Although legislation in UK aims at including the delegation of provision of services to the private and voluntary sector, the public sector, in contrast for instance to Germany, is still the biggest provider of personal social services for elders in the area of health and social care. In terms of providing social services for BME elders, the black voluntary sector plays a predominant role. Due to a lack of public and mainstream voluntary services, many of those services have evolved because BME voluntary organisations have chosen to fill in those niches. Compared to Germany, however, there is evidence that relations between BME organisations and public institutions are closer and are initiated by both sides. (Rex 1991)

2.1.3 Integration Policy and Anti-Discrimination Legislation

As mentioned above, until 1962 most immigrants from the Commonwealth automatically gained British citizenship when entering the country and thus the overwhelming majority of BME elders are British citizens and have full political rights. (Gerling 2001)

UK has had anti-discrimination legislation since 1965 that is based on the membership of individuals in ethnic or racial groups that are generally acknowledged and whose development is legally made possible and politically promoted. (Schulte 1995) The Race Relation Act (1976) forbids direct and indirect discrimination on grounds of skin colour, race, ethnic or national origin. (CRE 1997) With section 71, the Race Relations Act has also focused on local authorities since 1976. (Randall 1991) With the Race Relation (Amendment) Bill 2000, the area of responsibility has been broadened: all public institutions carrying out all public functions fall under the Act and similarly private institutions that carry out public functions such as education. Moreover, in case of illegal discrimination, the Act also aims at tightening up sanctions. (CRE 2000)

Furthermore , the UK views itself as a cultural pluralistic society and has a more multi-culturally orientated integration policy that defines integration "not as a flattening process of assimilation but equal opportunity, accompanied by cultural diversity, in an atmosphere of mutual tolerance" (Baringhorst 1991: 41f).

This legal framework has had a clear impact on the development of social services for elders from black and ethnic minority groups. First of all, providers of social services fall under the Act and can obtain relevant information by means of a host of guidelines and policy models of public and voluntary institutions. Ever since the topic of social services gained in importance within the last ten years, additional guidelines have been developed that support public providers of social care in considering the specific needs of elders from black and ethnic minority groups (for instance by the Commission of Racial Equality and the Social Services Inspectorate). Amongst other things, recommendations aim at a closer co-operation between relevant actors in the public service sector and ethnic minority groups themselves. The British multi-cultural approach of anti-discrimination legislation also has a clear impact on the delivery of social services for BME elders themselves: In contrast to Germany, specific and separate services for elders from black and ethnic minorities are more widespread and not regarded as an obstacle to integration. Following this approach, translated information material as well as translation and interpretation services are also more common than in Germany. (Gerling 2001)

However, in a 2001 Social Services Report, Leeds City Council emphasises that in the past, policy had over-emphasised either assimilation or alternative separate provision. The former failed to acknowledge cultural diversity, while the latter has led to marginalisation for some minority ethnic users. Thus, Leeds City Council is adopting the Commission for Racial Equality strategy which aims at delivering all services in a way that is culturally appropriate for all users, while leaving scope for minority ethnic groups to develop and provide services as well. (Leeds Background Report 2003)

From the German perspective, BME housing associations offering, for instance, sheltered housing for BME elders are a striking characteristic of the British welfare system.

British anti-discrimination legislation has also influenced the NHS and Community Care Act (1990) which is the legal basis of community care for elders. Following the NHS and Community Care Act (1990), local authorities must consult certain population groups such as users and carers when developing community care plans. (Means & Smith 1998) In this Act, people from BME groups are explicitly regarded as having specific needs and demands that have to be met. Social services departments in their role of public providers of social care for elders are made responsible for identifying specific needs of BME elders and for considering different ideas about community care. It is not clear, in how far the Act has contributed to a better provision of services for BME elders in general. In an exemplary manner, the city of Leeds has significantly improved its consultation of elders from black and minority ethnic groups. (Gerling 2001)

2.2 Germany

2.2.1 Type of Welfare State

Germany can be described as the prototype of the conservative welfare state. It belongs to the pioneer countries that implemented a social security system whose development goes back to the middle of the 19th century. In the beginning its provision didn't even cover basic life needs. The German system of social security was aimed at the working population and thus was not thought of as a minimum securing, which is still the case today. The original four pillars of pension insurance, health insurance, accident insurance and unemployment insurance have remained the same and were completed by the long-term care insurance in 1995. (Schmid 2002: 105f.)

The German constitution determines Germany as a 'social state under the rule of law'. Furthermore there are leading principles and political ideas that function as general political orientation and identification criteria and comprise freedom, equality / solidarity and social

fairness. Another important principle is that of subsidiarity, which means that self help plays a crucial role. The government or the society should only help when a person is not longer able to help himself.

2.2.2 Old Age / Services for Elders

The German pension insurance is based on a system of contributions of the working generation that are used to pay the pensions of the former generation ('generation contract'). Pensions in old age should provide for an adequate income and are more or less automatically adapted to rises in salaries and prices. The group of insured people consists of compulsorily insured blue and white collar workers and trainees and voluntarily insured housewives and self-employed people. Contributions are made equally between employers and employees. The amount of the pension is determined by three factors that are part of the so called pension formula. (Schmid 2001: 111)

In Germany, as well as in other countries, social services for elders comprise a broad spectrum. Just like in the UK, community care for elders aims at securing an independent and self-determined life in freedom and dignity. Within social services for elders there is in general a distinction between 1. so called 'open' community care services that comprise offers in the field of leisure and culture, 2. outpatient services (services at home), 3. inpatient services (institutional care) and 4. a combination between inpatient and outpatient services (intermediate care). Due to the principle of subsidiarity, outpatient services enjoy priority in comparison with services in institutions.

In Germany, there is a clear separation between social and health services that often leads to problems of co-ordination. Services in the field of 'open' community care are in general provided by the municipal level and the voluntary welfare sector.

Services for ill elders (health care) and elders in need of care are provided by the health care system and the long term care system for which the federal level is responsible. (Naegele 1999) Both are financed by health insurance and long term care insurance. Health care is mainly provided by the private sector such as general practitioners and hospitals. Long term institutional care is provided by nursing homes (mainly run by charitable associations) and long term outpatient care by private outpatient services and outpatient services run by the charitable associations.

Most social services in Germany are based on the welfare state principle and are financed publicly (i.e. through taxes). In terms of the provision of community care for elders, voluntary

organisations have a limited priority in comparison with public providers except for services in the field of responsibility of the German long term care insurance. That is due to the German principle of subsidiarity (Bäcker, Bispinck, Hofemann & Naegele 2000).

Thus, the so called Wohlfahrtsverbände (charitable associations) as providers of community care for elders as well as for other groups play a predominant role in Germany. Although the welfare sector is very large and has many different organisations, there are five of special relevance that are denominational or ideological ('weltanschaulich') in nature: Arbeiterwohlfahrt (AWO), Caritasverband (CV), Diakonisches Werk (DW), Deutscher Paritätischer Wohlfahrtsverband (DPWV), Rotes Kreuz (DRK) and Zentralwohlfahrtsstelle der Juden in Deutschland, and all of them also work at local level.

They do not only offer community care services for all age groups but also offer advice services for people from ethnic minority groups (so called Migrationsberatungsstellen). In the beginning, those services primarily focused on guest workers and thus issues that had to do with their status such as work related or legal questions. Meanwhile those advice services focus on all groups of immigrated people and the range of advice fields has been broadened. (Gerling 2001) Due to the ideological nature of the Wohlfahrtsverbände, they used to be responsible for advice to different ethnic minority groups: The catholic Caritasverband for instance used to advise catholic groups such as Spanish people and Italians and the non confessional orientated AWO concentrated on Islamic groups such as people from Turkey and former Yugoslavia. The Diakonisches Werk offered advice services for people from Greece. (Filtzinger & Häringer 1993) However, this splitting up of responsibilities has been weakened at local level within recent years.

2.2.3 Integration Policy and Anti-Discrimination Legislation

Today, Germany is the world's third biggest immigration country and although official politics still tend to deny that fact, there is a lot of experience with immigrated groups and there are some good examples of how indigenous and immigrated groups can live with each other. In terms of social services for foreign elders there were some bigger model projects in Germany that aimed at developing concepts and strategies of action on how to integrate BME elders within the German system of community care for elders and make sure their special needs are being met.

There is an ongoing debate on integration issues that is not yet resolved. Different political parties have obviously diverging opinions and concepts. In general, integration policy in Germany has a strong tradition of patronising immigrated people and is mostly seen as a one

sided process: According to that, immigrated people should adopt themselves to the German majority culture (whatever that is). Tradition and care of origin 'foreign' cultures is something that is not especially liked in Germany and is often seen as a cultural and social threat for the indigenous population. In this context, the provision of social services for foreign elders tends to take place in the mainstream sector and tries not to be too special, in the sense of, for instance, using translation services.

Although there are increasing numbers of immigrated people accepting German citizenship, most foreign citizens have only limited political rights. In general, foreign citizens do not have any right to vote (actively and passively). Only foreign people from the European Union have the possibility to vote at local level. No foreign citizens can vote on state or national level. Hence, politically, there is only a limited need to listen to 'ethnic' voices and thus immigrated people are restricted in applying pressure and lobbying. (Recommendation Report Dortmund 2003)

Germany does not have any anti-discrimination legislation. Compared to Great Britain, the development of social services for immigrant elders cannot be traced back to legal pressure, although the German Association (Deutscher Verein) explicitly points out that community care for elders has to focus on all senior citizens living in Germany: "The legal brief of community care for elders and its area of responsibility aims at all old people in Germany, i.e. also at immigrant elders" (Deutscher Verein 1998). Since the middle of the 1990s, the public sponsorship of model projects is a characteristic feature of the German attempt to gather information about the life situation of immigrant elders and about strategies for opening up services.

2.3 France

2.3.1 Type of Welfare State

The French welfare state is often described as a weakened conservative model. The French history of developing the welfare state can be divided into four phases: 1. original restraint of the state in the social sphere, 2. promoting private initiatives through subsidies, 3. progressive development of statutory duties, 4. actual generalisation of the 'sécurité sociale'. Based on a strong tradition of individualism and liberalism (meaning that the role of the state should be reduced to a minimum and individuals should be made solely responsible for their lives) emerging systems of social security were on a voluntarily base in the beginning and only covered more affluent population groups. More and more the principle of insurance was then

replaced by the principle of welfare which put a higher responsibility on the side of the state to care for its citizens. It was not until the 1930s that France introduced a comprehensive system of social security. Compared to the German system of social security which was mainly based on the system of insurance, that of France is more dominated by elements of welfare and thus is called a weakened conservative model. Due to an insurance structure that orientates itself strongly at profession groups the French welfare system is very complex and divided up into different sectors. The system is structured into four main systems that differ according to the groups covered:

1. The 'régime génerale' covers 75% of all insured persons and is a compulsory insurance for employees in the fields of trade, industry and services. It covers the risks old age, sickness, invalidity, work accidents and profession diseases, bereaved family members and family allowances.
2. The 'régime agricole' covers employees and self-employed people working in agriculture. However it only covers the risks of old age and bereaved family members.
3. The 'régime spéciaux' covers special insurance for special groups such as state officers, employees in the military and miners.
4. The régime autonome' for self-employed people covers the same risks as the 'régime génerale'.

In France unemployment insurance is not part of the general system and is run under a different law. Furthermore many different compulsory and voluntary insurances exist. The whole system of social security is mainly financed by contributions paid by employees and employers. (Schmid 2002: 140ff.)

2.3.2 Old Age / Services for Elders

In France, as well as in Germany, old age pension refers to employment and there does not exist an universal minimum state pension as is the case in the Scandinavian countries and the Netherlands. In old age, three types of pension can be obtained: a contribution based pension, a means tested supplementary benefit and a compulsory additional pension. It is a characteristic feature of the French pension system that the average amount of pensions is relatively low because an upper limit exists. However the compulsory additional pension must be added to get the real picture.

Beside these pensions the French state gives incentives to promote private precautions. (Schmid 149ff.)

In France, public policies for elder people have evolved a lot over the last few years because of the increased life expectancy of the population and changes in the ways that families are organised. The result today is that a new risk related to ageing is developing: dependency (that is, the need for elder people to seek assistance which allows them to carry on the various activities of everyday life).
The old-age benefit payment guarantees that all those aged 65 or above can receive a basic income.

At a local level the following services are available for elders:

⇒ *Home helps* aims to carry out a substantial and social job in the homes of older people, serving to maintain them where they are. Home-help tasks include housework (cleaning, shopping, cooking) as well as any support which enables people to stay in touch with the outside world.

⇒ *Home-help costs* can be provided for, in part, by a benefit (social security) granted according to age (65 or 60 and unfit for work), wealth, and the submission of a medical certificate.

⇒ *Home-care services* provide nursing and health care on medical prescription, together with chiropody and occupational-therapy visits. They provide overall care, treatment, and support. Those benefitting from these services are aged 60 and above. Health insurance takes care of the costs.

⇒ *Day centres*, usually part of an accommodation provider, offer a place to meet, as well as support in daily life, and meals. Their existence requires no legal basis.

⇒ *Council-run social-programme centres* are state-run establishments under the authority of town halls. Every district is obliged to have one. There are a variety of benefits for elders, for instance:

- canteens which provide meals at a reasonable price and places to meet,
- meals-on-wheels services and
- services providing odd odd jobs and repairs.

⇒ *The Individual Self-sufficiency Benefit* (I.S.B.), implemented in 2002, is financial aid aimed at older people, aged 60 or above and resident in France, who are losing their self-sufficiency. The level of assistance is related to wealth and the degree of loss in self-sufficiency. This benefit is designed to pay for home care (meals, alarm systems, home help, etc.) as well as housing with an accommodation provider.

When older people can no longer live at home, there are a number of types of accommodation available. Accommodation for elders comprises the following benefits:

⇒ *Communal housing*: This allows people to enjoy independent housing whilst benefiting from collective services (meals, etc.). This type of establishment is designed for elder people who are self-sufficient, whilst requiring occasional help.

⇒ *The retirement home*: Whether it is run privately or by the State, the retirement home offers rooms with one if not two beds, as well as collective services (care and treatment, accommodation, meals, laundry, room maintenance, etc.). Certain homes have their own medical treatment centre (with the necessary equipment and staff for providing the care required by the resident's state of health, where the resident's state of health does not require constant attention).

⇒ *The long-term care unit*: Part of a hospital, this unit houses older people who are no longer self-sufficient, and whose state of health requires constant medical attention and on-going treatment. For accommodation in retirement homes and long-term care units, different benefits are available: social security benefits and I.S.B.s (l'A.P.A.). It should also be noted that the notion of maintenance obligation exists in France. The families of people housed in a retirement home are obliged to contribute to the costs of accommodation according to their means.

Older people whose faculties have deteriorated need to be protected in their activities in civil life, as much from themselves as from others. There are three systems of protection which may be implemented when an older person has mental or physical difficulties which prevent him/her from managing his/her affairs correctly.

The penal code:

⇒ forbids the neglect of a person unable to protect him-/her-self because of his/her age;

⇒ forbids the abuse of a person's vulnerability by putting them in housing conditions unfit for a human being;

⇒ enables increased sentences to be given where the victim is a person whose vulnerability, related to age, is apparent or known. (Lille Background Report)

In France, in general, access to the compulsory social security system for foreigners depends on their residency in the country. However, an act from 1998 has brought some positive alterations. It created 'retired' cards for foreigners who have lived in France to enable them to receive an old age pension. French nationality is not a precondition any more for obtaining

non-contributory benefits. Still, some practical difficulties remain. (Alidra, Chaouite & Abye 2003: 43)

2.3.4 Integration Policy and Anti-Discrimination Legislation

Unlike other European countries, France has always been affected by a strong tradition of immigration. In the mid 19th century France was using a substantial foreign workforce and in 1881, there were about 1 million foreign people working there. Before World War II and during the 1920s, immigrants came almost exclusively from elsewhere in Europe and were mainly recruited by private companies. After the War immigrants came mainly from those countries that were linked to France by colonialism: the Maghreb, Asia and Africa. The state took a more direct role in controlling migration. Until the 1970s, most immigrants came as workers whose presence was just like in Germany considered to be temporarily. After the economic crisis in 1970 and due to family reunification, many temporary immigrants became settled and 'integration' became the watchword of immigration policies. The French way of integration is characterised by firm basic principles such as 'participation of immigrants in society', 'individual equality before the law', 'secularism' and the 'exclusion of minority logic'. However, for a long time, immigration policy was reduced to controlling the numbers of those trying to enter France.

As described above, immigrants in France can be divided into two groups: just like in Germany, under the legal definition an individual is either French (by birth or by naturalisation) or a foreigner. Thus a foreigner is somebody who lives in France but does not have French nationality. An immigrant, whether naturalised or not is defined as having an invariable characteristic which is his/her place of birth and according to that immigrants comprise people who became French by acquisition and people who are foreigners. In 1999, there were, from about 5.6 million immigrants, 2.4 French by acquisition and 3.3 foreigners. (Alidra, Chaouite & Abye 2003: 33ff.) Thus, just like in Germany, but to a lesser extent, there are high numbers of foreigners who have very limited political rights.

Up until 1945, there was no immigration policy, in a literal sense, only measures taken on an ad-hoc basis. The publication of the government order of November 2nd 1945 symbolises the start of the implementation of the State's real involvement in this area. If this order does not really represent a break with the preceding period, it is still nonetheless a key reference text fifty years later. Today, law sources are complex and include not only French legislation, but also conventions, treaties, and bilateral agreements. With the enforcement of the Treaty of

Amsterdam, the community sphere in the areas of immigration and asylum is clearly established (that is, after a period of 5 years; by 2004 at the latest). Until policies across Europe are brought into line with each other, the questions of immigration and asylum will largely be dealt with on the national level.

Like the UK and Sweden, France has anti-discrimination legislation. In contrast to the UK, the political logic does not refer to a multi-cultural policy of minority groups, but to a policy of individual equality. The basis of the latter is the individual regardless of their origin, their belonging to ethnic groups or their beliefs and thus yields at a an achievement of an equal status of individuals. Minority groups are not institutionally acknowledged and their development is not promoted. Underpinning ideas of the French approach are the orientation of Enlightenment, a central state and a unity of the nation and their citizens. This policy of individual equality tends to deny and neglect existing ethnic differences. It lays emphasis on assimilation and does not promote disadvantaged groups. Against this background, the French model of integration policy is also characterised as 'ethno-centric assimilation'. (Schulte 1995: 13)

The French anti-discrimination legislation goes back to 1972 and is termed 'Law Against Racism'. Since then it has been amended a lot of times. It covers the same range of discrimination and injuries with a racial intent as the 1976 British Race Relations Act . A person who appeals to discrimination, hatred, or violence against persons or groups due to their origin, ethnicity, nationality, religion or race can be prosecuted. (Kowalski 1995: 45) In contrast to the UK, there is no concept of indirect discrimination although institutional discrimination is recognised. (Lloyd 1991: 69)

Citizenship is not simply defined by the right to vote. But the right to vote is a component of citizenship and, of course, those immigrants who have become French are eligible and do have the right to vote. Immigrant people who do not have French nationality (apart from European nationals) are still excluded from voting at local elections.

What, then, is the status of immigrants (be they foreign or not) in society? With regard to accommodation, employment, sending their children to school, cultural and associative self-expression, as well as health, the same laws apply to everyone (employment code, penal code, social-security code, etc.). However, these regulations and laws do not always suffice to cut out discriminatory practices, as certain organisations testify, in terms, particularly, of access to work, council housing, and certain cultural structures.

Once they have been helped to settle in, immigrants (many of whom take French nationality) have in principle the same rights in all aspects of daily life: whilst there is no practice of positive discrimination in France, there are support programmes for certain groups (e.g. young new arrivals going to school, and people who wish to make a career change).

Whilst permanent residency is fixed as a condition for applying for council housing, having the right to certain benefits, and finding a job, it is no guarantee of these same basic rights, as revealed by numerous reports into discrimination, particularly those produced by *G.E.L.D.* (*Groupe d'études sur les discriminations* / Forms of Discrimination Study Group), and as acknowledged by politicians. (Lille Background Report)

2.4 Sweden

2.4.1 Type of Welfare State

Sweden can be regarded as the prototype of the modern welfare state or the classical social-democratic welfare state. In the 1930s the traditional welfare for the poor was replaced by a social policy based on the ideals of the social-democratic party. It was mainly characterised by three elements:

1. The metaphor of the 'Swedish Citizens Home' that combined the features of the future welfare state 'equality', 'consideration', 'co-operation' and 'helpfulness',
2. Comprehensive solidarity to reduce competition and social injustice
3. the definition of social policy as a social investment orientated at anti-cyclic economic politics.

According to those principles the existing system of social security was expanded. The central element was a non-contribution orientated minimum state pension that covers Sweden's entire population. From the 1960s on, the share of social expenditures within the national gross product grew from 15.9 per cent to 33.5 per cent.

The basic orientation of Sweden's political culture is more collectivist than individualistic and is reflected in the universality of the welfare system. Accordingly, the entire population and not merely employees are secured against central risks such as old age or sickness and the public provision of social benefits dominates. To avoid stigmatisation, means-tested supplementary benefits are avoided as much as possible. (Schmid 2002: 203 ff.). Financially, the Swedish welfare system is based on a combination of taxes and contributions that is increasingly related to income.

2.4.2 Old Age / Services for Elders

In 1999, a new pension system was introduced. There are two types of old age pensions: a minimum state pension that is financed completely by taxes and an additional income-related pension scheme that is based on contributions. (Schmid 209 ff.) After decentralisation in the 1980s, the elected councils are responsible for the administration and performance of health and medical care. The task of social services is traditionally the duty of the 288 elected municipalities. Due to the Social Services Act, the municipalities are responsible for providing their residents with services covered by the Act. They are relatively independent to design their programmes according to local needs and the goals stated in the Act. The spectrum of social services for elders is very broad and spans from residential homes for the very old to home help services that have been expanded from the 1960s on and now benefit

some 300 000 pensioners. There are municipal pensioners' dwelling that are an intermediate form of housing care based on a high degree of self-help. In Sweden, as in other European countries the concept of care of older people has changed from supporting them in institutions to assisting them to stay as long as possible at home. As a result, older people are now themselves paying more towards the services they receive. Due to economic crises, from the beginning of the 1990s on, there has been a trend for welfare cutbacks whose inevitability is accepted even by the Social Democrats. (Ahn & Hort 1999: 137ff.)

According to the law there is the 'National Action Plan on Policy for Elders'. Additionally, each city has to write a local plan. The new plan has three main priorities.
The first is to create good opportunities for older people to live an independent life so that the need for care of elders is delayed.
The second is that nursing and care are of such a good quality that older people feel secure in continuing to live at home, thereby reducing the need for places in homes for the elders.
The third is the need to extend collaboration between care of elders and nursing care as a joint commitment, so that individuals feel a sense of security and involvement in the transition between one form of care and another.

The goals can be described on three levels:
1. Structural level:
⇒ General views of society towards elders
⇒ Urban planning / co-operation
⇒ Communications / transportation system
⇒ Shopping accessibility
⇒ Service fields: medical, social, information
⇒ Standards of houses / apartments (elevators, surface etc.)

2. Group level
⇒ Information and service in fields of special knowledge, such as pension systems, health, style of living, rebuilding apartments
⇒ Meeting places
⇒ Meals on wheels
⇒ Support of clubs and voluntary organisations
⇒ Technical aids and equipment: easy to obtain

⇒ Alarm and security systems: use and further development

⇒ Good education and training of staff taking care of elders

3. Individual level

⇒ Care given on the basis of individual needs and not based on routine systems

⇒ Individual planning / co-operation of social and medical care

⇒ Evaluation of the care given at regular intervals

⇒ Help and care given from a rehabilitation point of view

⇒ Offer of a good every-day life and cultural and leisure-time activities

⇒ Final care at home in co-operation with medical care

Care of elders must be delivered with good quality, friendly service and clear goals. Preventive work and outreach activities are important issues for the districts. Almost all districts carry out prevention activities through day centres, senior weeks and days for elders, drop-in centres, etc. Many of these activities are organised in co-operation with pensioners' organisations and voluntary organisations. Several district committees also have outreach activities for 75 or 80-year-olds, providing information on topics such as the administration's activities, associations and care of elders.

In Sweden, there are inspection systems to maintain a good quality of care for elders. The local authority is responsible for evaluating and making sure that each individual has an adequate standard of living. Every Swedish municipality must have special nurses (Medical Nurses), who are responsible for clients receiving the medical care they need.

The 'National Board of Health and Welfare' gives general advice on the abuse of elders. If staff find that abuse of elders, who are depending on help and care, is taking place, it must be reported in a special way. The manager of a unit has to make sure that the entire staff know about this.

Challenges in Sweden lie in the maintenance of a good quality of care, of regular evaluation and support and further education of the staff.

2.4.3 Integration Policy and Anti-Discrimination Legislation

In Sweden, most of the BME groups are naturalised, for instance, regarding the group of elders born abroad, 76 per cent of them are naturalised.

The experience in Sweden of taking care of BME elders is short. During the 1950s to the 1960s the only immigrants who came to Sweden came for work. Many of these people moved back to their home country when they retired. In the last twenty years other immigrant groups have come to Sweden. Most immigrants are refugees with traumatic experiences and especially many BME elders suffer from mental illness.

The first Anti-discrimination legislation was introduced in 1986 ("The anti-discrimination law"). It has been revised twice and the present law dates from 1999.

The legislation for social welfare is from 1989 and is called " The Social Service Act" .This law guarantees a right of assistance if the help needed cannot be met in any other way. If an individual is dissatisfied with a decision, he or she can go to court.

Home help, transport services and organised daytime activities are examples of services, which, according to law, should be available in every municipality. For old people who cannot live at home anymore, the municipalities must provide special housing, e.g. old people's homes, group dwellings and nursing homes. (Gothenburg Background Report 2003)

3. Life Circumstances

Although BME elders are very heterogeneous groups in all four countries' respective cities and face very diverging life circumstances, there is evidence that compared to indigenous elders they tend to be more disadvantaged in many fields of life.

3.1 Income

In Great Britain, there are significant differences between and within BME groups in access to material and social resources. For example, Indian older people are least likely to experience multiple deprivation, displaying similar levels to white older people; while under half of older Pakistanis and Bangladeshis, two-fifths of older Black Caribbeans, and a quarter of Irish elders experience medium or high deprivation.

As to the economic situation of BME elders:

⇒ One third of older Black Caribbeans, half of older Indians, and three fifths of Pakistani and Bangladeshi older people are in the bottom fifth of income distribution. This compares to just over a fifth of white and a quarter of Irish older people.

⇒ A lower proportion of minority ethnic elders are in receipt of a pension from their former employer than white or Irish older people.

⇒ Three quarters of older Pakistanis and Bangladeshis and three-fifths of Black Caribbean elders are in receipt of Income Support. (Leeds Background Report 2003)

In Germany, there is also evidence that BME elders have less income than indigenous elders. This is due to migrants' specific lower earnings that go back to a shorter period of steady income, less qualified and thus less paid jobs and the fact that many guest workers transferred money to their countries of origin. Again, differences between ethnic minority groups exist. (Gerling 2001: 49)

In France too, many BME elders who used to work in the steel or chemical industriessuffer from invalidity or long-term unemployment and thus face difficult economic circumstances. (Lille Background Report 2003) In France in general, the income of immigrants is lower than the national average. (Alidra, Chaouite & Abye 2003: 41)

In Sweden, a parliamentary committee stated that the differences between immigrants and other citizens, with regard to economic and social status, were substantial. (ILO 1998)

3.2 Housing

In relation to housing in Great Britain, older Black Caribbeans are most likely to live in local authority or housing association properties. Over a quarter of older Pakistanis and Bangladeshis live in households with no central heating, and over a third live in households with more than one person per room. (Leeds Background Report 2003)

In Germany, housing conditions for BME elders are poorer than those of German elders: In average they have less space and more often do not have their own toilet and bath. This is also reflected in subjective satisfaction with the individual housing condition that is poorer for BME than for German elders. (Gerling 2001: 52f.)

In France, about 20% of BME elders of non-European origin have remained single as they have grown older and live far away from their families in migrant workers' hostels. (Alidra, Chaouite & Abye 2003: 39) The ageing of these people does, however, raise the question of how adequate these structures are in terms of specific care. It should be noted that very often the cultural and religious dimensions are taken into account in these hostels, and this explains

the attachment of residents to these places. (Lille Background Report 2003) Nothing is known at the moment about the living conditions of those BME elders living outsides these hostels. (Alidra, Chaouite & Abye 2003: 39)

3.3 Health

In Great Britain, BME populations are the highest users of primary care services, yet less likely to gain access to appropriate health services and treatment, and they report the worst health outcomes. Older people from minority ethnic groups are more likely to describe their health status as poor than the total population. Health status varies between different groups. Leaving aside refugees and asylum seekers, people from the Bangladeshi, Kashmiri and Pakistani communities tend to suffer the worst health. This is linked to their low socio-economic status as well as to access problems. Physical and mental health for all BME elders is also affected by harassment and violence, and by social isolation. Although many BME elders are registered with and use their GP services, the use of community health services (e g district nursing, foot care) tends to be low.

Findings of a recent Help the Aged and PRIAE report on the experiences of BME elders in hospital showed that older people receive a different level of service dependent on their command of the English language; food quantity and quality is often inadequate. The report also identified a need to employ more nurses from minority ethnic groups. (Leeds Background Report 2003)

From the data available in Germany, it can be stated that compared to the indigenous population, the health of the foreign population is poorer. (Heinicker, Kistler, Wagner & Widmann 2003: 65) That is especially the case for BME elders. BME elders also tend to suffer more from mental disorders. The poorer health of BME elders is also reflected by their own perceptions: a regional survey for Hamburg found that while some 14.7% of older German residents of Hamburg felt that their health was ‘very good’ and some 61.4% described it as ‘rather good’, the corresponding figures for the BME elders were 5.6% and 40.5%. Again, there were great differences between different ethnic groups. The percentage of those describing their health as poor was a lot higher amongst BME than German elders. (Freie & Hansestadt Hamburg 1998: 96)

Available data in France also suggests that the foreign population faces a higher risk from certain illnesses for instances regarding pathologies linked to bad housing conditions, tuberculosis and pathologies linked to nutritional deficiencies as well as diseases of the respiratory tract. (Alidra, Chaouite & Abye 2003: 45)

Evidence from Sweden suggests that especially the group of (elder) refugees and asylum seekers suffer from mental illness due to traumatic experiences. (Gothenburg Background Report 2003)

3.4 Access to Services

Because of a number of barriers, access to health and social services is a lot more difficult for BME elders than for indigenous elders. The barriers exist both on the side of BME elders themselves and on the side of service providers. They comprise at least the following:

Side of BME elders:

⇒ Language barriers
⇒ Insufficient knowledge of availability of, and rights to, social and public services
⇒ Low expectations of their lives
⇒ Negative experiences of retirement
⇒ Negative experiences with services used before
⇒ Certain cultural and religious concepts
⇒ Fear of being discriminated against
⇒ Poor mental and physical health
⇒ Inadequate support from their families

Side of service providers:

⇒ Racism – overt and often inadvertent – at individual and institutional levels. This includes 'professional' assumptions that their family will provide care and a 'colour-blind' approach to service provision and assessment
⇒ Myth 'they care for their own'
⇒ Universalistic and 'colour-blind' approach of service delivery
⇒ Lacking staff of matching ethnic background
⇒ Lack of knowledge of the life situation and life styles of BME elders
⇒ Lack of consultation with BME communities in service planning and delivery
⇒ Lack of cultural sensitivity (especially concerning communication, care, food and religion)
⇒ Lack of information about the services in languages of BME elders (Leeds Background Report 2003; Gerling 2001: 267)

The lack of cultural sensitivity is reflected in the high rate of people either not accessing or being refused to services.

3.5 Discrimination

There is evidence that in all four countries discrimination against BME elders occurs. Due to different legal frameworks the phenomenon is addressed differently. For instance, in the UK that has an anti-discrimination legislation it is openly addressed and often subsumed under the term racism. In Germany, the term racism is used more seldom and almost exclusively by members of the very left political wing.

In France, a poll from 2002 revealed that 59% of French people believed that there were too many immigrants in France – this is a view heavily promulgated by national populist political parties. The situation has partly and is still trying to be improved through ant-discrimination campaigns and the setting up of groups to study and fight against discrimination. (Alidra, Chaouite & Abye 2003: 37)

In 1993 the Swedish Discrimination Ombudsman published a survey concerning immigrants' experiences of discrimination in various fields and it was shown, for instance that discrimination played an important part in difficulties encountered by immigrants in the labour market. (ILO 1998: 1f.)

3.6 Supplement: Results from a Workshop in Leeds Concerning the Main Issues BME Elders Face

During the second project meeting of SEEM, there were four workshops hosted by the Leeds Association of Blind Asians (ABA) that aimed at extracting the main issues BME elders face in the four cities involved in the project. All four workshops came up with following issues:

⇒ Poverty

⇒ Difficulties in or lack of access to services

⇒ Cultural isolation, feeling of being oppressed

⇒ Lack of information about existing services

Although these results are not researched scientifically, they give evidence to the disadvantaged life circumstances of BME elders described above. (Minutes of SEEM Project Meeting in Leeds)

4. Summary: Similarities and Variations

In relation to the BME groups and migrations histories, socio-political and legal aspects and the life circumstances of BME elders in the UK, Germany, France and Sweden, the following conclusions can be made.

4.1 Migration Histories and BME Elders

4.1.1 Migration History

Although linked to different migration histories (the UK and France being strongly influenced by their colonial past) all four countries are characterised by increasing processes of immigration after World War II. Great Britain experienced immigration from the New Commonwealth (especially the Caribbean Islands, India, Pakistan and Bangladesh), the latter consisting of subjects of the British Crown coming to the 'mother country', and also from Ireland.

Until the beginning of the 1950s, the situation in Germany was dominated by large numbers of refugees who mostly came from the former Eastern parts of the German Reich and the Sudetenland and people from the Russian occupation zone and the later-built German Democratic Republic. From the mid 1950s on, Germany recruited guest workers from South East Europe, North Africa and Turkey.

France had already became a country characterised by immigration at the end of the 19th century when they recruited workers from the neighbouring countries (especially Italy and Poland). In the 1960s there was a decline of immigration from Italy but an increase from Portugal, Spain, Morocco, Tunisia, Algeria and Sub-Saharan Africa.

From the 1950s on, Sweden had an influx of migrant workers that was replaced by refugees and asylum seekers from the 1980s on.

4.1.2 National Shares of BME Groups

Using the different statistical systems and also different terminology, it is difficult to compare the current national shares of immigrants or BME groups. However, the following numbers function as a first orientation.

In England, the share of BME groups is about 13per cent of the total population. In Germany, foreign people comprise about 9 per cent of the whole population, although the total share of people with a migration background (including for instance late emigrants and naturalised people) is higher. In France, the share of immigrants (that are both foreigners and naturalised

people) makes up about 7.4 per cent. In Sweden, the share of BME groups is about 2 per cent of the total population.

4.2 BME Elders at Local Level

In all countries, the numbers of BME elders are still relatively small but will increase significantly within the next decades. The composition of BME elders in the four cities Leeds, Dortmund, Lille and Gothenburg is very different.

In Leeds, there are at least 9,167 BME elders aged 60 years and above. There is a wide diversity of BME groups, but the biggest groups are Indian (1,120) Irish (about 2,800), Black-Caribbean (about 1,490), Pakistani about 880) and Jewish (about 2,680). Smaller groups are Arab, Black-African, Chinese, Bangladeshi, Vietnamese elders and Gypsies and Travellers.

In Dortmund, there are about 10,300 so called foreigners aged 55 years and above of which around 70% stem from former recruitment countries. Within the different nationalities, Turkish people have the highest numbers of elders, followed by elders from former Yugoslavia, former Soviet Union, Greece, Italy, Spain, Poland, Morocco and Portugal.

In Lille, there are about 3,000 immigrant elders aged 60 and above (1,755 foreign elders and 1,243 elders who acquired French nationality). Of all elder immigrants the biggest groups are Algerian (762), other European nationalities (580), Moroccan (491), Austrian, Finnish and Swedish (479) and Italian (270) elders.

In Gothenburg, there are about 19,450 BME elders aged 55 years and above. The biggest groups are from: other countries (5,029), Finland (3,637), Denmark and Norway (3,076), former Yugoslavia (2,961), Germany (1,276), Poland (889), Iran (841), Hungary (716), Estonia (683) and Turkey (445).

4.3 Social-Political and Legal Aspects

4.3.1 Type of Welfare State

The four countries involved in the project represent different types of welfare states, of which Germany and France have the most similarities.

The UK is best described as a hybrid form of the three different models of welfare state analysed by Esping-Andersen in 1990 (conservative, liberal and social-democratic). The British tradition is liberal-collectivist, which means that on the one side, elements such as self help have always played a crucial role and on the other side that social security benefits compensate income on a very low level. However, in the tradition of Beveridge, the system of social security is universalistic and collectivist. It plays a bigger role than welfare benefits.

The three underpinning basic principles include universality, comprehensiveness and appropriateness.

Germany is the prototype of the conservative welfare state and was one of the first countries to develop and implement a social security system. The approach is not aimed at giving its entire population a minimum security (as it is in Sweden) but rather concentrates on the working population. It is dominated by the principle of insurance and has the five pillars of old age pension, health, accident, unemployment and long-term care insurance. Within its constitution, Germany is determined as a 'social state under the rule of law'. Leading principles are freedom, equality / solidarity, social fairness and subsidiarity.

The French model of welfare state is often described as a weakened conservative one. In the tradition of individualism and liberalism, the introduction of a social security system took place relatively late in the 1930s. Compared to the German model which is based mainly on the principle of insurance, the French model has more elements of the principle of welfare in it. The French welfare system is very complex and divided into different sectors and subsystems that cover different population groups.

Sweden is the prototype of the modern welfare state or the classical social-democratic welfare state. In the 1930s, the traditional welfare for the poor was replaced by a social policy based on the ideals of the social-democratic party. Its underlying principles are equality, consideration, co-operation and helpfulness and it aims at comprehensive solidarity to reduce competition and social injustice. The basic orientation of Sweden's political culture is collectivist rather than individualistic which is reflected in the universal approach of the welfare system which covers the entire population. A central element of the Swedish system of social security is a non-contribution orientated minimum state pension, that covers the entire population.

4.3.2 Legal Status of Immigrants

How far BME groups are excluded or included in the prevailing social security system is largely dependent on their legal status. In general, when they are citizens, meaning they do have the citizenship of the respective country, they have full political and social rights and are entitled to the whole spectrum of welfare services.

In this respect, the legal status of people from BME groups is best in the United Kingdom where the majority are UK citizens.

In Germany, most people from BME groups are foreigners and thus only have very limited political rights. However, so called late emigrants are advantaged as they are regarded as

German citizens and become German when entering the country. The proportion of naturalised people is not very high.
In France, there is a bigger group of naturalised people from BME groups (about 2.4 million). Still, there are about 3.3 million foreigners with very limited political rights.
In Sweden, most immigrated people are naturalised, for instance, regarding the groups of elders born abroad, 76 per cent.

4.4 Old Age / Services for Elders

All four countries have a distinction between social and health care services for elders which often leads to problems in co-ordination and provision. (Schulte 1996: 97)
In the UK, social services for elders comprise a broad spectrum. Community care for elders aims at securing an independent and self-determined life in freedom and dignity. Outpatient services (services at home) enjoy priority in comparison with services in institutions. Community care in a broader sense comprises the whole spectrum of services and care that can be chosen by different groups to get the right level of intervention and support but in a closer sense it focuses on outpatient care and services. (Means & Smith 1998) Compared to Germany, home support services are a lot more widespread in the UK. Although legislation in the UK aims at including delegation of delegating the provision of services to the private and voluntary sector, the public sector, in contrast for instance to Germany, is still the biggest provider of personal social services for elders in the area of health and social care.

In Germany, social services for elders also comprise a broad spectrum. Just like in the UK, community care for elders aims at securing an independent and self-determined life in freedom and dignity. Within social services for elders there is in general a distinction between 1. so called ‘open’ community care services that comprise offers in the field of leisure and culture, 2. outpatient services (services at home), 3. inpatient services (institutional care) and 4. a combination between inpatient and outpatient services (intermediate care). Due to the principle of subsidiarity, outpatient services enjoy priority in comparison with services in institutions. Services for ill elders (health care) and elders in need of care are provided by the health care system and the long term care system for which the federal level is responsible. (Naegele 1999) Both are financed by the health insurance and the long term care insurance. Health care is mainly provided by the private sector such as general practitioners and hospitals. Long term institutional care is provided by nursing homes (mainly run by charitable associations) and long term outpatient care by private outpatient services and outpatient

services run by the charitable associations. Most social services in Germany base on the welfare state principle and are financed publicly (i.e. through taxes). In terms of the provision of community care for elders, voluntary organisations have a limited priority in comparison with public providers except for services in the field of responsibility of the German long time care insurance. That is due to the German principle of subsidiarity (Bäcker, Bispinck, Hofemann & Naegele 2000).

Thus, the so called Wohlfahrtsverbände (charitable associations) as providers of community care for older people as well as for other groups play a predominant role in Germany. Compared to other European countries, the extent and the role of the German charitable associations is unique. They do not only offer community care services for all age groups but also offer advice services for people from ethnic minority groups (so called Migrationsberatungsstellen). (Gerling 2001)

France has a great variety of services, help and institutions for the elders which is especially the case for outpatient and institutional services. Intermediate care is not that widespread. In France, too, elder people should have the possibility to stay as long as possible at home. There are several services assisting older people at home: home helps, home care services, day centres and council-run social programme centres. Apart from living at home the elders can obtain support and care in communal housing, retirement homes and long-term care units. (Lille Background Report)

Sweden also aims at giving older people opportunities to live an independent life as long as possible at home. The spectrum of social services for elders is very broad and spans from residential homes for the very old to home help services that have been expanded from the 1960s on and now benefit some 300 000 pensioners. There are municipal pensioners' dwellings that are an intermediate form of housing care based on a high degree of self-help.

4.5 Life Circumstances of BME Elders

Although great differences exist between ethnic groups, it can be summarised that compared to indigenous elders the life circumstances of BME elders are disadvantaged in many ways, and especially in relation to income, housing, health, access to services and discrimination.

IV Personal Social Services for Elders from Black and Minority Ethnic Groups

Against the background of disadvantaged life circumstances, growing numbers of immigrant elders and general social-cultural and structural changes within minority ethnic groups, it cannot be disputed that there will be growing needs and demands for services for BME elders in all four countries involved in the project. These services are of all kinds, and range from creating possibilities for independent living and social participation to providing special health and care services for much older people. Care needs of BME elders result from universal biological and physical age processes and in that sense do not differ from those of indigenous senior citizens, as far as generalisations are permitted in this context at all. Additionally, there are specific needs due to migration that result from the prevailing legal, cultural, ethnic, religious and linguistic backgrounds of BME elders. As mentioned above, apart from these there are also distinct care needs due to disadvantaged life circumstances.

The following chapter presents an overview of the different approaches and models of good practice of the four cities and the underpinning principles and criteria of success that build the basis for the way forward.

1. Approaches and Models of Good Practice at Local Level

According to different legal and socio-political frameworks there are different approaches and models of good practice concerning the development and provision of personal social services for BME elders at local level. Also the level of advancement differs between the four cities. Summarised, in terms of experiences and existing models Leeds is without doubts the leading city, followed by Dortmund and Lille. Due to its specific migration history, Gothenburg has the least experiences.

1.1 Leeds

1.1.1 Structures for the Planning and Delivery of Services for BME Elders

The needs of BME elders are referred to in local planning documents of the City Council and the health organisations. Parts of the NSF for Older People draw attention to the specific needs of BME elders and the importance of planning to meet these needs.

Following the Race Relations Amendment Act (2000), Race Equality Performance Indicators are a requirement in all services. All service inspections (through the Social Services Inspectorate, the Audit Commission, the Commission for Racial Equality) have to report on

measures and progress for the delivery of service to BME people. Officers in the Social Services Equality Unit monitor progress against the Performance Indicators for scrutiny by the City Council. Social Services also has a Race Equality Forum, most of whose members are from the voluntary and community sector, which receives regular reports on BME service initiatives and progress in meeting targets.

The Older People's Forum has recently acquired funding specifically to develop and increase the involvement of the BME older people's voluntary sector in service planning and commissioning. It is intended that this project will build on the initial work carried out by SEEM. This involvement and participation is seen by all as a crucial element in providing equitable, appropriate services.

1.1.2 Initiatives in Place Specifically for Leeds BME Elders

'In the past, policy has over-emphasised assimilation or alternative separate provision. The former failed to acknowledge cultural diversity, while the latter has led to marginalisation for some minority ethnic users.' (2001 Social Services report on developing Leeds City Council practices to further develop the core value of equality and diversity).

Leeds City Council is now adopting the Commission for Racial Equality strategy: 'In order to promote integration while respecting diversity, it is now recognised that all services should be delivered in ways that are culturally appropriate for all users, while leaving scope for members of certain ethnic minority groups (for Pakistani, Indian, Bangladeshi, Black Caribbean, Jewish and Irish elders and service users and carers). Only by doing so can it be argued that all users and carers are being served in an equal and equitable manner and that they are being given acceptable choices. Such a strategy has the potential to enrich services for all users of whatever race or culture'. (Race, Culture and Community Care – an agenda for action – CRE).

Below are listed the areas of service where there are specific initiatives underway for addressing the needs of BME elders.

1.1.3 Improved Information Systems

Social Services is currently working with a group of final year Business students from the Leeds Metropolitan University to research further into the information needs of BME

communities in Leeds, with a particular emphasis on the needs of BME elders. The existing communication patterns already in place within the various groups are being looked at, and consideration given to the extent to which the department can either learn from them, or use some of the naturally existing routes. The work is proceeding at several different levels: quantitative research, postal survey, and face to face interviews with users and representatives from some of the major BME groups.

Age Concern Leeds (one of the major older people's voluntary sector organisations in the city) has managed to secure funding for a 6-month pilot project to provide information & advice services to BME elders. The project hopes to make use of information and good practice identified by the Social Services research.

1.1.4 Neighbourhood Network Services and Lunch Clubs

In Leeds there are now more than 35 neighbourhood network schemes. These can be defined as community-based schemes, to provide inclusive, accessible support and services to older people to enable them to live independently, safely, and in good health. The schemes are defined either geographically or culturally, and wherever possible they are managed by and for older people and their local communities. They are provided by the 'voluntary and community sector'. Most of them are funded by Social Services, but increasingly they are also supported by the Primary Care Trusts, and other Council and charitable sources. (also see Leeds model of good practice 1).

1.1.5 Home Care

Home Care includes services such as 'home helps' visiting people in their own home to help with basic tasks of daily living. In 1997, Social Services commissioned a research project 'Home Care Provision for Black Communities in Leeds – the views of black and minority ethnic groups, service commissioners and providers.' It identified a number of issues and problems: for example, BME people comprised 1.24% of the total number of Home Care Service users, (whilst BME people then made up 5.8% of the total population). This report summarised the success criteria for developing effective services for BME communities (17.4 below) and its recommendations provided a framework for improving services.

One early result of the recommendations was the development of two Black and Minority Ethnic Homecare Meals pilots. These aim to offer black and Kashmiri elders who are housebound, the possibility of a culturally suitable meals delivery service. If these are

successful, they may be taken on by the Social Services Meals Service. These pilots are being delivered through partnerships, so far based around Caribbean Care Meals on Wheels (based with Senior Citizens' Endeavour), and Woodsley Road (Kashmiri Association) Day Centre.

1.1.6 Carers

Leeds has a Carers' Strategy, and as part of this there is a BME Carers' development worker. A substantial part of her work is with older carers, and carers of people with dementia; and is in seeking to develop appropriate respite care.

1.1.7 Day Centres

There are 2 Social Services Day Centres specifically catering for BME elders: Frederick Hurdle in Chapeltown caters mainly for African Caribbean elders; the Apna Day Centre in Headingley is for Asian elders, with mainly Sikhs attending.

1.1.8 Residential and Nursing Care

Following the 2001 report on the low take-up of services by all groups of BME elders, and particularly Pakistani, Kashmiri and Bangladeshi elders, Social Services has set an action plan following the same priorities as those laid out for home care above. There is one voluntary sector residential home particularly for African-Caribbean elders, which has operated for a number of years. It is now facing difficulties due to the reduced demand for residential places (with the emphasis now being on people being supported in their own homes), and the increased demand for nursing homes (whose premises have to meet many more requirements and health and safety regulations).

1.1.9 Housing

As a result of the low take-up of sheltered housing by BME elders, a development post was established in the Council's Housing Department, to identify and match BME elders needs with housing association provision and policy development.

The Social Services and Housing also commission a home improvement agency, Leeds Care and Repair, to assist low income home owners (particularly elders and people from BME communities living in the inner areas) to repair, improve and adapt their homes.

1.1.10 Consultation and Involvement

One result of the national and local drive to monitor equality standards, is that all initiatives for older people now have to consult with, and consider the needs of, BME elders. For example, a research enquiry into the shopping and cleaning needs of elders will consult with BME elders groups and organisations specifically as part of its brief.

As already mentioned above, the Older People's Forum has funding to develop and support the involvement of BME older people's groups and organisations in the consultation process. Also, Leeds Involvement Project (which oversaw the production of the Home Care report described above) has been commissioned to set up an Older People's and Carers' Reference Group, which is just starting to meet regularly. This group includes elder and carer representation from BME communities.

1.1.11 Leeds BME Elders - Issues and Problems

As can be seen from the information above, in Leeds there is a whole range of national and local plans to implement. None of these strategic plans focus specifically on BME elders services, but they do give the frameworks and targets for addressing and meeting needs.

There is also a diverse range of BME communities and a growing number of BME elders, but there are not as yet accurate figures on the numbers of elders, and it is necessary to rely on national research and information for gauging need in a number of areas. The task is complex and growing.

The main issues and problems facing BME elders both nationally and locally have been outlined above. If service providers are to improve the quality of life for BME elders in Leeds, they need to meet challenges on a number of fronts:

⇒ Providing appropriate information on services
⇒ Addressing low income levels
⇒ Providing access to appropriate health and social care
⇒ Ensuring the availability of suitable, affordable, warm and safe housing within or near an elder's own community
⇒ Ensuring the availability of appropriate residential nursing care
⇒ Providing access to information, support and respite care for carers
⇒ Combating social isolation through culturally appropriate services
⇒ Reducing racist harassment and fear of crime

⇒ Ensuring BME elders are effectively involved in consultation and development of their services

These challenges involve:

⇒ Stimulating uptake, knowledge and information through a range of outreach and other mechanisms which utilise formal and informal networks

⇒ The support and development of the infrastructure of the BME voluntary sector to enable them to become sustainable providers

⇒ Flexibility on the part of statutory organisations, to balance being experimental with understanding and responding to practical development needs

⇒ Openness and commitment by statutory sector agencies to change existing policies, procedures and conventions, in order to accommodate different ways of working and the different needs of BME providers

⇒ Developing clear career paths, development opportunities and additional support for BME staff

⇒ Providing training for home care staff within an anti-discriminatory framework

⇒ Setting clear targets that are regularly monitored

1.2 Models of Good Practice in Leeds

The following chapter shows models of good practice that demonstrate how to meet the needs of BME elders.

1.2.1 The Leeds Model of Good Practice I

Neighbourhood Network Schemes for Black and Minority Ethnic Elders

Background
The 'good practice example' consists of a number of existing neighbourhood network schemes delivering services to BME elders; and also the development of new, or enhancement of existing neighbourhood schemes to meet gaps in existing provision for BME elders.
The main groups of BME elders in Leeds are currently: African-Caribbean, Chinese, Irish, Indian, Jewish, Kashmiri, Pakistani, Sikh and Vietnamese elders.
'Elders' are defined as those aged 60 years and over. However, it is understood that, particularly in some of the local Asian communities, the term is used for people aged 50 years and over. Where people under 60 years are involved, they are often included as 'volunteers' to the scheme.
The first neighbourhood network schemes started in the early 1990s, through partnerships between local older people and communities, and Leeds Social Services (SSD). The initial push for development came from both local communities and committed SSD staff.
Development was a combination of targeting areas at most need, and responding to applications from active and committed local groups. In this way, the first BME schemes were established.
By 2002, there were 12 established schemes, each with its own individual character, which could all be defined as providing 'neighbourhood network' services.
In April 2002 Leeds SSD agreed a policy of further investment to meet the gaps in existing neighbourhood network services for BME elders.

The aims of this policy are:
⇒ To identify and meet the neighbourhood service needs of elders from black and minority ethnic (BME) communities
⇒ To provide BME elders with a local, culturally appropriate access to the health and social care services they need
⇒ To develop and build the capacity of the BME elders' voluntary sector.

A description of the schemes
'Neighbourhood Network Schemes' are community-based schemes, which provide inclusive, accessible support and services to older people to enable them to live independently, safely, and in good health. The schemes are defined either geographically or culturally (in other words, for BME elders), and wherever possible they are managed by and for older people and their local communities.

All the schemes are expected to:
⇒ Be run by and for older people and their local communities and agencies.
⇒ Work systematically to encourage use of the scheme by elders from BME communities, or should they choose it, to refer elders on to a more culturally appropriate scheme.
⇒ Have a commitment and resources from the local health services (Primary Care Trust).

Proposals for new BME elders' neighbourhood network schemes specifically also need to identify:
⇒ A gap in appropriate provision for black and minority ethnic elders
⇒ Numbers and projected numbers of older people in the targeted community (SSD bears in mind the difficulties in obtaining accurate information).

The schemes' services and activities vary, because they are determined through detailed consultations with the older people and their carers. However, they are expected and likely to include:

⇒ home support visits and befriending
⇒ advice and information
⇒ social activities
⇒ transport
⇒ healthy living activities
⇒ security
⇒ practical home support services (eg gardening, decorating, maintenance, shopping)

There is at least one worker to each scheme, and a varying number of volunteers. SSD staff oversee the strategy for developing and supporting new and existing schemes. The schemes are based in the middle of the communities they serve, in buildings belonging to the council, or other voluntary, cultural or religious organisations.

Schemes provide for elders from particular BME communities living across the city. Most communities tend to be focused particularly in the inner areas of Leeds, although some people, such as Chinese elders, are spread fairly evenly across the whole city.
The schemes already underway, and the schemes proposed, are listed in appendix 1.

Schemes' management:
The schemes themselves are managed and run by local people, including elders, from the minority ethnic community which is to be the main recipient of the services. The schemes also usually have people from health and social care services on their committees, in an advisory or support role. Leeds Social Services (SSD) has developed the strategy for supporting and developing the schemes.

Decisions on allocating money to new schemes are overseen by a multi-agency board, which includes representatives from SSD, health services, voluntary sector. (These representatives take recommendations concerning their own agency's money back to their own agency for final approvals).

Numbers of people benefiting:
Approximately 1000 people benefit each year from the existing BME neighbourhood network schemes. This project is attempting to reach and offer services, to the 8000+ Leeds BME people aged 65 years and over, plus people below this age who require the services.

Funding and resources:
SSD provides core funding towards the services they provide. So far, SSD has invested over £330,000 per year towards the development and running of the BME neighbourhood services.
The SSD funding is made towards core costs of running the schemes: staff and volunteer costs, rent, office, activities. The provision of core funding for at least 3 years at a time (contracts are reviewed each 3 years), is intended to enable the schemes to seek matched funding to cover the total costs.
Funding also comes from other agencies such as the Primary Care Trusts (local health services), charities and trusts, and other fundraising activities - a substantial amount of additional funding comes from other agencies and charitable sources.
All the schemes rely to a greater or lesser extent upon volunteers. Some volunteers provide the management committee of a scheme. Other volunteers assist with home visits, activities and outings, or administrative support.
Most schemes are supported by SSD and health staff based locally. These include SSD Voluntary Resource Co-ordinators, and other staff with appropriate language skills and specialisms.
Some schemes are based in rent-free premises, either Council owned, or provided by a larger organisation or religious organisation.

Monitoring and evaluation:
The provision of neighbourhood network services to BME elders is reviewed and updated as part of the ongoing evaluation of older people's neighbourhood network schemes as a whole.
SSD has recently overhauled its contracts with the voluntary sector, and 3 year service level agreements are being set with all the neighbourhood schemes. These agreements require the scheme to

supply quantitative and qualitative monitoring information to be supplied on a regular basis. Schemes are expected to carry out 'customer surveys' with their service users and carers.
This monitoring information is then to be reviewed annually by SSD staff. The reviewed information will then be taken to the multi-agency board mentioned above, so that any problems and gaps in service can be identified, and the strategy updated as necessary.
Any major reviews and changes will be fed into the SSD Departmental Management Group, the Leeds Older People's Forum, and into the city's Older People's Modernisation Team. This is to link the schemes into the wider planning of services for older people.
Information about the services provided may also come from SSD's other consultative procedures for finding out from older people what they think about the services they get from the Department.

Problems encountered in setting up and running this project:
⇒ Sufficient resources (support as well as funding) to ensure the successful development and running of appropriate services.
⇒ Capacity: the communities with the greatest need tend to have the most difficulty both in establishing and sustaining the required voluntary management group.
⇒ Finding the right setting: a scheme employing sometimes only one or two people to begin with requires suitable office space, ideally with a bigger local provider who can share resources and give support. As it develops, the scheme needs an accessible space in the middle of the area where most of the elders targeted live. Meeting both of these needs often causes big delays, and compromises can seriously weaken the scheme's development.
⇒ Timing: often funding becomes available at short notice. There can be difficulties bringing the funding and a group together at the right time.
⇒ Responding to change: for example, when some of the schemes were first instigated by their local communities, this was done through religious bodies – at that time the most organised and active groups for their respective communities. Some gender and cultural needs were hard to meet by schemes in their original form. Change can be stressful for schemes which are under-resourced and putting their energies into everyday survival.
⇒ Developing the same quality of services to all elders, and finding appropriate ways to evaluate that quality.

How this project fits in with other services provided for elders/ BME elders:
Currently these neighbourhood network services 'fit in' through the quality of the local contact and communication between the schemes' staff and volunteers, and other local health and social care professionals.
There is a lot more to be done, to try and ensure that BME elders have systematic access to the whole range of services they need, in the way that they need them. Also the systems need to be in place to track and monitor this progress.
This project is just one aspect of the wider task.

The limitations or drawbacks to the schemes:
⇒ Although the schemes provide the potential for good access to services, they are a very small contribution to the total range of Leeds services for older people
⇒ Not enough resources are available for most schemes to reach their full potential
⇒ The BME voluntary sector is over-stretched, trying to tackle demands on a number of fronts, with limited numbers of people/volunteers available to manage and run all the schemes needed by all the different communities
⇒ The provision of the neighbourhood schemes may involve too great a reliance on the part of the statutory agencies, on volunteers and on the 'self-help' concept.

It is intended that these schemes will provide:
⇒ A better range of information from BME elders to assist with the commissioning of older peoples services
⇒ Better access for BME elders to older people's services generally

⇒ Greater involvement by local BME communities in planning and providing services for their elders

SSD wishes these schemes to be a way for BME elders to get onto the ladder of health and care services, as they get older, and their support needs change and possibly intensify. Most of the projects, being based in their local communities, are well supported by community activists and local politicians. However, this is not always enough to secure their success, and it does not always operate to the same degree for each community. (Leeds Background Report 2003)

1.2.2 The Leeds Model of Good Practice II

The Leeds Older People's Forum

The Leeds Older People's Forum is an independent Voluntary Organisation and a Registered Charity. Funding is from a variety of sources including Leeds Social Services, West Leeds Primary Care Trust, Comic Relief and the Community Fund (Lottery). It is based at Voluntary Action-Leeds.

It was established in March 1994 and has a membership of over 100 voluntary sector organisations working with older people (22 are BME groups).

The aims of the forum are:

⇒ To provide information to older people's groups
⇒ To offer opportunities for networking
⇒ To monitor plans, services and other developments affecting older people
⇒ To provide opportunities for older people to give feedback to statutory organisations and others about current and proposed services.
⇒ To influence policy and practice at a local and national level
⇒ To ensure that voluntary organisations working with older people are fully involved in shaping services

The original focus was on community care issues: social services, housing and health. The broader agenda now includes: community safety, transport, lifelong learning, leisure, social exclusion and poverty.

The values are:

⇒ To empower older people
⇒ To enable older people to have an effective voice
⇒ Put power in the hands of older people through the Forum's Constitution
⇒ Only people 60 years and over can be Honorary Officers of the Forum
⇒ Only people 60 years and over can vote at Forum meetings
⇒ On the Forum Management Committee, of the 20 elected members, 75% must be people 60 years and over
⇒ The Forum meets 4 times a year, and so does its management committee. Forum meetings are a combination of receiving reports, speakers, discussions and sharing information.

Topics and policy issues covered include:

⇒ National Service Framework for Older People
⇒ Housing and Older People
⇒ Community Safety
⇒ Adult Protection
⇒ Leeds City Council and Older People
⇒ Intermediate Care
⇒ Fairer Charging Policy
⇒ Direct Payments
⇒ Also One-Off Meetings and Mail-outs

⇒ Home Care
⇒ Transport
⇒ Lifelong Learning
⇒ Libraries
⇒ Older People and Safety (Accident Prevention)
⇒ 'Best Value'
⇒ Positive Images of Older People Project
⇒ Better City for Older People Project
⇒ International Day of Older People 2003

Forum Consultations: the Forum has submitted formal responses to a number of important initiatives over the past few years at both a local and national level.
Responses to Leeds based initiatives: Charter for Long Term Care in Leeds City Council; consultation on the establishment of 5 Primary Care Trusts in Leeds; Leeds Health Improvement Programme 3; proposed changes to Hospital Services in Leeds. Responses to national initiatives: Better Government for Older People. These responses ensured that the views of Leeds Older People and their organisations are heard by policy makers at both a local and national level.

Achievements of the Leeds Older People's Forum include:
⇒ They have 'a place at the table'. For example they have forged links with the Older People's Modernisation Team, with Social Services, Health, Housing, Libraries, Adult Education, Transport Executive, etc.
⇒ There is an improved recognition of the contribution of voluntary organisations who work with older people (for example concerning the importance of "preventative" services)
⇒ They have raised the profile of older people's issues
⇒ The voice of older people and voluntary organisations who work with them is now heard more than in the past.

Leeds Older People's Forum and BME Organisations in Leeds
⇒ About 20% of member organisations serve BME communities.
⇒ BME communities are well represented on the Management Committee.
⇒ Voice on policy making bodies means LOPF are able to continually raise the profile of issues relevant to older people, including BME concerns

BUT:
⇒ Leeds Older People's Forum plays a vital role in supporting strong BME representation on policy making bodies.
⇒ There is always room for improvement. LOPF is looking at ways to ensure BME elders and their carers are most effectively in consultation on service development. (Minutes of SEEM Project Meeting in Leeds 2003)

1.2.3 The Leeds Model of Good Practice III

The Association of Blind Asians (ABA)

The Association is a neighbourhood network project for Asian people with visual impairment and families, carers and friends. It is financed by LCC Social Services, Community Fund (National Lottery) and various other bodies including the national Healthy Living Centres Initiative.
The Association was set up in 1989 as a self-help group and is located in Headingley at the Shire View Centre for Blind and Partially Sighted. It works in areas of Leeds which have a higher proportion of BME communities and has an office in one of these. It also focuses on Asian elders who are blind or visually impaired.

From March 2001 onwards, ABA has employed four highly qualified workers. ABA works closely with the Nuffield Institute for Health at Leeds University and provides placements for 2nd year medical students. ABA members and staff have contributed to a number of research projects carried out by the Centre for Disability studies.

ABA offers the following culturally appropriate services for blind and visually impaired Asian elders:
⇒ A place to meet and socialise
⇒ Training (for instance, how to use different aids and equipment that help people to live independently)
⇒ A library
⇒ Advocacy and support and counselling (help with benefits and with transport)
⇒ English classes with IT (special speech packages)
⇒ Indian Dance classes and stress relief
⇒ Drama classes
⇒ Obtaining specialist equipment such as talking books, watches and reading aids
⇒ Massage and walking for health
⇒ Social activities, visits and trips
⇒ Empowerment and self-help training
⇒ Carers support by respite care provision

Through their manager, ABA is involved in various meetings and committees and lobbies for the needs of older blind and visually impaired Asians. (ABA 2003)

1.2.4 The Leeds Model of Good Practice IV

Frederick Hurdle Day Centre

The Frederick Day Care Centre has been open for 11 years now and it is a multicultural Day Care centre. It is open 6 days a week from 08:30 till 16:30 and has visitors who are from all ethnic backgrounds. Initially, visitors can try the centre on a drop-in basis, to see if they like it.
They may be referred by their doctor, a social worker, their family, or simply by themselves. To start with, they are invited for a day visit which is free, which then leads to a full assessment of the person's needs. Members get a cup of tea and toast, a warm meal, and they do exercises and different activities (including sewing, drawing, bingo, cards, quizzes, talk groups, dominoes etc) each day. The centre also organises social evenings, for which there is a bus provided to take the members to and from home.

The service users are asked what they would like to do as well. The users are also on a committee which meets and has input from users' suggestions (even for what food they prefer- there is always an alternative). In total there are 5 care staff. The centre provides personal care (for example bathing, bringing washing, shopping etc). There is also a tutor who comes in and some of the user groups have made the murals and the coloured glass window decorations in the centre. There are volunteers who go on trips with the users to help with wheelchairs etc.

The centre is funded by social services and is linked to Leeds Black Elders Association who do friendly and useful activities like putting locks on doors, taking people to the doctors etc. There are 107 members- some of whom come more often than others-perhaps twice a week. There are 30 places per day.

The members come from all over Leeds. The centre makes a special effort to bring people from further afield. The main reasons why people come to the centre is because they feel isolated or lonely in their homes, or perhaps they are disabled. The members' average age is 60, but some are slightly younger than that as the Centre does not discriminate against age, and they come from Caribbean and Asian

backgrounds (the majority are black although there are some white people visiting). (Minutes of SEEM Project Meeting in Leeds 2003)

1.3 Dortmund

Compared to other German cities Dortmund started quite early to take a look at the specific needs of immigrant elders and to develop adequate services. On the different levels of community care the following measures were taken up to improve the life situation of immigrant elders and to facilitate their access to social services.

1.3.1 City level

At local level in Dortmund, there are two separate written basic documents for social services within the field of community care that are called Altenplan ('open' community care plan) and Pflegebedarfsplan (community care plan). As mentioned above, there is a clear distinction between care services on the one hand (as for instance nursery homes and care services at home) for which the community care plan is the legal basis and so called 'open community care' services that aim mostly at the promotion of social contacts and leisure offers for which the 'open' community care plan is the basis.

However, as the cities in Germany suffer from shortcomings of public money that is needed to finance so called 'open' community care services, this is a field of community care that is increasingly being neglected. (Gerling 2001)

In the context of the growing heterogeneity of older people and their changing needs, the city of Dortmund has commissioned a study to analyse in how far existing services in the field of the so called 'open' community care still meet the needs of elders and what has to be done to adapt services to changing needs. As to the group of BME elders the final reports concludes that against the background of growing numbers and needs municipal efforts should be strengthened to integrate those groups and to develop adequate services in the fields of open community and outpatient care. (Schmitz 2002)

In Dortmund, both basic pieces of community care also aim at the improvement of life quality of BME elders. In 1991, the first 'open' community care plan was set up and proposed a stronger involvement of elders from minority ethnic groups within the work of day care centres and a better information policy for this group. In this context, some attempts were made to open up a typical German day care centre for foreign elders. However, for different reasons, this attempt was not successful at last.

The city also funded a different day care centre that set up special and separate services for black elders on separate days which was more successful. It still exists today as a model of good practice and is now organised by the voluntary sector groups named 'Association for

International Friendship' (Verein für Internationale Freundschaften) and will be presented later on in this report.

In terms of improving the information policy for BME elders regarding social services in general, only little has been achieved, which was first of all due to financial problems.

The first 'open' community care plan from 1991 aimed also at analysing the question, whether there was a necessity to built up special, separate institutional care for immigrant elders or if they should be integrated in existing mainstream services. The social services department was responsible for the conduction of the study and came to the conclusion, that the amounts of immigrant elders in nursery homes and other institutional care services were still very small and thus there wasn't any need seen for further requirements of action.

The current community care plan again aims at investigating the existing and future care needs of elders from ethnic minority groups but also concludes that up to now, due to small numbers, no short term measures have to be taken to built up special services. This was also the result of a workshop held two years ago examining the question whether existing care services are sufficiently taking into account the needs of immigrant elders.

There are two other approaches of the city of Dortmund to take into account special religious needs of immigrated people that are worth mentioning.

In 1996, on the inquiry of the Immigrant Advisory Council, the city installed grave fields for Moslems on the municipal cemetery. For Moslems in Germany, this is the only possibility of bereavements according to Islamic rules because Moslems are not allowed to found their own cemeteries. Additionally, in municipal hospitals the city of Dortmund has built up special prayer rooms for Islamic people. [Gerling 2001]

1.3.2 Level of the Voluntary Sector

As mentioned above, the Wohlfahrtsverbände (charitable associations) play a crucial role in the German welfare system. In Dortmund, almost all of them have taken up special measures to open their mainstream services for elders from black and ethnic minorities.

Arbeiterwohlfahrt: From 1992 to 1995, the Arbeiterwohlfahrt Bezirksverband Westliches Westfalen took part in a model project "Developing concepts and strategies of action for the care of immigrant elders" and tried to open up a typical German Day Care Centre (Eugen-Kreutscheid-Haus) for Turkish elders that is located in the Western downtown district of Dortmund. Although there were some short term successes (for instance a group for Turkish women was set up and information events were visited by a lot of Turkish elders), it was not successful in the long run. Some of the reasons comprise the following: It was impossible to

find a good liaison worker who could built up contacts with the Turkish community, German users of the Day Care Centre had not been sensitised enough before the start of the project and thus were afraid of getting too many Turkish people in their centre. There were also rivalries between the AWO and another self organisation of Turkish elders that was located very close to the centre and wasn't integrated enough in the project. After the failure of the project the AWO has not made any further attempts to set up 'open' community care services for BME elders.

However, in the field of outpatient services, the AWO has taken steps to open their services for immigrant elders. For instance, the AWO tries to win Turkish trainees for the care of elders and employed two Turkish people who had completed the training. They are needed for two reasons: on the one hand, Turkish employees should sensitise their German colleagues for the special care needs of Turkish elders and on the other hand, they should also make contacts with the Turkish community and inform them about the existence of social services for elders. For this reason, the AWO information brochure was translated into Turkish.

As mentioned above, the AWO also offers advice services for immigrants regarding topics like work, integration, legal questions etc. Many of the people who seek advice have grown older and thus many of the questions deal with age related topics like pensions, the question of return etc. Against this background it becomes clear that the different services of the AWO have to co-operate.

Caritasverband: The Caritasverband was one of the first organisations in Dortmund that became aware of the emergence of the 'new' group of immigrant elders and did a lot to sensitise the Immigrant Advisory Council on this matter.

As to outpatient services the CV uses the same strategies to adapt their services to the needs of elders from ethnic minority groups as the AWO. The organisation is also very active in the field of counselling and advice and offers a lot of 'open' community care services for people from different ethnic minority groups. However, up to 1998, no special emphasis was laid on the group of immigrant elders. Within the work of the Bernhard-März-Haus, a meeting centre in the northern downtown district of Dortmund, the CV set up a group for Turkish elders.

Diakonisches Werk: This charitable association offers advice services for refugees, accepted asylum seekers and foreigners (predominantly for people from Greece. In total, there were 18 042 advice contacts in 2001. There are no data concerning the age groups of advice seekers.

The advice centre additionally offers a centre 'Café International' and information and cultural events. (Diakonisches Werk 2001)
A sub-organisation of the DW (Diakonische Dienste) that is also providing outpatient services has also employed people from ethnic minority groups to be able to care for BME elders. Furthermore, the Diakonische Dienste translated their information material in different languages (Turkish and Serbo-Croatic), built contacts to self-help organisations of ethnic minority groups, went into their centres to inform about their services, and got in touch with foreign general practitioners. (Gerling 2001)

Deutsches Rotes Kreuz: Day care centres of this charitable association are hardly visited by BME elders. In one of their homes used to live a Turkish man who resettled back to Turkey 2 months ago. The advice service for immigrants deals primarily with refugees and asylum seekers who are in general young people and with late emigrants of which about one third are elders. Experiences of the DRK show that special services for elder late emigrants are not accepted probably because of family duties, fear and the lack of need for being together with peers (Interview DRK 8.1.03).

Jüdische Kultusgemeinde Dortmund und Umgebung: This Jewish community organisation looks after so called Spätaussiedler (so-called 'late emigrants' from people of German origin living in the Eastern parts of Europe) and Jewish contingent refugees from territories of the former Soviet Union. It is one of eight associations for Russian speaking immigrants in Dortmund and cares for about 4 000 community members. About one third of them are elders and they are mostly living in the city districts Hörde, Scharnhorst, Huckarde and Hombruch. The Kultusgemeinde offers different services for their members and has a day centre that is open five days a week. Some of the services explicitly focus on Jewish elders. (Schmitz 2002)
The community centre aims at integrating refugees into German society and thus offers German classes, some especially for elder people. Cultural services comprise for instance excursions and exhibition visits. However, its 12 workers mainly offer advice and services for daily life such as hospital visits, visits at home, translating and interpretation and so on. Because many Jewish elders suffer from severe mental problems, mother language psychological services are desired most urgently. There is also the need for Jewish residential care. In terms of outpatient service, some specialised services have emerged. There are some mother tongue social municipal administration workers and one nursing home in Hörde has Russian speaking staff. (Schmitz 2002)

80% of the people asking for social work and advice are aged 65years and above. Main problems and questions concern social security, health and legal aspects. (Interview Jüdische Kultusgemeinde Groß-Dortmund 29.1.03)

Der Paritätische - Kreisgruppe Dortmund: This charitable association is mainly an umbrella organisation for charities. As mentioned above, it also offers social advice and vocational training. In Dortmund, this organisation has about 200 member charities, of which 15 have to do with migration issues in general. Those charities are partly self-help organisations of ethnic minority groups and partly German charities that focus on multicultural questions. Those organisations offer services such as: general social advice, day centres, language classes, special advice in terms of job search and many more. However, only one organisation (the Verein für Internationale Freundschaften) focuses explicitly on the target group of BME elders.

In 1998, Der Paritätische founded a local working group 'migration' that meets four to six times a year. The working group exchanges information about the work of the different charities and works out strategies to lobby. Additionally, the Paritätische offers special vocational training for their member charities.

Within the scope of another European project (URBAN II) a new intercultural community centre (House of Cultures) is going to be established in spring 2003.

1.3.3 Level of the BME Voluntary Sector

In terms of providing social services for BME elders, the black voluntary sector plays a predominant role. Many of those services have evolved because black voluntary organisations have chosen to fill in niches that are due to a lack of engagement of public and mainstream voluntary services. Self-help organisations of ethnic minority groups have a big advantage, as they know the needs of their older members very well, however they also face many difficulties, first of all having to do with funding problems. In Dortmund, there are two self-help organisations of minority ethnic groups who focus exclusively on the groups of immigrant elders. Furthermore, there are a lot of other self-help organisations that do not exclusively offer services for their elders, but take care of their needs in general. For instance, more than half of the members of Islamic mosque associations are 60 years and above and for them those associations have the function of day care centres.

Bund der älteren Einwanderer (Association of Elder Immigrants): This association was founded in 1994 and focuses predominantly on Turkish elders. Its aim was to provide advice to fill the niche, as many elder Turkish people did not feel sufficiently taken care of by mainstream services. The Main goal of the association is to strengthen the self help potential of Turkish senior citizens. The association offers a range of services such as advice and advocacy and a day centre for older Turkish men that is open seven days a week from 10 to 23 o'clock. In co-operation with other providers, the association also offers different education services such as German classes and classes to learn reading and writing.
The association is financed by membership and fundraising and also gets some funding from the Immigrant Advisory Council. It has about 190 members, most of them older immigrated men and works on a voluntarily basis.

Verein für Internationale Freundschaften (Association for International Friendship): This association was founded in 1987 in the northern downtown district of Dortmund. It aims at taking up and smoothing social processes and conflicts and promoting a living together with solidarity and reciprocal integration. In 1993 the association got the chance to set up special services for elders from ethnic minority groups in a then municipal day care centre. Meanwhile the provider of the day care centre has changed from the local authority to the AWO but the international day care centre still exists. It is open on two days a week (Monday and Friday) from 15 to 18 o' clock and offers services such as visits to advice services, municipal offices and institutions of community care services for elders. Together with their members they also visit the leisure activities of other providers. Within the rooms of the day care centre the association organises information events regarding topics such as health or pension. The common language is German. Once a year the association organises study trips for instance to the European Parliament.
The work is also done on a voluntary basis, although there was some funding of project workers in former times. The association has about 40 older members coming from a range of different countries.

Mosque Associations: In Dortmund, there are about 12 Turkish and some other mosque associations, most of them located in the northern downtown district of the city. Most of the services are addressed mainly to Islamic men although women do have the possibility to participate at the prayers and sometimes have their own rooms. The mosque associations mainly aim at the practise of religious duties but more in general also at the promotion and

tradition of Turkish and Islamic culture. Although most of their members are elders, the mosque associations focus especially on young people and try to keep them away from the streets by offering them services such as football teams. For their other members they also offer language classes (German and mother tongue), day centres, religious classes, libraries, organisation of festivals and inter religious meetings and homework help for pupils. Most of the mosque associations were founded in the 70s and 80s. They are mainly financed by their members and to some extent by the Immigrant Advice Council. Some of the language classes are funded by the charitable institutions AWO and CV and the Imams are sent from Turkey for a certain period of time.

Most of the mosque associations do not have good networking with other institutions or organisations and in their work they do not focus predominantly on their elders and thus do not offer special services for them. One of the reasons is that the Turkish culture does not differentiate between different ages as the Western culture does, another one is that there is a tendency to repress negative sides of old age. However, especially for older Islamic men and especially during the winter time, mosque associations play a crucial role in their lives as many of them spend a lot their time in the rooms of the mosques and sit and talk with other older men. (Gerling 2001)

1.3.4 Level of Political Involvement

In Germany, the possibilities of elders from ethnic minorities to take part in political life and in political decisions are quite small as most of them do not have German citizenship and as foreigners they are not allowed to vote. Only members of the European Union are allowed to vote at local level. However, at local level there are two institutions that give foreigners the chance to get politically involved although only on an advisory level: the Immigrant Advisory Council and the Senior Citizens Advisory Council.

Immigrant Advisory Council (Ausländerbeirat): The council was founded in 1972 and from 1983 on its members are voted in directly by the foreign population of Dortmund aged 16 years and above. Its period of office amounts to five years. The council has 25 members of which most are of Turkish origin. The council meets at least six times per year and mainly aims at lobbying the interests of the foreign population in Dortmund and supports topics such as classes for native languages, improvement of life and training situation of foreign young people and the integration of foreign elders. The political influence is that of consulting with and advising the city council and its committees and is thus limited. As to elders from ethnic

minorities groups the council has been active in this field in former times (for instance by organising information events on questions such as pensions and care insurance) but it cannot be stated that this is one of its main areas of work.

Seniorenbeirat (Senior Citizens Advisory Council): There are no members of ethnic minority groups in this council and although the council itself is also quite committed to working for elders from ethnic minority groups it is not very active in this field as it has not been able up to now to set up partnership structures with the Immigrant Advisory Council. (Gerling 2001)

1.3.5 Private Level

Ambulante Krankenpflege Cieminski: A private outpatient health care service built up in May 2000 focuses especially on older people from ethnic minority groups. It is located in the Northern city district Eving and has a staff of 12 people originating fromPoland, Bulgaria, Turkey, Yugoslavia and Portugal. Over 60% of their clients are foreign elders with mental health problems and dementia. (Schmitz 2000)

1.3.6 Local Strategies

In summary, the following strategies are used by the different providers of community care in Dortmund to take into account the special needs of elders from ethnic minority groups:

⇒ *Special information and public relations work:* Some providers have translated their information brochures into different languages.

⇒ *Recruitment and Employment of staff of matching ethnic origin:* Providers that offer outpatient services have started to recruit and employ staff from ethnic minority groups to function as a bridge between the provider and the communities of ethnic minority groups.

⇒ *Outgoing Social Work:* Some providers have also started to visit the centres of ethnic minority groups and to inform about their services there. (Gerling 2001)

1.3.7 Problems / Recommendations

Within the frame of her thesis, Gerling has analysed the following barriers that prevent social services for BME elders from being developed further and can be viewed as a potential to optimise those services. It is based on a comparison of the local provision of social service for BME elders in Dortmund and Leeds.

⇒ *Lack of co-operation and networking*

Many of the relevant organisations and institutions in Dortmund do not co-operate although quite a few attempts have been made to built up co-operative partnership structures. This is also the case for many of the Turkish self-help organisations that have a tendency to retreat and to work in niches.

⇒ *Lack of consultation policies*

On the side of the city and the charitable associations, there is no real tradition in consulting with ethnic minority groups and their organisations.

⇒ *Strong competition between self help organisations and charitable associations*

Especially between the smaller self help groups and the bigger charitable associations there is a strong competition and disassociation that prevent them from working together. Also there seems to be a lot of competition between the charitable associations that focuses on the maintenance of their market shares.

⇒ *Hesitant behaviour of the BME voluntary sector / lack of information on the situation of BME elders*

For many reasons, a lot of the organisations belonging to the BME voluntary sector do not view the needs of BME elders as an urgent matter and thus do not lobby sufficiently. Especially Islamic community groups do not want to focus on the negative sides of old age as this is often seen as a failure of Islamic culture. Although many people realise that because of changing social structures some elders will not be taken care of by their children or other younger relatives, they make it a taboo subject due to fear and being ashamed. Another reason for this is the lack of information on existing community care services for elders amongst ethnic minority groups themselves.

⇒ *Poorly visible needs and demands / poor lobbying*

Because for many reasons (such as fear and a lack of information) a lot of BME elders do not express their needs and the demand for social services for these groups are not visible. That can lead to a vicious circle.

⇒ *Lack of political influence of ethnic minority groups*

Due to a very limited political influence of foreigners in Germany, there are no ways of building up pressure with 'ethnic' votes. Additionally, at local level in Dortmund, the Immigrant Advice Council is not very active in this field.

⇒ *Lack of information and advice about community care services in native languages*

Many BME elders and their relatives do not express their needs because they are not informed about existing community care services and do not know their entitlement to those services. This is because many of them are not fluent in German and do not get relevant information in their mother languages.

⇒ *Lack of commitment from the relevant persons in charge*

It seems that in Dortmund only a few people are sensitised to the issue of social services for BME elders.

To improve social services for BME elders, the following recommendations are made:

⇒ Ethnic minority groups should built up more pressure by lobbying for the needs of their elders.

⇒ At all levels of community care there should be a more intensive involvement and consultation of ethnic minority groups.

⇒ Relevant actors and organisations should built up better co-operation and networking structures.

⇒ The self help potential of BME elders should be strengthened. (Gerling 2001)

1.4 Models of Good Practice in Dortmund

This chapter shows models of good practice that meet the needs of BME elders in Dortmund.

1.4.1 Dortmund's Model of Good Practice I:

The International Day Centre for Elders in Dortmund

The project is run by the Verein für Internationale Freundschaften (Association for International Friendship) which is a registered charity of the (black) voluntary sector. It was set up in the beginning of the 1990s.

Its main aims are:

⇒ To give elders from different ethnic and national backgrounds a possibility to meet and to exchange experiences

⇒ To support self-help abilities
⇒ To practice the German language
⇒ To organise information and social events

The services it delivers comprise:
⇒ Providing a place where elders from different national backgrounds can meet (twice a week: Mondays and Fridays from 15-18)
⇒ Organising information events for instance regarding topics such as pension, health care, long term care insurance etc.
⇒ Organising self help such as advocacy and mutual visits at home or in hospitals
⇒ Celebrating birthdays and holidays
⇒ Visiting services and institutions for elders
⇒ Organising excursions and leisure activities
⇒ Arranging German and health classes

The project aims at elder people from different ethnic and national backgrounds (including Germans) On a regularly basis the group comprises between 20 to 40 elder people from Chile, Spain, Italy, Iran, Iraq, Ukraine, Morocco, Russia, Turkey and Germany.
On special occasions such as information events or holidays there are up to 80 elders.
The project is managed on a voluntary basis, there are no paid workers. There is a group of 3-5 people who is especially active in organising events and meetings.
The project is based in the rooms of a day care centre for elders that is owned by the city of Dortmund and run by the Arbeiterwohlfahrt (German charitable association). The building is based in a neighbourhood with very high numbers of immigrants (about 50%) in the northern inner city district of Dortmund.

Background
When the Association for International Friendship was founded in 1987 it became slowly clear that many of the migrant workers (so called 'guest worker') in Germany would not return to their home countries but would grow old in Germany. As the mainstream voluntary sector did not respond to these new arising needs of BME elders, the Association wanted to fill in this niche and to provide a day centre for elders from different ethnic and national backgrounds. In 1993, they were able to use a day centre of the city of Dortmund twice a week for that purpose. Ever since, the International Day Centre has been existing. In the meanwhile it received some funding from the EU and German ministries and was able to employ paid workers. Within the last years however, there has been no funding and the day centre has been run on a voluntary basis. The project has won two important German prices lately.

Problems
Most problems are due to the lack of funding and thus to the lack of qualified employed workers. There are a lot of inquiries from students, welfare associations etc. but due to limited time and energy of the voluntary members, most of the inquiries can not be dealt with.
There are not enough financial resources to print detailed information material or to pay for entrance fees for needy members.

Funding and Resources
The rooms are owned by the city of Dortmund and rented by the Arbeiterwohlfahrt. The Association for International Friendship does not have to pay any rent for it. The Association also has a small office close to the centre. Rent and extra charges sum up to about 2.400 € per year. Charges for telephone, copying, postage, travel and insurance sum up to another 2.500 € per year. All charges are paid for by donations and membership fees. Food and beverages at the meetings are provided by the members themselves. Additional costs are covered by capital from the awards (12 500 €).
There is some funding (3.000 € per year) provided by the Paritätischer Wohlfahrtsverband (which is a charitable association and the umbrella organisation of the Verein für Internationale Freundschaften)

that is used to pay the fees for some people working on an hourly basis (for instance giving integration classes).
The main work is done on a voluntary basis by the members of the association. For special information events some guest speaker do not charge any money for their lectures. Due to limited resources, there is no professional monitoring or evaluation.
Lately, the project has won two national awards that also show the importance of the scheme.
There are some contacts for instance to the city of Dortmund, to some of the charitable associations and to some other self-help groups of ethnic minority groups such as mosque associations. However, the level of co-operation is not very strong and the Association mainly works for itself.

1.4.2 Dortmund's Model of Good Practice II

Bund der älteren Einwanderer (Association of Elder Immigrants – AEI)

The Association is a registered charity and belongs to the (black) voluntary sector in Dortmund. It was set up in 1994.
Its main aims are:
⇒ To promote emotional and spiritual welfare in old age for foreign senior citizens
⇒ To promote self help

The AEI:
⇒ offers support services and advocacy (f. i. helping with filling in forms or writing letters to official places etc.)
⇒ runs a day centre for elder Islamic men (open from Monday to Saturday from 10 am to 23 p m)
⇒ offers education services in co-operation with other institutions (such as German classes and classes against illiteracy)

The services sre aimed at Islamic elders concentrating on male elders
There are about 130 members, mostly stemming from Turkey (95%). Some of the language classes are also visited by late emigrants from the territory of former Russia.
Especially one member of the management committee is very active and vocal and co-ordinates the whole project.
The day centre and the office of the AIE is based in a neighbourhood with high numbers of immigrated people that belongs to the western inner city district of Dortmund. The rooms are rented privately.

Background
The scheme was set up in 1994 by German and foreign inhabitants of Dortmund. The founders recognised the fact that many Turkish elders did not feel treated well by mainstream advice centres (for instance by charitable associations) and thus wanted to fill in a niche. In 1994 there was a local project in Dortmund aiming at setting up services and opening up an existing day centre for elders to Turkish senior citizens that was run by the Arbeiterwohlfahrt (charitable association). The goal was to participate at this project which however was not successful in the long run.

However, the scheme has to deal with some difficulties, especially:
⇒ Funding problems
⇒ Problems of co-operation with other existing projects and institutions (a lot of negative competition)
⇒ Political problems between the members of the association: by changing the statute, the number of members was reduced and politically active members were excluded
⇒ Not enough rooms for Islamic female elders

The funding and resources
The scheme is funded by:
⇒ the Ausländerbeirat (Immigrants Advisory Council) (very little amounts),
⇒ Fundraising
⇒ Donations
⇒ Membership fees

The money pays mostly for the rent of the rooms and costs of the office (telephone, postage etc.).
The biggest resources are the volunteers and the members themselves.

Monitoring and Evaluation
Due to the lack of financial resources there is no professional monitoring and evaluation.

Limitations or drawbacks include:
⇒ Funding problems
⇒ Lack of co-operational networks
⇒ Difficulties in finding the right leadership
In general the work of the scheme is seen city wide as quite positive, however, due to negative competitions and personal fights there is a lack of networking and support.

1.5 Lille

The Town of Lille has signed a local charter to support the struggle against discrimination.

Furthermore, the city has set up a commission to accompany its deliberations and actions in the context of older people's politics, and to bring together all those involved in the field: the 'instance locale de coordination gerontologique'.

This forum meets regularly as an open forum with 60 people representing 40 or so organisations which work for and with older people (trade unions, retirement homes, social workers, pensions offices, institutions etc.). It is a place for organising and sharing information for concrete initiatives. The forum has sub groups for planning and action organised by workers in the field who produce regular programmes of work.

These groups work around different social themes, such as building a project with newly retired people, looking at issues of increasing dependency in old age, inter-generational work, and, notably, around the different populations of migrant elders.

The reason for this concern is that older people housed in hostels for young workers, and who are getting older, cannot usually stay in the hostels. Also they imagined living out their retirement in a country to which they will never return.

At the same time, the westernisation of families, including those of Maghreb origin, produces more and more examples of the rejection of the old ways, in favour of the sometimes very pressured participation in 'ordinary' daily life. Many Maghreb women of 80 years have found themselves expelled from the family with virtually no means of support.

A number of experiments have been set up to:

⇒ Help to bring together different cultures

⇒ Organise information campaigns, intergenerational work

⇒ Assist individual older people to play a part in their own future

Examples comprise the following:

⇒ A retirement home in the 'Camanettes' area held an event to bring together elders of European and Magreb origin. There was talking, tea and coffee. The discussion was not easy.

⇒ A meal was organised by a South Lille 'integration association', in an area with a high density of people of Maghreb origin. The aim was to celebrate culinary tradition and folklore. The meal was organised and prepared by Maghreb people. It would have been interesting to organise something the other way round.

⇒ Retirement information campaigns were organised, at a very local level, particularly for involving retired people of foreign origin who often have both difficulties in participating, and with displacement.

⇒ To coincide with the introduction of the Euro, information sessions were held in the workers hostels, with satisfactory results.

⇒ In the local areas, older people's social workers try and offer company to people who have been identified as needing help, but with this it is more a question of support. The proposition of participation and self help is more delicate.

⇒ An experiment was carried out in a 3rd Age club 'l'echange et discussions francopolonaise', with Polish music and traditional songs, dress, and food recipes.

⇒ A project called 'café crème et the a la menthe' based in a social centre has proved interesting. Older men of Maghreb origin had nowhere they could meet and so had got into the habit of meeting out on the street. So the 'coffee with cream and mint tea ' association was formed, and they were invited to use the social centre to meet. Games and refreshments were offered. Since then, these people continue to meet several afternoons a week in the centre, take part in excursions with their wives who were already integrated into the centre activities, and take part in meals with other local inhabitants. Nevertheless, they have not developed closer contact with local people, and even less so with the third age club which is just nearby.

It is apparent from this list of actions that they are as yet modest, but what is being attempted is not easy. This confirms the intention to further develop and deepen today's experiments, so that we are better organised for tomorrow.

1.6 Models of Good Practice in Lille

This chapter describes a model of good practice in Lille that demonstrates how to meet the special needs of BME elders in Lille.

1.6.1 Lille's Model of Good Practice I

The 'Muslim square'
Lille operates a 'Muslim Square', space in a cemetery which is reserved for people of the Muslim faith and where Islamic burial customs are observed. At the same time, it has become necessary to undertake a study to determine future demand, before planning the necessary extensions and informing the population concerned about these services. In practice, a large number of burials take place in the country of origin because the existence of the 'square' is not known.

A strategy of integration and of struggle against discrimination, has as its main aim the guarantee of liberty, equality and fraternity for all, whatever their origins:

This strategy can be summarised under three key headings:

⇒ Resolving individual problems

⇒ Establishing equal access to rights and benefits and struggling against discrimination

⇒ Living better together and valuing the contribution of people who have immigrated.

1.7 Gothenburg / Gunnared

As mentioned before, Gothenburg's experience in developing and providing social services for BME elders is very limited and it wishes to learn from the other cities in the project.
Examples of best practice consist of four activities delivering services for BME elders in Gunnared.

1.8 Gothenburg's / Gunnared's Models of Good Practice

This chapter describes models of good practice in Gothenburg that show how to meet the special needs of their BME elders.

1.8.1 Gunnared's Model of Good Practice I

Ilta Tähti - Aftonstjärnan (The Evening Star)

Aftonstjärnan is a day-centre for Finnish older people. It was started in 1994 and has approx. 200 members. The day-centre is an economic association that each year applies for grants from Gunnared District Administration to cover cost for rent for premises. They also have a small membership fee.
Aftonstjärnan is open Monday through Friday 9 am to 3 pm. They have weekend activities to celebrate Mothers Day, special holidays as Midsummer Eve, Christmas Eve for the lonely.
Other activities are: serving lunch two days a week at cost price, elementary help with interpretation and making doctors appointments.
Aftonstjärnan organises different kinds of activities such as trips, Easter and Christmas fair, chiropodist, healthy food-course.
The number of visitors per week is 120.

1.8.2 Gunnared's Model of Good Practice II

Oliven (The Olive)

In December 1998 the Swedish Government presented a bill, Development and Justice - A policy for metropolitan areas in the 21st century. The Bill is the first step in a process in which residents, NGOs, municipalities, the regions and country councils work together with the central government to create growth in vulnerable metropolitan areas. The goals of the metropolitan policy are:
To provide the foundations for sustainable growth in the metropolitan regions.

To stop social, ethnic and discriminating segregation in the metropolitan regions, and to work for equal and comparable living conditions and gender equality amongst the people living in the cities.
Gårdsten, one of Gunnareds most disadvantaged residential areas is part of "The Commission on Metropolitan Areas" and designated a national area for development. Several projects have started within Gunnareds District Administration to counteract segregation, reduce unemployment, increase the level of education, strengthen the knowledge of languages, improve school, raise comfort and safety in the neighbourhood and improve people's health. All projects should be based on the desires and involvement of the citizens of Gårdsten.

The Olive, which is a meeting point for elder immigrants, was started in august 2002 within the above described stake and in co-operation with the elders care in Gunnared. The Olive is:
⇒ a meeting point for elder immigrants aged 55 +
⇒ an information centre for elders

⇒ including a network for relatives

The Olive is intended mainly for older immigrants who have a need for social commitment and offers many organised and planned activities such as language classes in Swedish and English, needle work, cooking, light physical training, walks, visits, information on health etc. The staff at the Olive also supports elders in contacting authorities and similar where it may be hard to understand information in the Swedish language. During 2003 a study circle on dementia has been carried out. There are plans to start a network for relatives in co-operation with an association for dementia.
The Olive is at the moment a project but works and plans to be a co-operative. There are two staff . The staff has succeeded in engaging some elders in taking responsibility to operate some of the offered activities. Attempts have been made during 2003 to start a staff pool.

1.8.3 Gunnared's Model of Good Practice III

Hälsodisken (Health Information Center) in Gårdsten

Hälsodisken is yet another project within "The Commission on Metropolitan Areas" in Gårdsten. The information centre has been invented to promote people's health. The objective is to provide conditions for a more healthy life through taking into account the factors that the citizens of Gårdsten consider good for their health.
Five "Culture-interpreters" work at the centre. Together they master the languages: Arabic, Kurdish, Persian, Somali, Cantonese, Mandarin, Serbian, Croatian and Bosnian.
Hälsodisken offers literature, magazines and brochures about medical care, health care and how to take care of one self.
There are also three computers for Internet search. Hälsodisken organizes courses, meetings, activities and group discussions. The "Culture- interpreters" give health information to groups as well as to individuals. The centre is open Monday through Friday, 9 am to 16 pm.

1.8.4 Gunnared's Model of Good Practice IV

Finnish group dwelling "Rauhala"

Since 2001 we can offer a special group dwelling for elders with Finnish background.
This group dwelling is integrated as part of a bigger "Old people's home". You will have your own room with a small kitchenette, a large and well-equipped bathroom. You can bring your own furniture except the bed.
The staff speak, of course, Finnish. Finnish food and cultural leisure-time activities shall be offered.

Problems / Recommendations

Sweden has had the opportunity to build up good organisations for care of the elders. There is also well educated staff available. Nowadays however, Sweden has to face the fact of meeting increasing needs of service and care among a greying population with fewer resources available due to the economic recession. Generally speaking immigrants and native Swedes are exposed to different conditions in a number of respects. This is also the case between immigrants from different countries and applies to both cultural and social-economic backgrounds. It is also the case that immigrants from the same country differ considerably

depending on the time or the reason of immigration. There are also differences concerning gender and age, educational background and traumatic experiences, the latter mostly depending on the situation in the home country that led to emigration.

To deliver appropriate social services it is important to remember that these differences affect the conditions of health and integration for different groups of immigrants. There is a major challenge in finding ways to improve these conditions. Against this background, Gunnared wishes to learn from the experiences of other countries, for instance in what way local authorities and voluntary organisations are dealing with these issues.

1.9 Strategies to open up and develop appropriate social services for BME elders

Analysing the different models of good practice at local level, the following strategies are being applied within the four cities to open up and develop appropriate social services for BME elders:

1.9.1 Outreaching Social Work

Getting in touch with BME elders at their community centres and not waiting for them to come to mainstream providers of care for elders.

1.9.2 Information Policy for BME Elders

Using a particular strategy to make sure that BME elders are informed about existing social services, taking into account that many are not fluent in the language of their host society and often are not able to read and write their own language. Using for instance translated information material and audio-visual media. Using a plain and simple language, and – for instance in hospitals - symbols instead of written signs.

1.9.3 Translation and Interpretation Services

Providing professional translation and interpretation services for BME elders when offering social or health services. Not relying on family members or cleaning staff at hospitals to translate, which is often embarrassing for people in need and does not necessarily provide a good quality translation.

1.9.4 Advocacy

Actively supporting BME elders to express their needs and demands. Not speaking for them but helping them to speak for themselves. Accompanying them to Social Services Departments or other institutions.

1.9.5 Conducting Studies / Working with Universities

Using universities or colleges in town to conduct studies on the life situation on BME elders, their needs and demands.

1.9.6 Evaluation of Existing Services

Evaluating services offered,to see how far they meet the needs of their clients, especially the needs of BME elders.

1.9.7 Recruitment of Staff with Matching Ethnic Background

Making sure social and health services employ staff of different ethnic origins in order to better communicate with BME elders and give them the feeling of belonging. Trying to match the composition of the care workforce to that of local BME communities.

1.9.8 Ethnic Monitoring

Monitoring the ethnic composition of staff and of service users to become aware of demands and gaps.

1.9.9 Development Work with Organisations of BME Groups

Giving support to BME groups to strengthen self help potential, to give advice on applying for funding, and on how to meet the criteria to be able to receive funding.

1.9.10 Cultural Awareness Training

Giving all care staff further education and training on different cultures and how to make sure services are delivered in a way that is culturally appropriate.

2. Principles

Against the background of different legal and social political backgrounds it is not possible to simply transfer solutions or models of good practice from one country to another. However, there are certain principals that offer the framework for developing and improving social

services for BME elders that all project partners have agreed upon during their second meeting in Leeds. These comprise the following:

2.1 User Empowerment

Providers of social services are increasingly becoming aware that providing and using services is a two-sided process. To help elders receive the services that actually meet their needs, a better information policy on existing services is necessary. In relation to BME elders it is important to develop a special information policy, such as road shows in minority ethnic community centres and translated written and audio-visual information. When actually providing the service, it has to be made sure that the whole process is completely understood by the person receiving the service. Thus language barriers need to be overcome for instance by proper translation and interpretation. Above all, people have to be given the opportunity to decide which of the available services they wish to receive, when and how to enable them to live as independently as they are able and to remain in control of their lives.

2.2 Respecting Individual Needs / User Involvement

This should be the basis for any service delivery. In doing so, ethnic or cultural needs are automatically being taken care of such as specific food or religious requirements (for instance female Islamic elders being washed only by female cares). To achieve this, professional and voluntary carers must be better qualified to meet the needs of people of different cultural or ethnic backgrounds (see below). However, it is impossible to learn everything about different cultures so carers need to ensure that they ask the individual about their needs. This also has to do with a better user involvement in the process of service delivery.

2.3 Consultation

In general, service users themselves are the best source to find out about their needs. There are different levels of consultation: consulting organisations as advocates, as well as the individuals themselves. As at present there are only very small numbers of elders from minority ethnic groups actually using services, the first step for Dortmund, for example, would be to intensify links with relevant self-help organisations and ask them about their needs and demands.

2.4 Collaboration / Partnership

In order to provide better services for elders from ethnic minority groups, a better collaboration and partnership between the different actors involved is urgently needed. Regarding a better consultation practice in general (see above), it is important to built up closer links with minority ethnic groups and organisations. At the same time it is also necessary to intensify co-operation and collaboration between the different service providers. These, of course, as described above, differ between the cities and countries involved in the SEEM project. For Great Britain, for instance, there would need to be an intensified co-operation between local authority, health services and BME voluntary sector organisations and groups. The statutory agencies have the funding and often the infrastructure, but the voluntary sector has the involvement of, access to, and the trust of, the people in need, in this case BME elders. In doing so, the local authority (Social Services) would be better able to combine resources and use them more effectively. This is especially the case for being able to exchange experiences and learn from each other.

2.5 Equality

This principle means that all service users should have the same rights and possibilities to access whichever service is needed. In this context, it has to be made sure that existing barriers (such as cultural or linguistic barriers) are being tackled. There must not be any discrimination against service users from different ethnic or cultural backgrounds.

2.6 Active Citizenship

This principle refers to the broader involvement of BME communities in the political and cultural life of their city. Again, the SEEM partner cities have very different situations and possibilities, according to the nationality and status of their BME communities.

2.7 Underpinning Principles

Underpinning those principles are:

⇒ **Strengthening Self Help:** It has to be made sure that service users do not become increasingly dependant on the service provider. Their independence and self-help abilities need to be supported. As many elders from minority ethnic groups suffer from bad health, there should be more on offer to help improve health and prevent illnesses, such as sport

classes, diet classes etc. To reach this goal, a better collaboration with the organisations of ethnic minority groups is badly needed .

⇒ **Actively Supporting Voluntary Organisations:** The (BME) voluntary sector is differently developed in the cities involved in the project. Where such organisations exist, they should be supported (financially, organisationally, strategically or otherwise), because minority ethnic organisations and groups are themselves especially close to the needs and demands of BME elders (see also collaboration above).

⇒ **Networking / Developing Links:** In order to develop or improve services for BME elders and to built on existing experiences , there should be good links between the statutory, private and voluntary sector (see also consultation).

⇒ **Evaluation:** There has to be an ongoing evaluation process to see how far social services actually meet the needs of BME elders.

⇒ **Sustainability:** To be successful in the long run, there needs to be a sustainable strategy to provide ongoing social services for BME elders specifically. This has to be achieved in each city, regardless of the completion of the project SEEM.

As the remarks on terminology above show, some of these principles have a different meaning in different countries and this is especially the case for the term “self-help”. Thus, the practical application of the principles may vary between the cities involved in the project. However, the agreed principles form the basis for the way forward in phase II of the project – should the application be successful. Phase II will focus on a mutual exchange of experiences based on the principles described above.

V The Way Forward: Recommendations

As described in more detail above, because of diverging legal and political frameworks it is not possible to simply transfer solutions from one country to another.
However, SEEM partners have agreed on certain recommendations, that address different levels of policy and service delivery and that are more abstract and general than particular approaches in each of the cities. Because of the different legal and political circumstances, it is difficult to address the issues at the level of individual governments. Thus, the recommendations are aimed mostly at a practical level and at the level of the EU.
They are comprised of the following:

1. Planning and Commissioning Services for Elders at a Local Level

In planning services:

⇒ Make sure the specific needs of BME elders are addressed in the local planning documents for elders' health and social care, bearing in mind that different BME groups are themselves very diverse and have different needs

⇒ Ensure BME elders are effectively involved and consulted in planning and development of their services

⇒ Improve links to and partnerships with local BME communities and their organisations

⇒ Commission research regarding the needs of BME elders

⇒ Co-operate with other service providers to make sure the needs of BME elders are met

⇒ Be open and committed to changing existing policies, procedures and conventions, in order to accommodate different ways of working and different needs

⇒ Be flexible, to balance being experimental with understanding and responding to practical needs

⇒ Evaluate services and set clear targets that are regularly monitored

⇒ Monitor ethnicity of staff and service users

In planning and providing services, address the issues of:

⇒ Social isolation

⇒ Low income levels

⇒ Community safety - racist harassment and fear of crime

⇒ Accessible and affordable transport

Provide access to culturally appropriate health and social care by:

⇒ Supporting and developing the infrastructure of the BME voluntary sector to enable organisations to become sustainable providers

⇒ Providing appropriate information on services for BME elders, their families and carers

⇒ Stimulating uptake, knowledge and information through a range of outreach and other mechanisms which utilise formal and informal networks

⇒ Provide access to information, support and respite care for BME carers

⇒ Ensuring the availability of suitable, affordable, warm and safe housing within or near an elder's own community

⇒ Ensuring the availability of appropriate residential nursing care and respite care

⇒ Providing support services for BME carers.

In terms of health and social care staff:

⇒ Provide education and training for care staff on the cultures and needs of BME elders

⇒ Develop clear career paths, development opportunities and additional support for BME staff

⇒ Making sure the special needs of BME elders are referred to in the local basic planning documents for elders' health and social care

⇒ Bearing in mind BME groups are very heterogeneous and have different needs

⇒ Improving links to and partnerships with local BME communities and their organisations

⇒ Ensuring the availability of suitable, affordable, warm and safe housing within or near an elder's own community

⇒ Ensuring the availability of appropriate residential nursing care

⇒ Addressing low income levels

⇒ Providing access to information, support and respite care for carers

⇒ Reducing racist harassment and fear of crime

⇒ Ensuring BME elders are effectively involved and consulted in planning and development of their services

⇒ Supporting and developing the infrastructure of the BME voluntary sector to enable organisations to become sustainable providers

⇒ Providing further education and training for home care staff on the cultures and needs of BME elders

⇒ Monitoring ethnicity of staff and service users

⇒ Conducting research studies regarding the needs of BME elders

2. Recommendations Regarding the European Union

⇒ Continuing to address the topic of BME elders

⇒ Enabling further exchanges of good practice between state members

⇒ Enabling further exchange between academic and research organisations

⇒ Enabling further exchange between service providers

⇒ Commissioning international comparative studies

⇒ Publishing recommendations for member states

⇒ Monitoring the EU guideline concerning equal opportunities regardless of race or ethnic origin (guideline 2000/43/EC of the Council from 29.6.2000, article 3c)

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VII Appendix

1. Schemes specifically targeting at BME elders in Leeds

A) Neighbourhood Network Services Specifically for Elders from BME Communities

Scheme name	**Area covered**	**Services provided / for**
Association of Blind Asians	City-wide/ North West	• Asian elders with a visual impairment, city-wide
Guru Nanak Day Centre	South	• Day Centre. • Sikh elders, (women) city-wide particularly South & inner areas
Leeds Black Elders Association	North East/ city wide	Services include home support, advocacy and information, decorating, gardening, befriending, transport, reminiscence group. • All BME elders, particularly African-Caribbean elders, NE and inner areas • African-Caribbean elders city-wide (particularly North) • All Chapeltown elders
Leeds Irish Health and Homes	East/ city wide	Services include home support, advocacy and information, befriending, transport. • Irish elders
Leeds Islamic Centre	North East /East	Two activity days at Montague Burton Resource Centre. • Muslim elders, North Leeds, especially NE & East • Separate provision for men and women (2x0.5 posts)
Montague Burton Resource Centre	East/city wide	Home support; older people's groups, lunch clubs, healthy living activities. • Indian women (Hindi & Gujerati speaking) city –wide • Partnership with Islamic Day Centre (men & women); Irish Health & homes. • Neighbourhood scheme for Harehills • Increased grant from o1/ 02, so numbers of service users will rise
South Leeds Elderly and Community Group	South	Services include advocacy and befriending, advice and info, drop-in, lunch club, health promotion, interpreting and translation. • Mostly Asian elders • Separate provision for men and women • Specific scheme for Bangladeshi men
West Indian Family Counselling Service	North East	• African –Caribbean elders (mainly), NE and inner areas
Baba Dal Day Centre	North East/ North	Day centre – 5 days. • Sikh and other South Asian men, • Have space but not running costs for women's scheme
Care and Repair Leeds	City-wide	Home improvement agency for low income homeowners.

		• provide all services in Bengali, Punjabi and Urdu, city-wide, particularly inner areas • 89% of work with people aged 60 years and over
Leeds Jewish Welfare Board	North East/ city wide	i) Queenshill Day Centre ii) Older People's Social Work Team • Mainly Jewish elders
West Indian Centre	North East	• Leisure activities, daily

B) BME Lunch Clubs

Lunch Clubs	**Numbers attending**	**Days provided**
Caribbean International (supported by Older Active People Neighbourhood Scheme)	14	Thursdays
Chinese Elderly	100	Wednesdays
Chinese Community Tuesday	30	Tuesdays
Hindu Women's (at Montague Burton)	22	Wednesdays
Islamic Day Centre (at Montague Burton)	35	Mondays & Tuesdays
Queenshill (Leeds Jewish Welfare Board)	300	Weekdays
Leeds Vietnamese Community Association		Being reviewed by Social Services
Senior Citizens' Endeavour	30	Wednesdays & Fridays. Caribbean food
Woodsley Rd Kashmiri Association	40	Tuesday, Thursday, Sunday - lunch club and support
Leeds Irish Health & Homes (at Montague Burton)	20	Fridays
Roscoe Luncheon Club (West Indian Family Counselling)	20	Weekdays