Minority Elderly Care in Europe:
Country Profiles
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Country Profiles

United Kingdom
France
Germany
Netherlands
Spain
Finland
Hungary
Bosnia-Herzegovina
Croatia
Switzerland

Edited by Naina Patel
MEC project leader and director of PRIAE

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PRIAE Policy Research Institute on Ageing and Ethnicity
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Minority Elderly Care in Europe: Country Profiles is a milestone in the establishment of a sound knowledge base aimed at determining practical response to the needs of Europe’s growing minority ethnic elderly population.

This book, a first in the series on Minority Elderly Care in Europe, provides useful information on the diverse population who settled in Europe as a result of colonial links, refugee status, economic necessity, as well as long-established minorities in specific countries. Each country profile assesses the socio-economic status, health condition, care provision and much more for specific minority ethnic groups. What is clear is that, in almost all cases, minority ethnic groups are not simply waiting for the state to respond to their emerging and growing needs. The research finds good examples of best possible care and support by community organisations despite their limited resources and often precarious existence. Such support indicate the strengths and resilience of minority ethnic communities. However this is not sufficient.

The authors in this book show that policymakers and professionals need to do much more, and act now, so that minority ethnic elderly in Europe experience ageing with dignity and respect, free from fear of ill-health and insecurity. With this aim in mind, policymakers and planners also need to increase the knowledge base and develop relevant services.

This book by the MEC Minority Elderly Care project team, with the support of the European Commission Fifth Framework Research Programme, is the first attempt to provide detailed multi-country information on the circumstances, experiences and care needs of minority ethnic elderly. It is an important digest and I hope that can be regularly updated. In the next year or two we will see further significant and timely publications from the MEC project team, when the research on health and social care needs of minority ethnic elderly and service providers’ perspectives is completed.
On behalf of the MEC partners, we would like to express our special thanks to our Scientific Officer Dr Maria Theofilatou (DG Research) and Adam Tyson (Anti-racism section DG Employment) for encouraging the completion of this publication. The MEC project is part of the Quality of Life and Management of Living Resources programme, falling under action line 6.5, ‘Health and social care services to older people’, supported by the European Commission. The MEC proposal was awarded the highest research rating in its stream and is the first research project to be supported in ageing and ethnicity in the EC’s 24 years of Framework funding.

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The delivery of high quality health and social care is a fundamental objective of developed nations. In light of the rapid demographic shift towards an older population throughout the western hemisphere, health and social care are issues that have assumed a high political priority. In broad terms, MEC’s research investigates the effectiveness and quality of health and social care delivery; more specifically, its focus is on investigating the quality and effectiveness of provision to ethnic minority elderly.

Hence the project’s fundamental importance in producing rigorously researched empirical evidence on important issues facing policy-making bodies. The research attempts to evaluate the ‘best’ way to manage the delivery of health and social care to minority elders, requiring examination of the efficiency, quality and user-acceptability of different modes of health and social care organisation and delivery.

The research adopts a perspective that underpins the concept of ‘quality management’ and that stresses the importance of the process through which aims are achieved. Fundamentally, such a philosophy of management is concerned with continuous and consistent delivery of value to the customer. Under a quality perspective, value is defined in terms of the needs of the customer (in our case, ethnic minority elders); efficiency is assessed in terms of the ability to deliver value for money (the best use of resources); effectiveness is an assessment of how far delivery meets needs (the appropriateness of the delivery). To facilitate all of this, good process is essential. The process defines the activities and actions necessary to deliver quality efficiently and effectively. In terms of MEC, what this means is that the issues that its research covers, as examined below, define the parameters within which research instruments (primarily questionnaires) are designed and implemented. Wherever possible, in order to facilitate essential broader comparative analyses, the research design either includes a comparison with relevant research on majority populations in each country and/or incorporates a comparative element in the questions posed to the groups under study.

The MEC project began in May 2001 and is to end in April 2004. It generated 11 full-time-equivalent posts over the three-year period.
Due to limitations of time and resources, MEC research design is necessarily selective: each country’s focus is on three ethnic groups (large and small) in two or three regional locations.

We list below for each country the ethnic groups and regions.

**UK**
- African Caribbean
- Asian (Indian, two language groups; Pakistani, two language groups; Bangladeshi)
- Chinese and Vietnamese
  - London, Yorkshire and Scotland

**France**
- Algerians
- Moroccans
- South East Asia, mainly Vietnamese and Cambodians
  - Ile de France, Rhône, Isère

**Germany**
- Turkish
- Repatriates from the former Soviet Union
- Italian
  - Berlin; Munich; Augsburg

**Netherlands**
- Turkish
- Surinamese
- Moluccan
  - Amsterdam–West Leiden/Alphen aan den Rijn

**Spain**
- Roma
- Moroccan
- South Americans
  - Andalucia and Catalonia

**Finland**
- Russian
- Vietnamese
- Sami
  - Capital area and Lapland

**Hungary**
- Roma
- German
- Croatian

**Bosnia-Herzegovina**
- Hungarian
- Czech
- Roma
  - Cantons of Sarajevo, Tuzla, Zenica-Doboj, Central Bosnia; Region of Bijeljina, Region of Banja Luka

**Croatia**
- Hungarian
- Bosniak
- Czech
  - Counties of Zagreb, Bjelovar-Bilogora, Primorje-Gorski Kotar, Osijek-Baranja

**Switzerland**
- Italians
- Spanish
- Former Yugoslavians
  - Geneva and Basle
The order of country reports: ‘large’ countries, in which the sample is larger and research resources are greater, come first. These are followed by ‘small’ countries with smaller samples and fewer research resources.

Such terms as minority ethnic elders, black and minority ethnic elders, minority elderly, migrant elders are used to describe those in minority communities, characterised by disadvantage and discrimination, in each country examined.

Variations in terminology between different chapters reflect the different usages in each country, although we recognise that some of the terms used here may not be to the preference of all. Thus references to the Roma community in Bosnia and Croatia and the Gypsies in Spain. Within Spain for example Romany is also used.

For France we have retained the official data, which designates Turkish minorities as Asian.

Elders or elderly are classified here as those aged 50+. We recognise that individuals in this age group may not see themselves as ‘old’, whether they come from minority or majority backgrounds. The age classification is, however, used to describe a group that, in one way or another, experiences issues of ageing.

Mainstream organisations are those that the general population depends on for services; they are, in the main, financed by various levels of national or regional government and/or state insurance.

Black and minority ethnic organisations or minority ethnic organisations refer to those organisations whose main purpose it is to serve the needs of particular minority ethnic populations. They are largely financed by individuals and/or non-government grants and usually work on a voluntary basis.
Introduction

Naina Patel

Setting the context for MEC research

There is a Hindi saying that ‘an old person’s teaching sets the world aright’, yet not only are the wisdom and the rich human resources of our elder populations overlooked and the contributions they can make to wider society disregarded, but the very conditions of their day-to-day existence, the social and economic backdrop to their lives, are too often characterised by shameful neglect. Of none is this more true than those who form the focus of the MEC Minority Elderly Care project. While a steadily increasing population of minority ethnic elders has been growing in significance and visibility in the countries of Europe, the path to recognising that old age is an issue for Europe’s minorities has not been straightforward. Individuals working in the fields of race and/or ageing have, for some time, been raising the need for policy makers, social planners and professionals to examine the plethora of issues thrown up by the ageing of minority ethnic populations across Europe. It is to that need and those concerns that the MEC project addresses itself.

Rationale

MEC stands for minority elderly care, and this publication is the first product of a three-year research cycle. The MEC project germinated from a suggestion, made by this author to a number of researchers and different government departments, that a tripartite approach to research into ethnicity and ageing, involving service users, mainstream service suppliers and voluntary/minority ethnic organisations catering to particular communities, was essential. This message was not heard. Thus PRIAE (the Policy Research Institute on Ageing and Ethnicity, set up in 1998) determined, like so many other self-organised minority ethnic bodies, to make progress on this issue itself and on its own terms. To that end, it was instrumental in creating the MEC project in 2000, conceptually linking users, mainstream providers and suppliers and minority ethnic suppliers. The most prominent feature of the project, structured into it, was the importance it vested in the ‘users’ of services, in minority ethnic elders themselves. What was significant – and, in this field, revolutionary – about PRIAE’s approach to the work was that, as a priority, it sought the views of elders; first and foremost, it listened attentively to what elders themselves felt was necessary. It then supplemented this with the views of practitioners,
care workers, managers of projects, and so on. Its approach, both practical and theoretical, was imbued with the concept of social justice and, therefore, racial justice.

The MEC project was designed and undertaken as a serious attempt to contribute to a health and social policy agenda relevant to the growth of the minority ethnic elderly population across Europe. The easy stereotypes hitherto underlying much thinking on social policy in many European countries, that ‘their families look after their own’ or that ‘they will return home’ and, hence, that ‘nothing much needs to be done’, were not a foundation for proper action. ‘Nothing much needs to be done’ was not an option and not borne out by reality.

Moreover, the focus in some countries on the limited range of ‘needs’ to be met had, in the past, skewed the nature of research. It is a social good that elders should have quality services, and this applies as much to minority ethnic elders. At the start of the 21st century, therefore, the search for sound empirical knowledge on which to base policy and practice meant that MEC could not be satisfied with simply developing an exploratory framework within which to conduct research. It needed to provide quantitative and qualitative information through

- investigating the perspectives of minority ethnic elders on their needs and establishing criteria for levels of acceptability in services
- assessing the perceptions of mainstream health and social care providers concerning minority elders’ needs
- assessing the services that such mainstream providers deliver and their assessments of minority organisations as providers of care
- assessing how minority organisations perceive the needs of minority elders, the services they deliver and how they assess mainstream providers.

Key issues

The MEC project operates as a consortium in 10 countries – in Bosnia-Herzegovina, Croatia, Finland, France, Germany, Hungary, the Netherlands, Spain and Switzerland and the UK – in cooperation with universities, specialist institutes and NGOs. The aim is to generate knowledge to provide practical policy responses on how best to meet the health and social care needs of minority elders from different ethnic and racial backgrounds. How should we conceptualise the organisation and delivery of services? Who currently provides them? Should such provision be ethnically separate and specialist or integrated into mainstream existing health and social care provision? What do minority elders, as users, regard as ‘acceptable’ or satisfactory health and social care services? What lessons can we learn and how can we identify good practice on which to build for the future as the numbers of minority elderly expand?

In May 1999, Article 13 of the Treaty of Europe came into effect in relation to racial discrimination and xenophobia. It was followed by the introduction of European Race and Employment Directives covering age, which are to be implemented in 2003.
Long-established minorities and those of relatively recent origin, and those among them who are growing old, are thus becoming more ‘visible’ on both the ‘age’ and ‘race relations’ agendas.

As this report shows, the growing need to address black and minority ethnic (BME) ageing emerged at around the same time that the issue of the ageing of the population generally began to be discussed in relation to policy and service provision. Ageing as an issue impacted particularly on the BME population because of its age structure at the time of its initial entry. In the UK, immigrants entering as adults soon established settled black communities. Thus, an age ‘bulge’ is working its way through the system of those who entered in the late 1950s and early to mid-1960s, settled as UK citizens and had families.

This is an issue, however, that does not only affect the UK. While other European countries, notably France and Germany, believed that they could import labour as required during the post-war period and return it when no longer needed (the guestworker system), this situation did not materialise. They also ended up with permanent minority ethnic populations, of whom many were non-white and of varying status as regards their rights. The same demographic issues of an ageing population that affect the UK are generalised throughout western Europe, with Germany being one of the most severely affected countries. In other EU countries, once exporters of migrant labour and more recently importers of it (such as Spain), the age structure of immigrant populations is younger, but the same issue of the ‘age bulge’, while not as immediate as, say, in Germany, will eventually surface. This is even more true of Finland, which, although not formerly a country of immigration, has in recent years seen increasing numbers of migrants, mainly asylum seekers and refugees and repatriates who have returned following the collapse of the Soviet Union.

In fact, the populations that the MEC project covers originate from three main sources. First, there are those who came, often from former colonial possession, to countries like the UK, the Netherlands, France and Germany during the period of post-Second World War reconstruction. Second, there are those who came more recently, fleeing today’s wars and economic dispossession. A country like Switzerland, for example, with its elaborated and precise allotment of different status categories to different types of migrants, covers the whole range from those recently seeking asylum, to those who came as economic migrants in the post-war period, to those whose skills are eagerly sought. Third, and finally, there are those whose case is, in some ways, the most difficult to redress, those who have known no other homeland, yet are endemically discriminated against in their countries of origin. Some of the most deep-rooted discrimination, affecting in profound ways their life chances, is that directed against the Roma throughout Europe. However, this is an issue that affects not just the Roma, but also groups who have been turned by warfare and ‘ethnic cleansing’ into new targets for racism and hostility, as the tragic history of Bosnia-Herzegovina demonstrates.
Approach

The strength of the MEC project is that it offers a practical perspective on a real social issue that affects the whole of Europe – eastern, central and western – in a variety of different ways and that, until now, has scarcely registered as needing to be dealt with. Focusing on the problems of ethnic minority elders also focuses attention not only on the general social problems confronting the elderly, but also on a racism against sections of the population that urgently needs to be addressed at governmental and policy levels. Each country study, by implication, sheds light on the others. The differences are profound and illuminating, but so also are the similarities in terms of need, of the types of issues that have to be tackled and the problems facing elders who are all too often impoverished and ignored by service providers.

The need for more data, however, remains paramount. This volume has begun to map the terrain, but substantial work remains to be done on issues that have all too long been ignored or even actively rejected as worthy of consideration (see ‘MEC and its aims’).

In this book, we have used a research template developed by PRIAE’s UK staff, in collaboration with colleagues from Finland and Germany, as a basis for exploring and explaining issues of age and ethnicity. A book along the lines of Minority Elderly Care in Europe: Country Profiles has never before been compiled; the difficulties in producing it were substantial, for authors in each country faced a range of problems. These included, for example: difficulties in data collection and collation because of a lack of ethnic monitoring; variable and imprecise classifications of different population groups; and the almost complete absence of any earlier relevant research from which data could be extrapolated – hence the resort, on occasion, to informed and expert opinion from practitioners in the absence of firm, up-to-date data. Despite these difficulties, however, it is our hope and expectation that this first, groundbreaking MEC publication will be used as a reference tool for each country and will be updated in the future.
Introduction

As they grow old, black and minority ethnic (BME) elders in the UK face many of the same challenges as other elders, but also bear the additional burdens of racism and discrimination. Their experience as a minority adds a specific dimension to their lives as young adults, which goes on to affect their experience of old age in Britain. However, it is true that, due to persistent efforts by BME elders, organisations in the field and others, there has been a growing acceptance among policy makers and professionals that BME elders’ needs should come on to the agenda. This report highlights the position of BME elders in the hope that this acceptance leads to effectual action and that BME elders can experience dignity and care in their lives in Britain.

The first section looks at the history of the BME community in the UK in order to establish the context of elders’ experience. The second section provides a demographic profile of the BME population. Section three, a socioeconomic profile of the BME population, focuses on employment and housing – two areas in which significant data are available – to indicate this population’s current circumstances. The fourth section provides a health profile of the BME population generally and, where information exists, of BME elders specifically. The fifth section briefly outlines the bodies that currently act as service providers to BME elders, and the final section analyses service usage patterns of BME elders and discusses the barriers that affect service use and the quality of the services available.
General context for black and minority ethnic communities

People from different areas of the world have settled in the UK throughout its history, including, of course, those from groups that are today designated as ethnic minorities. Despite this, there remains a general reluctance to talk about ‘race’ as an issue, and a ‘them’ and ‘us’ attitude is still held by a large section of society.

The experience of BME people in the UK has been bedevilled by racial discrimination. While much prejudice towards the BME population still exists today, the 1976 Race Relations Act and the 2000 Race Relations Amendment Act attempt to protect minority groups from discrimination in employment, housing and education. However, the limits of the effectiveness of anti-discrimination measures can be seen from Sir William Macpherson’s report (1999) into the murder of the black teenager Stephen Lawrence, which highlighted the existence of institutional racism in vital public bodies such as the police. The Macpherson report was described by The Economist as a ‘defining moment in race relations … by exposing the cancer of racism … it has stripped away any complacency that all is well’ (27 February 1999).

Migration

It was not until after the Second World War, in response to demands for labour from the UK, that the mass migration of ‘visible’ ethnic minorities took place. It was at this time that the collection of detailed statistics on entry began, indicating a conscious effort by the government to monitor this particular immigration. Although the categories used to classify ethnic groups have changed, the statistics show that the growth in the population of ethnic minorities has been substantial. In 1951, approximately 0.1 million non-white people were living in Britain who had been born in the New Commonwealth and Pakistan. By 1991, the census showed that the BME population (those who considered themselves ‘non-white’) had risen – by natural growth far more than by migration – to 3 million (Owen, 1995).

Immigrants who moved to meet the demand for labour came mainly as young adults. The first large-scale migration of immigrants of minority ethnic origin was of African Caribbeans in the late 1950s and early 1960s. They were more likely to move with their families, whereas the young males who arrived from India and Pakistan during the second wave of immigration in the 1960s mainly came without family members, who followed at a later stage. Further migrations of East African Asians and Bangladeshis took place in the late 1960s and early 1970s. The smaller minority groups present today, including the Chinese and the African, have migrated at a more constant rate. By the 1980s, primary immigration had been significantly curtailed under an increasingly prohibitive immigration policy; the only new communities granted entry to the UK consisted of fairly small numbers of Somali and Iranian refugees. Whereas the increase in the BME population in the UK before the 1980s was largely due to immigration, its increase since then has been as a consequence of growth in the existing population (see the section below on the ethnic composition of the population).
As Clarke and Speeden (2001: 17) state: ‘The ethnic minority population is no longer immigrant; a fact that is politically, legally, educationally and culturally important.’

Concerns over ‘the contaminating effect’ of non-white immigration, expressed by the government, endorsed by some of the mass media and reciprocated by a large section of the public, have been the main driving force behind an increasingly restrictive immigration policy. The first formal legislation to cut immigration was introduced in 1962 in response to racial tension in the late 1950s. All immigration policies since have contained preferential rights for those with some kind of family or background links to the UK. The aim of this has been to reduce the number of visually distinct immigrants, although the level of overt racial bias against settled communities has diminished to a certain extent. Recent policy has focused on restricting immigration by asylum seekers and refugees, who are portrayed as the present threat to the UK’s identity. These people currently face tremendous hostility, including concerted attacks in the mass media. Hard empirical data are difficult to come by, but anecdotal evidence suggests a high incidence of racial attacks against asylum seekers, high levels of ill health, including mental problems, and extreme impoverishment. Those who achieve refugee status or exceptional leave to remain are then legally entitled to work, but, of the 27,000 people who applied for refugee status in 1995, 80% were refused permission to stay (Salt, 1995). According to the latest Home Office figures for 2002, out of a total of 85,865 applicants, only 8100 were initially granted asylum – just under 10%.

Employment conditions

The need to fill the gaps in the labour market has already been established as the main force behind immigration to Britain. Such employment, however, was riddled with discrimination. As existing workers moved out of the least desirable jobs to those with better pay and conditions, ethnic minority workers ‘replaced’ them in these industries. This led to an uneven distribution of ethnic minority workers in the poorest paid sectors of employment, particularly in the manufacturing industries (Patel, 1990). Then, as large-scale unemployment began to hit British society from the early 1970s, ethnic minorities suffered higher rates of unemployment than the white population. While this could be attributed in part to the overrepresentation of ethnic minorities in those sectors most vulnerable to recession, there is clear evidence that, even within similar sectors, minority unemployment was greater than for whites. The discrimination that existed in finding employment is documented in Smith’s research from the 1970s. He found that 79% of white men with degrees were in professional or managerial jobs compared to just 31% of black men (Smith, 1977). The current employment profile of the BME population in the UK will be discussed later on.

As would be expected, these employment disparities affected the earnings of ethnic minorities. Such differences were most marked between the 1950s and mid-1970s. The average annual wage of a white worker in 1972 was £1519 compared to the average of £1294 for an ethnic minority worker (Patel, 1990).
National insurance (NI) contributions made during the working life determine the level of pensionable income; thus the arrival in the 1950s and 1960s of ethnic minorities already of working age meant that their NI contributions were reduced. This was not only because of lower earnings, but also because of a shorter working life in which to accumulate such contributions. The large discrepancy that this has caused today between the average pension income of BME elderly and that of white elderly will be discussed later.

Housing conditions

Although the government encouraged immigration in the 1950s and 1960s to enable the continued expansion of the British economy, the provision of facilities and services for immigrants was neglected. Just as ethnic minorities did the jobs that white people were no longer prepared to do, so they accepted the housing that whites had moved on from and no longer found acceptable (Runnymede Trust, 1980). Although the quality of housing varied from place to place in the 1950s, some of the areas inhabited by ethnic minorities could be characterised as slums in terms of the low quality of housing, high levels of overcrowding and the lack of amenities (Lakey, 1997).

Final considerations

It is important to note that the discrimination faced by the BME population was not accepted passively; the community actively tried to challenge the disadvantage and discrimination it experienced. This is evidenced through a variety of community-based and self-help initiatives, through attempts to affect policy so that it is more reflective of multicultural Britain and also through the outbreak of pent-up frustration at social and racial injustice expressed in the riots in London in the 1980s and in many northern towns in the summer of 2001. Many of today’s BME elders will have been involved in the struggles for racial and social justice in the 1950s and 1960s. Some even continued to pioneer services for their ethnic group as they approached old age in the 1980s and 1990s.

The UK’s black and minority ethnic older people have faced the experience of old age with remarkable aplomb. They are dealing with personal challenges of ageing and struggles for racial justice on a daily basis. Many individuals from these communities have also led initiatives, which give social, cultural and spiritual support to older members and their communities.

(Lord Herman Ouseley, former chairman of the Commission for Racial Equality and chair of PRIAE)

What is the relevance of this historical perspective to the work that we are undertaking in the MEC project? BME elders are an extremely diverse group and, in order to understand their position and the issues that face them today, it is necessary to look at the circumstances in which they have grown old. Employment, qualifications, income, expectations, investment, savings, current levels of social and economic capital and life experiences (including racism) are some of the factors determining how BME people experience old age. Poverty, for example, will contribute to the early onset of ageing.
As Patel (1999: 266) puts it:

For the emerging generation of elders, we must add the effects of long-term unemployment, characterised by the decline of the manufacturing base (foundries, textiles, transport) where many ethnic minorities had been concentrated. These factors may contribute to the ‘early ageing’ of minority ethnic elders beginning from the age of 55 years and the associated increased use of elder services, particularly regarding care.

**Demographic trends**

Having crossed so many continents
To settle in Glasgow,
We still have time and energy left
To develop the recommendations of your report.
(A 91-year-old elder at the PRIAE–CRE seminar)

**Ethnic composition of the UK**

The latest estimates suggest that the proportion of BME people within the UK population has increased from 5.5% at the time of the 1991 census to approximately 6.2% currently. As Figure 1a indicates, the principal cause of this growth are the relatively high fertility rates typical of communities that have a younger age structure than the white population. Additional factors that account for the BME population’s expansion include: new attitudes towards self-identification; family reunification; and the immigration of successful asylum seekers.

As Table 1 overleaf shows, the Indian population accounts for approximately one-quarter of the total BME population and is arguably the most diverse of the groups. The Pakistani population has recently overtaken the black Caribbean population as the second largest ethnic minority group; each group constitutes around 15% of the total BME population. After these comes the black African population; currently just under 10% of the BME population, it is growing at the fastest rate. The Bangladeshi population of over 280,000 makes up around 6% of the ethnic minority population. The smallest population specifically identified is the Chinese, which, it is estimated, has slightly reduced since the 1991 census. That England is the preferred domicile of most of the BME population is indicated in Table 1, but the distribution of minority groups within the UK will be discussed in more detail later.

---

1 PRIAE estimate calculated from projections based on the BME population in Northern Ireland, 1997 (Irwin and Dunn, 1997) and latest estimates for the BME population in the UK, 2000 (Schuman, 1999).
### TABLE 1  Ethnic composition (2001, thousands)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>UK</th>
<th>England</th>
<th>Wales</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>White</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>50,365</td>
<td>42,747</td>
<td>2786</td>
<td>4832</td>
</tr>
<tr>
<td>White Irish</td>
<td>692</td>
<td>624</td>
<td>18</td>
<td>50</td>
</tr>
<tr>
<td>White other</td>
<td>1423</td>
<td>1308</td>
<td>37</td>
<td>78</td>
</tr>
<tr>
<td><strong>Mixed</strong></td>
<td>13*</td>
<td>13*</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Mixed white and black Caribbean</td>
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<td>232</td>
<td>6</td>
<td>n/a</td>
</tr>
<tr>
<td>Mixed white and black African</td>
<td>78</td>
<td>76</td>
<td>2</td>
<td>n/a</td>
</tr>
<tr>
<td>Mixed white and Asian</td>
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<td>184</td>
<td>5</td>
<td>n/a</td>
</tr>
<tr>
<td>Mixed other</td>
<td>155</td>
<td>151</td>
<td>4</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Black</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>566</td>
<td>561</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Black African</td>
<td>485</td>
<td>476</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Black other</td>
<td>97</td>
<td>95</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>South Asian</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td>1052</td>
<td>1029</td>
<td>8</td>
<td>15</td>
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<tr>
<td>Pakistani</td>
<td>747</td>
<td>707</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>283</td>
<td>275</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Asian other</td>
<td>248</td>
<td>238</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td><strong>Chinese and other</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>243</td>
<td>221</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Other</td>
<td>230</td>
<td>215</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>57,104</td>
<td>49,139</td>
<td>2903</td>
<td>5062</td>
</tr>
</tbody>
</table>

* Scottish ethnic group data collected as any mixed rather than as individual mixed groups

Age structure

Who has sent old age?
Strength in the body disappears,
Work progresses in slow motion
But I like the ‘ladoos’ (cakes)
And the idea of visiting places – an adventure
Faith in god and belief in oneself
will see that this adventure comes –
There is so much to see and learn!
(Shantaben, aged 78 years)

The age structure of the UK population overall is similar to that of most other western European countries. The pattern is that of an ageing society. At present, the age profile of western populations bulges in the centre and presses upwards as the post-war baby boom generation ages. The demographic structure of the BME population is younger than that of the majority population but the ageing trend witnessed in the majority population will soon be mirrored in the minority populations.

Table 2 overleaf is based on data from the Labour Force Survey and highlights the proportional age structure of specific ethnic minority populations. The migrants who moved to the UK in the post-war era were mainly young adults, and the current age profile of each minority ethnic group is greatly influenced by the period of their immigration. As would therefore be expected, the black Caribbean population, which was the first to arrive, has the oldest profile, whereas the Pakistani, Bangladeshi and black African populations have a younger age structure and have rates of growth at least five times as great as that of the black Caribbean population. The majority of the Chinese community, which has a low birth rate and few elders within it, are either young or middle-aged adults. While the proportion of those aged 65+ is significantly lower among all minority groups than among the white population, the percentage of the black Caribbean population in this age group has trebled since 1991. Similarly, the percentage of the Indian population in the same age cohort doubled over the same period.
<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>0–14</th>
<th>15–29</th>
<th>30–44</th>
<th>45–64</th>
<th>65–74</th>
<th>75+</th>
<th>Median age</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>19</td>
<td>19</td>
<td>23</td>
<td>19</td>
<td>14</td>
<td>7</td>
<td>37</td>
</tr>
<tr>
<td>All ethnic minorities</td>
<td>30</td>
<td>25</td>
<td>25</td>
<td>12</td>
<td>6</td>
<td>1</td>
<td>26</td>
</tr>
<tr>
<td>Black</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>22</td>
<td>19</td>
<td>30</td>
<td>14</td>
<td>13</td>
<td>2</td>
<td>33</td>
</tr>
<tr>
<td>Black African</td>
<td>31</td>
<td>26</td>
<td>31</td>
<td>9</td>
<td>3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Black other (non-mixed)</td>
<td>41</td>
<td>27</td>
<td>28</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Black mixed</td>
<td>58</td>
<td>25</td>
<td>13</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>South Asian</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indian</td>
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<td>24</td>
<td>27</td>
<td>16</td>
<td>8</td>
<td>2</td>
<td>31</td>
</tr>
<tr>
<td>Pakistani</td>
<td>34</td>
<td>31</td>
<td>20</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>22</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>40</td>
<td>29</td>
<td>18</td>
<td>8</td>
<td>6</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Chinese and other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>16</td>
<td>31</td>
<td>31</td>
<td>14</td>
<td>7</td>
<td>2</td>
<td>31</td>
</tr>
<tr>
<td>Other Asian (non-mixed)</td>
<td>21</td>
<td>23</td>
<td>34</td>
<td>16</td>
<td>5</td>
<td>1</td>
<td>32</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td>23</td>
<td>31</td>
<td>14</td>
<td>3</td>
<td>1</td>
<td>29</td>
</tr>
<tr>
<td>Other mixed</td>
<td>52</td>
<td>23</td>
<td>15</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>12</td>
</tr>
</tbody>
</table>

Source: PRIAE adaptation from Scott et al., 2001: 11
Settlement patterns of the BME population

The great majority of the BME population of the UK, approximately 97.2%, live in England. A further 1.6% live in Scotland and 1.2% in Wales (Schuman, 1999).

Within England, the distribution of the ethnic minority population tends to be concentrated in and around urban areas, particularly London. The latest information from the Labour Force Survey estimates that approximately half of the ethnic minority population lives in London compared to just over 10% of the white population. Other regions with considerable ethnic minority populations are the West Midlands, the Northwest, Yorkshire and the East Midlands, with their large conurbations where immigrants first settled in the 1950s. Data from the 1991 census illustrate a direct correlation between the areas in England in which BME people live and the existence of deprivation. Over three-quarters of the 29 local authority districts with ethnic minority populations above 15% are listed among the 40 districts with the highest overall degree of deprivation. (These 40 districts account for 7% of the total number of districts in England.)

Table 3 overleaf looks at the regional distribution of each individual minority group in 2001. The areas featured are the English regions as defined in the 2001 census. The data shows that the BME population is unevenly located with concentrations in specific areas of England. The Pakistani community is the only one that does not have the highest percentage of its population living in London, instead being spread relatively evenly across other urban locations, including the West Midlands, West Yorkshire and Greater Manchester. The black Caribbean, Indian and Bangladeshi population is concentrated in London, with a significant presence in the West Midlands, followed by East Midlands, Yorkshire and Humber and the North West. The ethnic group least concentrated in urban areas is the Chinese, which are the most diffuse group. The highest proportion of its population lives in Scotland.

Although there are no data analysing the geographical distribution of different age groups within each ethnic minority, it is believed that elders are most concentrated in urban areas. That ethnic minorities are concentrated in certain locations should make it easier to provide services for them as a community. But where ethnic minorities are found in much smaller numbers, such as rural areas, their specific requirements are often ignored; they become ‘invisible’.
### TABLE 3 Regional distribution of ethnic minorities in England (thousands)

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>North East</th>
<th>North West</th>
<th>Yorks &amp; Humber</th>
<th>East Midlands</th>
<th>West Midlands</th>
<th>East of England</th>
<th>London</th>
<th>South East</th>
<th>South West</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>2,425.6</td>
<td>6,203.0</td>
<td>4,551.3</td>
<td>3,807.7</td>
<td>4,537.9</td>
<td>4,927.3</td>
<td>4,287.9</td>
<td>7,304.7</td>
<td>4,701.6</td>
</tr>
<tr>
<td>Irish Irish</td>
<td>8.7</td>
<td>77.5</td>
<td>32.7</td>
<td>35.4</td>
<td>73.1</td>
<td>61.2</td>
<td>220.5</td>
<td>82.4</td>
<td>32.4</td>
</tr>
<tr>
<td>Other Other</td>
<td>21.1</td>
<td>74.9</td>
<td>57.2</td>
<td>57.1</td>
<td>63.2</td>
<td>136.4</td>
<td>594.8</td>
<td>221.9</td>
<td>81.2</td>
</tr>
<tr>
<td>Mixed Mixed white and black Caribbean</td>
<td>2.8</td>
<td>22.1</td>
<td>18.1</td>
<td>20.6</td>
<td>39.8</td>
<td>19.9</td>
<td>70.9</td>
<td>23.7</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>Mixed white and black African</td>
<td>1.7</td>
<td>9.8</td>
<td>4.1</td>
<td>3.4</td>
<td>3.7</td>
<td>6.1</td>
<td>34.2</td>
<td>9.5</td>
</tr>
<tr>
<td></td>
<td>Mixed white and Asian</td>
<td>4.7</td>
<td>17.2</td>
<td>14.2</td>
<td>11.1</td>
<td>18.1</td>
<td>17.4</td>
<td>59.9</td>
<td>30.0</td>
</tr>
<tr>
<td></td>
<td>Mixed other</td>
<td>2.9</td>
<td>13.3</td>
<td>8.5</td>
<td>7.9</td>
<td>11.6</td>
<td>14.6</td>
<td>61.0</td>
<td>22.5</td>
</tr>
<tr>
<td>Black Black Caribbean</td>
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<td>20.4</td>
<td>21.3</td>
<td>26.7</td>
<td>82.3</td>
<td>26.2</td>
<td>343.5</td>
<td>27.4</td>
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<td>17.0</td>
<td>379.0</td>
<td>24.6</td>
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<tr>
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<td>3.3</td>
<td>3.6</td>
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<td>5.3</td>
<td>60.3</td>
<td>4.9</td>
<td>2.3</td>
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<tr>
<td>South Asian Indian</td>
<td>10.1</td>
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<td>122.3</td>
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<td>51.0</td>
<td>437.0</td>
<td>89.2</td>
<td>16.4</td>
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<td>142.7</td>
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<tr>
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<td>6.9</td>
<td>31.4</td>
<td>18.5</td>
<td>153.9</td>
<td>15.3</td>
<td>4.8</td>
</tr>
<tr>
<td>Asian other</td>
<td>3.2</td>
<td>14.7</td>
<td>12.3</td>
<td>11.8</td>
<td>21.0</td>
<td>13.4</td>
<td>133.0</td>
<td>23.5</td>
<td>4.8</td>
</tr>
<tr>
<td>Chinese and other</td>
<td>Chinese</td>
<td>6.0</td>
<td>26.9</td>
<td>12.3</td>
<td>13.0</td>
<td>16.1</td>
<td>20.4</td>
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<tr>
<td>Other</td>
<td>4.2</td>
<td>13.3</td>
<td>9.5</td>
<td>7.3</td>
<td>14.1</td>
<td>14.5</td>
<td>113.0</td>
<td>29.2</td>
<td>9.3</td>
</tr>
</tbody>
</table>

Population projections

The 1998-based national population projections, carried out by the government’s Actuary Department, show that the population of the UK was expected to increase only slightly from 59.2 million in 1998 to over 63.5 million by 2021. However, the age structure of the population is expected to change dramatically. The number of people aged 45+ is expected to increase by 29%; correspondingly, the number of people under 45 is expected to fall. The median age of the population is projected to increase from 36.9 years in 1998 to 41.8 years in 2021 (Shaw, 2000).

While the number of dependants per 1000 people of working age is projected to fall slightly, the percentage of dependants aged 65+ is set to rise. Furthermore, it is forecast that, by 2011, there will be more dependants aged 65+ than under 16. This transformation from a majority of child dependants to a majority of elderly dependants will have profound effects not only nationally, but also at the level of communities and families.

Although there are no national projections for the BME population in the UK, the London Research Centre (LRC) has produced estimates of the future BME population in London (Lodwell et al., 2000). Since a great proportion lives in London, the LRC projections provide a useful insight into the future population structure of BME communities, including the older age cohorts. According to these, the number of BME people aged 65+ in London is expected to treble by 2011 from the 1991 level. The biggest growth will be in the numbers of elders from the black Caribbean and Indian communities. Over the same period, the white population aged 65+ is expected to fall. Overall, the proportion of London’s BME population aged 65+ is predicted to increase from below 5% in 1991 to over 15% in 2011.

Socioeconomic situation

Employment and ethnicity

Direct and indirect discrimination in the area of employment has, at times, been almost ubiquitous. There is clear evidence of major disparities between the ethnic minority population and the majority population in accessing employment, in the nature of the employment obtained and in opportunities to progress within organisations. Levels of unemployment are indicative of these processes. The latest data show that the unemployment rate for the BME population is 11% compared to 4% for the white population (Labour Market Trends, 2002).

Although unemployment rates differ between minority ethnic groups, in every age band unemployment is lower among the majority white population. Labour Force Survey figures indicate that among the group becoming old (i.e. males aged 45–64 and females aged 45–59), the unemployment rate for all BME groups combined is three times that of the white group. Within this age group, the Pakistani and Bangladeshi populations together have the highest rate of unemployment (about 26%), which is five times greater than that of the comparable white population.
FIGURE 1  Income level by ethnic group of head of household

Source: DSS, 2001: 69
When migrants first arrived in the UK, they usually only found work in the sectors of the economy with the poorest pay and worst conditions. Although employment levels have improved for some minorities, most notably the Chinese, Indian men and black Caribbean women, overall only a small proportion achieve positions of significance while a high proportion remain in the low-paid manufacturing sector. For example, almost 20% of Indian and Pakistani women are employed in the manufacturing industry. Similarly, 10% of Pakistani men are employed in manufacturing textiles and clothing, compared to just over 1% of all men (TUC, 2000). Clear evidence of discrimination over access to employment is found in data on the unemployment rates of graduates. Among graduates with equivalent qualifications, BME applicants are five times more likely to get rejected when seeking employment (Cabinet Office, 2002). It is worth noting that the discrimination and racial hostility that earlier migrants experienced is now being replicated – if anything, even more starkly – against asylum seekers who, with few rights in the UK, are forced into a clandestine world of illegal cheap labour.

Household income and ethnicity

Those who have means must pay
Those who have no means must be provided for
without hesitation or humiliation.
(An elder at PRIAE’s Royal Commission seminar)

Figure 1 shows the proportion of each ethnic group in each quintile band of income distribution for the total population. If there was no relationship between ethnicity and income, one would expect to find 20% of each ethnic group in each band. But, as can be seen from the figure, 30% of non-Caribbean blacks and 58% of Pakistanis/Bangladeshi are in the bottom fifth of income distribution. Compared to the total of adults of working age, all BME groups are overrepresented in the bottom quintile.

The income distribution profile for elders is no different from the general BME picture. Lodwell et al. (2000) report that 27% of white people aged 60+ are in the bottom fifth of income distribution compared to 65% of Pakistani/Bangladeshi elders, 55% of Indian elders, 43% of black Caribbean elders and 46% of Chinese elders. Clearly this has implications for their health, social care and housing needs. As PRIAE’s report to the City Parochial Foundation (2000: 15) states:

where elders were previously in low status, low wage occupations;
where, as adults, they were excluded from opportunities; where their experience of adult life was one of disadvantage, the cumulative effect has been to place many Black and Minority Ethnic elders in a worse position – economically and socially – than the majority White population of equivalent age. And, given the lamentable position of many White elders, this is a dismal comparison.
FIGURE 2  Income support and National Insurance pensions by minority ethnic group

Source: Adapted from Lodwell et al., 2000: Table 3.12d

<table>
<thead>
<tr>
<th></th>
<th>Pakistani/Indian</th>
<th>Bangladeshi</th>
<th>Black Caribbean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local authority housing</td>
<td>29</td>
<td>11</td>
<td>34</td>
</tr>
<tr>
<td>Owned with mortgage</td>
<td>11</td>
<td>42</td>
<td>22</td>
</tr>
<tr>
<td>Owned outright</td>
<td>55</td>
<td>42</td>
<td>39</td>
</tr>
</tbody>
</table>

Source: Evandrou, 2000a: 13
Income support is a means-tested benefit payable to people on low incomes. As such, it is a good indicator of any financial inequality faced by members of a particular community or age group. Data presented in Figure 2 highlight the fact that a significantly high proportion of people aged 40–59 from BME communities receives income support compared to the equivalent white age group. One-third of the combined Pakistani/Bangladeshi group receive income support, whereas the equivalent figure for white people in the same age band is merely 8%, highlighting the severe inequality faced by Pakistani/Bangladeshi people in preretirement. NI pension entitlement figures also differ between ethnic minority groups. There seems to be a negative correlation between those in receipt of NI pensions and entitlement to income support. As indicated above, the Pakistani/Bangladeshi group appears to be in the worst situation of all. Clearly this has direct implications for the ability of those in such communities to contribute financially to the cost of their health and social care.

Household composition

There are two main patterns to note in analysing the household composition of ethnic minority elders. First, most black Caribbean people aged 60+ live, like white elders, in small households. Almost one-third live alone and a further 43% live with their partner. In contrast, South Asian elders live in much larger households than the majority population. Of Indians aged 60+, 58% live in households with at least three adults, with or without children; among the same age group in the Pakistani/Bangladeshi communities, the proportion is 70%. Within these populations, Indians are less likely to live with children. Pakistanis/Bangladeshis aged 60+ live, on average, in households with 1.2 children, whereas only 0.6% of Indian elders and 0.02% of white elders do so (Evandrou, 2000a).

Housing

There is a significant disparity in the pattern of tenure between the various ethnic minority groups. Around 80% of Indian and Pakistani households own their own homes compared to 66% of white households, 62% of Chinese, 48% of black Caribbean, 46% of Bangladeshi and just 28% of black African households. Over one in three black Caribbean, Bangladeshi and black African households rent from the public sector. Bangladeshi homes are the most crowded and almost half have over one person per room (Owen, 1993). It is worth noting, however, that higher levels of home ownership among Asians do not necessarily imply a higher standard of living, but are due to the lack of suitable accommodation. (Scottish Homes, 1997).

As Table 4 shows, the housing tenure of BME elders shows some parallels with that of BME communities in general, with Indian elders having the highest rate of owner-occupation. However, fewer Indian elders own their homes outright in comparison to white elders whose economic position is generally better. Pakistani/Bangladeshi and black Caribbean elders are more likely to live in local authority accommodation; the former because of their poor economic profile and the latter also because of their smaller household structure.
### TABLE 5 Limiting longstanding illnesses by age and ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Men 16–34</th>
<th>35–54</th>
<th>55+</th>
<th>All men</th>
<th>Women 16–34</th>
<th>35–54</th>
<th>55+</th>
<th>All women</th>
</tr>
</thead>
<tbody>
<tr>
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<td>22</td>
<td>39</td>
<td>24</td>
<td>16</td>
<td>21</td>
<td>53</td>
<td>27</td>
</tr>
<tr>
<td>Indian</td>
<td>7</td>
<td>21</td>
<td>42</td>
<td>21</td>
<td>8</td>
<td>26</td>
<td>62</td>
<td>25</td>
</tr>
<tr>
<td>Pakistani</td>
<td>10</td>
<td>30</td>
<td>49</td>
<td>22</td>
<td>14</td>
<td>30</td>
<td>57</td>
<td>23</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>15</td>
<td>36</td>
<td>61</td>
<td>30</td>
<td>12</td>
<td>39</td>
<td>53</td>
<td>22</td>
</tr>
<tr>
<td>Chinese</td>
<td>8</td>
<td>13</td>
<td>28</td>
<td>14</td>
<td>6</td>
<td>12</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>General population</td>
<td>10</td>
<td>23</td>
<td>39</td>
<td>25</td>
<td>12</td>
<td>22</td>
<td>42</td>
<td>26</td>
</tr>
</tbody>
</table>

Source: Adapted from Health Survey of England, 1999: Table 2.2
Access to consumer durables and car ownership are also commonly used as quality of life indicators. A convenient means of transport, such as a car, is an important determinant of an elderly person’s mobility. It also facilitates social participation and inclusion, but some 63% of black Caribbeans aged 60+ live in households without a car compared to 48% of Pakistanis, 43% of whites and 33% of Indians in the same age group. It is worth mentioning, however, that elders living in the large households more typical of the Pakistani/Bangladeshi populations may well have only limited access to any car belonging to the family. Another significant quality of life indicator is the telephone. This is an important means of maintaining relationships and also offers a greater sense of security. Of Pakistani/Bangladeshi elders, 18% do not have a telephone in their homes, twice the figure for white, Indian and black Caribbean elders.

Health profile

The elderly! What elderly?
My legs are only a little tired
And death is due
But do I think about it?
No!
(A 92-year-old man from the Maghreb)

A full health profile involves lengthy analysis of a large number of constituent factors. This section will therefore feature the available data on recognised indicators of physical and mental status to generate a summary health profile for BME elders.

Limiting longstanding illness

So-called limiting longstanding illnesses are important indicators of a general health pattern. A limiting longstanding illness is one that causes disability or infirmity affecting a person’s activities over a period of time. Among the general population, 25% of men and 26% of women are reported to suffer from a limiting condition.

As Table 5 shows, South Asian men and women as well as all black Caribbean women aged 55+ report relatively high levels of limiting longstanding illness compared to the general population. The propensity for people of South Asian origin to report relatively higher levels of chronic ill health is also confirmed by Evandrou (2000b) and the results of the Fourth National Survey. Chinese men and women are less likely to report acute sickness than men and women in the general population or in all other minority ethnic groups.

Prevalence of cardiovascular disease conditions

Despite the reduction in mortality from cardiovascular disease (CVD) conditions in most industrial countries since the 1970s, these are still a leading cause of death, particularly coronary heart disease.
TABLE 6  Prevalence of cardiovascular disease conditions among those aged 55+ by minority ethnic group (%)

<table>
<thead>
<tr>
<th></th>
<th>Black Caribbean</th>
<th>Indian</th>
<th>Pakistani</th>
<th>Bangladeshi</th>
<th>Chinese</th>
<th>Irish population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angina</td>
<td>5.3</td>
<td>18.2</td>
<td>11.4</td>
<td>12.8</td>
<td>4.0</td>
<td>13.3</td>
</tr>
<tr>
<td>Heart attack</td>
<td>1.7</td>
<td>11.6</td>
<td>11.5</td>
<td>11.1</td>
<td>5.8</td>
<td>9.9</td>
</tr>
<tr>
<td>Heart murmur</td>
<td>1.8</td>
<td>5.8</td>
<td>2.5</td>
<td>1.6</td>
<td>1.1</td>
<td>1.5</td>
</tr>
<tr>
<td>Abnormal heart rhythm</td>
<td>3.0</td>
<td>6.1</td>
<td>4.3</td>
<td>1.5</td>
<td>1.1</td>
<td>10.3</td>
</tr>
<tr>
<td>‘Other’ heart trouble</td>
<td>1.1</td>
<td>4.1</td>
<td>–</td>
<td>6.0</td>
<td>1.8</td>
<td>5.3</td>
</tr>
<tr>
<td>Stroke</td>
<td>7.9</td>
<td>9.6</td>
<td>2.8</td>
<td>3.9</td>
<td>3.7</td>
<td>6.8</td>
</tr>
<tr>
<td>Diabetes</td>
<td>17.9</td>
<td>19.2</td>
<td>39.0</td>
<td>30.6</td>
<td>16.1</td>
<td>11.8</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angina</td>
<td>7.1</td>
<td>8.2</td>
<td>7.4</td>
<td>4.6</td>
<td>1.3</td>
<td>9.3</td>
</tr>
<tr>
<td>Heart attack</td>
<td>1.3</td>
<td>1.3</td>
<td>5.8</td>
<td>–</td>
<td>–</td>
<td>3.7</td>
</tr>
<tr>
<td>Heart murmur</td>
<td>2.9</td>
<td>5.2</td>
<td>7.5</td>
<td>2.6</td>
<td>2.1</td>
<td>4.1</td>
</tr>
<tr>
<td>Abnormal heart rhythm</td>
<td>6.4</td>
<td>8.3</td>
<td>6.3</td>
<td>3.6</td>
<td>3.4</td>
<td>5.7</td>
</tr>
<tr>
<td>‘Other’ heart trouble</td>
<td>2.4</td>
<td>1.4</td>
<td>–</td>
<td>2.2</td>
<td>1.3</td>
<td>4.3</td>
</tr>
<tr>
<td>Stroke</td>
<td>2.9</td>
<td>1.9</td>
<td>5.2</td>
<td>1.7</td>
<td>1.3</td>
<td>6.0</td>
</tr>
<tr>
<td>Diabetes</td>
<td>25.7</td>
<td>15.3</td>
<td>28.3</td>
<td>26.0</td>
<td>11.8</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Source: Adapted from Health Survey of England, 1999: Table 3.2

TABLE 7  GP consultations in the previous year for anxiety, depression, mental, nervous or emotional problems by age and minority ethnic group (England, %)

<table>
<thead>
<tr>
<th>Consulting GP on own behalf</th>
<th>Men</th>
<th>16–34</th>
<th>35–54</th>
<th>55+</th>
<th>All men</th>
<th>Women</th>
<th>16–34</th>
<th>35–54</th>
<th>55+</th>
<th>All women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Caribbean</td>
<td>7</td>
<td>24</td>
<td>12</td>
<td>13</td>
<td></td>
<td>13</td>
<td>21</td>
<td>19</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td>6</td>
<td>13</td>
<td>22</td>
<td>13</td>
<td></td>
<td>13</td>
<td>12</td>
<td>24</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Pakistani</td>
<td>14</td>
<td>16</td>
<td>23</td>
<td>16</td>
<td></td>
<td>17</td>
<td>27</td>
<td>30</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>8</td>
<td>20</td>
<td>10</td>
<td>12</td>
<td></td>
<td>6</td>
<td>14</td>
<td>25</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>8</td>
<td></td>
<td>9</td>
<td>10</td>
<td>4</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>General population</td>
<td>11</td>
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<td>13</td>
<td>14</td>
<td></td>
<td>18</td>
<td>24</td>
<td>16</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from Bajekal, 2000: Table 11.6
Table 6 shows that Indian men and Pakistani women aged 55+ report higher rates than the general population of most CVD conditions. Old age diabetes also seems to be very common among ethnic minority groups, particularly South Asian elders.

Blood pressure

It is widely accepted that the relationship between blood pressure and CVD is continuous and there is no threshold effect in risk for CVD. Genetic and environmental factors, known and unknown, are among the variables that determine blood pressure. Different blood pressure levels among BME elders would therefore be expected. Thus, black Caribbean elders (aged 55+) have higher blood pressure levels than the general population. The Health Survey of England (1999) reports that black Caribbean men and all BME women aged 55+ have a greater incidence of high blood pressure than the general population. Nazroo (1997) reports similar rates of hypertension among ethnic minority groups. While Indian, African, Asian and Chinese respondents report lower rates, black Caribbeans are almost 50% more likely to report hypertension than white respondents.

Mental health

Research evidence and statistical data presented in this report suggest that BME groups experience considerably greater levels of social and material inequality. Hence, it would be surprising if they did not also experience a high level of mental health problems.

Table 7 indicates the frequency of general practitioner (GP) consultations by ethnic minority patients over anxiety, depression, mental, nervous or emotional problems, according to age, for England. The data indicate that, among men aged 55+, Indians and Pakistanis consult their GP on mental health matters almost twice as often as the general population. South Asian and black Caribbean women aged 55+ have higher rates of consultation than the general population. This is particularly true of Pakistani women aged 55+. Although data presented in Table 7 show high rates of anxiety, depression and other symptoms of mental ill health, these may not be reflected in hospital referrals and admission records.

Among older age groups, in which depression is an important feature but often remains undiagnosed, dementia is also increasingly significant. PRIAE’s CNEOPSA2 Satellite Model currently provides both training and a model for carers of BME dementia sufferers (Patel et al., 1998). No national data exist on the prevalence of dementia among the BME population, but estimates are available for London (PRIAE, 2001). These estimates, based on the assumption that rates of dementia in the BME population are equivalent to those in the white population, suggest that the number of BME elders in London with dementia is currently around 6270. This figure is projected to rise to around 10,100 by 2011.

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2 The CNEOPSA Satellite Model on meeting the needs of BME sufferers of dementia is an ongoing PRIAE project. It focuses on London, home of some 50% of the BME population and the majority of asylum seekers and refugees.
Service providers

There are three main sources of health and social care provision in the UK: statutory provision, private sector provision and voluntary community organisations.

Statutory provision

The National Health Service (NHS) was created in 1948 to provide health care for all citizens of the UK, based on an individual’s need rather than ability to pay. The NHS provides primary and secondary care. Primary care is received at the first point of contact with the health care system, with GPs. They act as the principal gateway to other health and social care services. These locally-based professionals are highly skilled and will carry out diagnosis or refer a patient on to a specialist. Consultations are free. Other primary care services include opticians, dentists and pharmacists. Secondary care is specialised health care treatment, usually provided by a hospital. Except in emergencies, hospital treatment is arranged by referral through a GP. Secondary care appointments and treatment provided by the NHS are free to any UK citizen.

Unlike health care and other mainstream facilities like education, social services do not serve the broad population, but are aimed at the socially disadvantaged (Patel, 1990). Social care is care that is provided to vulnerable people both in the community and the home or in locations in which particular, specialised services are offered such as a nursing home. Social care usually allows more independence and privacy than health care. The care provided is extremely diverse; it includes help to elders with some of their daily routines, such as cleaning and personal care, support for those with learning disabilities and assistance for those with problems concerning drug or alcohol abuse.

The provision of social care in England is the responsibility of individual local authorities. All local authorities are not expected to provide exactly the same services, but are given flexibility to meet the specific demands of the populations they serve. They work alongside voluntary and private organisations as well as the NHS and other statutory bodies to provide social care to every individual within their administrative boundaries.

The Social Care Group is responsible for monitoring service provision at the local level, developing new standards and ensuring that the best care possible is given to everyone who needs it, within the limits of available resources. The Social Care Group along with the NHS and the Public Health Group, which is responsible for improving public health, come under the remit of the Department of Health (DoH). This has overall statutory responsibility for ensuring that the health and social care needs of the British population are met in a fast, fair, convenient way, while a high level of quality is maintained (DoH, 2001d). The National Service Framework for Older People is a major development in setting standards on service provision and delivery across the sector.
Private sector provision

The private sector is part of the larger independent sector, which includes both private and non-governmental voluntary organisations that provide health and social care. The private sector was originally established out of the desire for an alternative source of health and social care for those who wanted to pay. The growth rate in private health care has increased since the 1980s, when it was just one of many sectors to benefit from government incentives to encourage private enterprise. Statistics from the DoH indicate that the number of beds in the independent sector has increased from 23,000 in 1983 to 193,000 in 2000, during which time the number of beds in the NHS has decreased from 480,000 in 1979 to 189,000 in 2000 (Pollock and Kerrison, 2001).

This shift in the number of beds provided by the NHS and the independent sector is one factor underlying the current involvement of the private sector in helping statutory providers meet the needs of non-private patients. The DoH now contracts with the private sector for the delivery of specific services to elderly and disabled people. The private sector now provides by far the highest proportion (78%) of the nursing and long-stay hospital care for elderly chronically ill and physically disabled people; 15% is provided by the NHS and 7% by the voluntary sector (Laing & Buisson, 1998).

BME voluntary community organisations

The roots of BME organisations in the UK go back to the beginning of the 20th century, but most current organisations have grown out of the self-help initiatives of the ‘first generation’ of BME settlers. They set up their own services in areas in which their communities were ill-served, despite the obvious need. This is clearly the case in relation to BME elders, and many small projects emerged some 20 years ago that are now substantial organisations – although many others did not survive due to lack of funding. Such organisations have been critically important in providing support to BME elders (Patel, 1990). Their experience, capacity and understanding of the issues facing BME communities have been drawn on in order to inform policy makers and planners (Patel, 1999). The MEC project will yield important information in this regard, for analysis of the role of independent BME organisations is one of the three key elements of its investigation. However, despite their long existence, there is little data on this specific sector. The only national work on BME organisations to date was undertaken by McLeod et al. (2001). Although their report provides some basic information on BME organisations, significant gaps remain.

McLeod et al. found that BME organisations are usually, but not always, established to serve a specific ethnic community. The size of the area that they cover varies, but is generally fairly local. Most organisations offer a range of services and aim to serve several sectors of the population, such as the elders and women.

As would be expected, the proportion of organisations that provide services for the elderly is related to the age profile of the particular community.
Thus, while 83.3% of organisations targeted at African Caribbeans serve elders, just 42.9% of organisations targeted at Pakistanis do so (McLeod et al., 2001). However, a significant proportion of all BME organisations provide services for elders. The services provided were analysed only in terms of an organisation’s size, measured by its annual income and not in terms of its clientele. Provision of training, information, advice and advocacy were found to characterise almost all BME organisations. These organisations also act as gateways to other services; over half offer assessment or referral services and most of the larger organisations (annual income over £250,000) are able to offer access to specialised services from other agencies (McLeod et al., 2001).

In focusing on services that are particularly useful to elders, it becomes clear that BME organisations by and large only provide alternative social services specific to their communities and not health care services, mainly because health care provision is both expensive and highly specialised (Askham et al., 1995). McLeod et al. (2001) found that over half of all BME organisations offer outreach support, including home visits. Other services include day care facilities such as drop-in centres, lunch clubs and transport facilities. Some of the larger organisations are able to provide residential facilities.

The principal reason for the inability of BME organisations to offer more facilities and serve a greater number of people is their inadequate funding. Many BME organisations, and almost all of those with a low annual income, are dependent on funding from statutory bodies, principally local authorities. This is despite the gradual erosion of statutory funding and the change in the relationship between funder and service provider that has taken place over the last decade (McLeod et al., 2001). Furthermore, the funding received from the state is normally short-term (for a maximum of three years), which restricts strategic planning. Excessive reporting and accounting procedures are also demanded, generating a widespread belief in the sector that funders do not trust BME organisations to manage themselves and their budgets efficiently (Institute for Public Policy Research, 2001).

As such, grants are often made by a local authority to fill a gap that it, as a statutory provider, has failed to cover. BME organisations feel that they should be treated on an equal footing with core services and given ongoing and sufficient incomes. Instead they have to make frequent and repeated justifications of their services to maintain grant funding. Obtaining grants is also difficult for BME organisations; their initial low funding levels often mean that they do not have the staff, infrastructure or access to information to compose good quality bids in what are often unnecessarily complicated and time-consuming application procedures.

The Institute for Public Policy Research (2001) considers that, currently, ‘large sections of the minority ethnic voluntary sector are vulnerable and the level of exclusion faced by many of these groups remains considerably high’. It is worth noting that the Council of Ethnic Minority Voluntary Organisations (CEMVO) has recently been established as an umbrella organisation to represent all minority ethnic voluntary groups. One of its aims has been to establish a grant-making trust that will amalgamate all the funds available to the sector to ensure that dedicated funding remains available.
In relation to BME elders and organisations, PRIAE is the leading body. It focuses only on this group, supporting BME organisations through trying to influence policy, provide information and promote service developments. It is creating an ‘organised voice’ in an attempt to raise standards for BME elders.

Service usage pattern and barriers to services

Data are, at present, lacking on the precise role of minority organisations in the provision of care, as almost all work has focused on the statutory services and the reasons for the failure to meet BME needs. A recent report by the DoH (2001a) on social service usage highlights the general pattern for the BME population. Whereas the white population is three times more likely to use independent residential services than those provided by the local authority, the BME population is seven times more likely to do so. Whether the independent providers were voluntary or private was not analysed; however, the relative economic profiles of the populations suggest that the white population is more likely to be able to afford private care whereas the BME population is more likely to rely on voluntary community organisations.

Yet research consistently shows that BME groups (particularly elders) have higher consultation rates with GPs than the white population, indicating higher levels of problems for which some element of social care provision might be appropriate (Bajekal, 2000). Frequency of contact with a GP, however, does not reflect the quality of consultation received, and the referral rates to secondary health and social care services for BME elders are disproportionately lower than for the comparable white population. Research shows that there is a relatively high incidence of failure to give appropriate treatment (Ahmad and Walker, 1997). The two main factors that affect the use of services can be summarised as: a) how services are accessed; and b) the nature of service provision.

Access

With regards to access, it is first necessary to analyse the quality of consultation with the GP, and here lower satisfaction rates have been recorded for the BME population (Rudat, 1994). Quality of communication is a recurring problem; the non-availability of trained interpreters often results in a reliance on children, which can lead to difficulties with medical terminology. Another problem may also be a GP’s failure to identify the correct referral path for BME elders.

As social services provide particularly for the socially disadvantaged, there is a need for statutory providers to promote awareness and provide information on the services they offer. Studies have consistently shown that awareness among BME groups of these services is much lower than among the white population, leading directly to underuse of the services (Patel, 1990; Ahmad and Walker, 1997). Measures have been taken to produce literature in different community languages, which has been beneficial, but literacy in these languages is not guaranteed. Additional approaches, involving other media and outreach programmes in the community, have been found to be effective (Patel, 1990).
Access to social services is further complicated by the assessment procedure which has regularly been identified as culturally inappropriate, with eligibility criteria discriminating indirectly against BME elders (PRIAE, 1999). A study by the DoH categorised the potential sequels to assessment and found that, overall, BME elders were slightly less likely to receive a service after an assessment than the white population (42% and 44% respectively). But the rate at which an assessment led to service provision was much lower for some minority groups; for black Africans and Chinese, it was 29% (DoH, 2001a).

Care provision

The problems with social service provision for BME elders were first identified in the 1980s. It was found that mainstream providers were reluctant to provide culturally specific services, labouring under the delusion that: a) to provide specific needs is discriminatory; and b) that BME communities ‘look after their own, don’t they?’. Patel (1990) concluded that not only was mainstream provision inadequate, but BME organisations were filling the role of ‘primary providers’, acting as substitutes rather than ‘complementary providers’ to mainstream health, social and housing services. However, these organisations were underfunded, requiring and deserving greater support.

Little changed in the provision of BME elderly care in the 1990s. Some attempts have been made to provide specific services for BME communities such as meeting specific dietary requirements. Overall, however, the situation is patchy: ‘some authorities are making good progress, while others are slow and some are not doing anything at all’ (PRIAE, 1999). In practice, BME elders are largely treated as ‘apart’ rather than ‘a part’ of society.

As previously stated, BME organisations do not have the resources to provide alternative health care, so most BME elders receive care from statutory providers. Hence, the issue here is to improve mainstream services. The reasons for the dissatisfaction felt by ethnic minority elders often have to do with the failure of mainstream services to provide culturally appropriate care. This includes: not catering for dietary and religious requirements; lack of interpreters or advocates to ensure that linguistic differences are not a barrier; lack of staff from similar backgrounds who are able to establish relationships with ethnic minority service users; limitations in the quality of training for professionals responsible for serving BME elders; and, by no means least, racism from both other service users and staff. Furthermore, when mainstream bodies have attempted to provide culturally specific services, this has been done in an ad hoc manner and based on stereotypical assumptions about a BME group.

Mainstream health and social care services for the elderly now have to attempt to attain the targets set out in the National Service Framework for Older People. This sets new standards of care for all older people, whether they live at home, in residential care or are being cared for in hospital (DoH, 2001c).

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3 The MEC project, with its three-way focus, will provide empirical information on this conceptual link.
The programme of action laid out in the National Service Framework makes specific mention of the need to make services culturally appropriate to BME elderly. As a recent DoH report (2001b) acknowledges, ‘councils should be planning to mainstream services for black older people either through ensuring that all services can meet the needs of all people effectively without a fuss; or through sustained funding and support of proven local black voluntary organisations and independent providers’. The National Service Framework sets out a programme of action and standards that aims to bring about this change, highlighting four basic themes: 1) respecting the individual; 2) intermediate care; 3) providing evidence-based specialist care; and 4) promoting an active, healthy life. Each theme is supported by standards:

- Standard 1: Rooting out age discrimination
- Standard 2: Person-centred care
- Standard 3: Intermediate care
- Standard 4: General hospital care
- Standard 5: Stroke
- Standard 6: Falls
- Standard 7: Mental health in older people
- Standard 8: Promoting an active, healthy life in older age

(DoH, 2001c: 12–13)

The MEC project will contribute to the implementation of the National Service Framework in several ways. First, it will highlight BME older service users’ assessments of health, social care and housing services vis-a-vis their expectations. This aspect of the MEC project will provide data for the theme labelled ‘respecting the individual’ (standard 1: rooting out age discrimination; and standard 2: person-centred care). Second, service usage patterns of BME older service users will be fully explored which will highlight the implementation of ‘intermediate care’ standards (standard 3). Third, the project also aims to provide data for assessing the lifestyle and health status of the BME older population. Data analysis for this aspect of the research will highlight the implementation of the theme ‘promoting an active, healthy life’ (standard 8). Finally, interregional and international comparisons carried out on the MEC database will provide policy makers with valuable information on interregional service quality disparities and gaps. Furthermore, previous national studies (Askham et al., 1995) did not include BME organisations’ service provision in their research design. The MEC project, by its three foci approach, aims to capture BME elders’ needs from individual users, mainstream providers and BME providers’ perspectives.
The future

At the time of preparing this chapter, the national analysis on ethnicity and age of the 2001 census had not been published. While more detailed analysis and cross-tabulation of the 2001 census remains to be completed, the figures indicate that the ethnic minority population has grown from 6 to 9%. Preliminary indications are that black Caribbean and Indian communities in the BME groups have the largest proportion of UK residents aged 65+ (Office for National Statistics). Age/ethnic data analysis from the 2001 census is possible for Scotland and this suggests at least a quadrupling of the BME elderly population among certain subethnic groups in the Asian population and some Chinese groups. 2001 census data indicate that 8.3% of the Indian community, 6.2% of the Pakistani/Bangladeshi community, 7.2% of the Chinese community and 6.75% of all ethnic minority communities in Scotland are aged 60+. 1991 and 2001 census data display a similar pattern, one that indicates increasingly older service users among South Asian, Afro-Caribbean and Chinese communities.

The MEC project in the UK aimed to sample these three ethnic minority groups in its research design. Moreover, given the BME issues discussed, we decided that it was necessary to subdivide the three main ethnic groups to be researched: Asian, Afro-Caribbean and Chinese and Vietnamese. Under the Asian group are the following subethnicities: Indian, Pakistani and Bangladeshi. Languages spoken within these groups vary, as do their culture and religion. Diversity within these broad groups is enormous – after all, India is the size of Europe! In the UK, while there are common issues of being a minority, there is a need to look at them separately, within the cluster called ‘Asian’, for example. This is because, apart from culture, each socioeconomic pattern is different as well as demographic change. By organising the work in this way, we can see where, if any, are the differences within the subgroup and how policy makers can in turn target their policies better.

Conclusion

All western economies now face the issue of ageing populations and have begun to be aware of the impact that this change in demography will have on society, particularly the rising cost of care. While the demographic structure of the BME population is younger than that of the majority population, it will undergo the same transformation in the near future.

However, those who are elders now cannot be ignored; they are growing old in a country that many may not consider their home. They are facing the prospect of old age in a country in which attitudes towards elders are different from those in their countries of origin and in which the threat of racism is very real. A recent Home Office report found that over one-quarter of BME elders were extremely worried about the possibility of racial attacks. Regarding service provision and its adequacy, a recent study by Valins (2002) for the Institute for Jewish Policy Research points to the growing problems of long-term care and support for Jewish elders. The report indicates the significance of problems experienced by BME elders who are not Jewish.
This conclusion is reached on the basis that if the Jewish community, which is more economically resourceful than many and has a history of self-organised provision, is and will experience care problems due to changes in its own community and demography, what of those BME elders who experience poverty and disadvantage with lower levels of service development, as we have shown in this chapter.

The National Service Framework sets out to ‘ensure fair, high quality, integrated health and social care services for older people’ (DoH, 2001c). Yet current mainstream health and social service provision for BME elders is unfair and of substandard quality. The experience of this group in the health and social care system can be summarised as, at best, inadequate; at worst, BME elders are simply marginalised. The Acheson Report (1999) recommends that ‘the needs of minority ethnic groups are specifically considered in needs assessment, resource allocation, health care planning and provision’, yet previous initiatives that have promised to deliver this have failed to bring consistent and ongoing change.

Research has repeatedly shown that BME elders would use a range of social and health care services if they were appropriate, accessible and adequate to their social and cultural needs (Patel, 1999; PRIAE, 1999), for such needs arise out of the very essence that makes our identity, makes us all who we are.
Introduction

Immigration and the ageing of the population have long been correlated in France as two aspects of demographic reality. This, however, has not prevented migration from being treated, politically and socially, as an isolated phenomenon in which issues of control predominate (Sassen, 2002). This approach has tended to create a gulf between social policy concerning migration and the changing realities for immigrant minorities. Conditions for settler immigrants as they age have probably been most affected by this gulf between policy and lived reality.

This summary presents a snapshot of the current situation in France. It provides a brief context, describes some of the characteristics of immigrant minorities and concisely identifies the health and social environment in which the issue of the ageing of this section of the population is now emerging.

General situation

France: a country of immigration

Unlike other European countries that were, until recently, countries of emigration, France is a country where immigration has long been a ‘tradition’ (Noiriel, 1988). Indeed, the country was using a substantial foreign workforce by the mid-19th century in its drive to industrialisation. By the time of the 1881 census, the number of foreign workers had reached 1 million. Today (the last census was in 1999), there are 5,618,479 ‘immigrants’ in France, which includes those who have acquired French nationality. The majority of these large migration flows were made up of manual workers, often taking jobs rejected by the French as too hard or too badly paid, for example in mining or the iron and steel industries, and so on. However, immigration has also always been linked to political exile, which constitutes the other French ‘tradition’.
### TABLE 1  
Population distribution according to place of birth and nationality (1946–99, thousands)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total population</th>
<th>French-born</th>
<th>French by acquisition (a)</th>
<th>Foreigners (b)</th>
<th>Total immigrants (a + b)</th>
<th>% of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1946</td>
<td>39,848</td>
<td>343</td>
<td>552</td>
<td>1434</td>
<td>1986</td>
<td>5.0</td>
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<tr>
<td>1954</td>
<td>42,781</td>
<td>377</td>
<td>773</td>
<td>1520</td>
<td>2293</td>
<td>5.4</td>
</tr>
<tr>
<td>1962</td>
<td>46,456</td>
<td>905</td>
<td>931</td>
<td>1931</td>
<td>2861</td>
<td>6.2</td>
</tr>
<tr>
<td>1968</td>
<td>49,756</td>
<td>1766</td>
<td>1019</td>
<td>2262</td>
<td>3281</td>
<td>6.6</td>
</tr>
<tr>
<td>1975</td>
<td>52,599</td>
<td>1858</td>
<td>1112</td>
<td>2775</td>
<td>3887</td>
<td>7.4</td>
</tr>
<tr>
<td>1982</td>
<td>54,296</td>
<td>1991</td>
<td>1167</td>
<td>2870</td>
<td>4037</td>
<td>7.4</td>
</tr>
<tr>
<td>1990</td>
<td>56,652</td>
<td>1719</td>
<td>1308</td>
<td>2858</td>
<td>4166</td>
<td>7.4</td>
</tr>
<tr>
<td>1999</td>
<td>58,520</td>
<td>1560</td>
<td>1560</td>
<td>2750</td>
<td>4310</td>
<td>7.4</td>
</tr>
</tbody>
</table>

Sources: INSEE, 1997, 1999

### TABLE 2  
Total population in France (1999)

<table>
<thead>
<tr>
<th>Category</th>
<th>Total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>58,520,688</td>
</tr>
<tr>
<td>French-born</td>
<td>52,902,209</td>
</tr>
<tr>
<td>French by acquisition (a)</td>
<td>2,355,293</td>
</tr>
<tr>
<td>Foreigners (b)</td>
<td>3,263,186</td>
</tr>
<tr>
<td>Immigrants (a + b)</td>
<td>5,618,479</td>
</tr>
</tbody>
</table>

Source: INSEE, population census  
(http://www.ined.fr/population-en-chiffres/france/migrations/nbimmig.htm)

### TABLE 3  
Distribution of the total foreign population (1962–90) (%)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
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<td>Europe</td>
<td>78.7</td>
<td>76.4</td>
<td>67.2</td>
<td>57.3</td>
<td>50.4</td>
</tr>
<tr>
<td>Portugal</td>
<td>2.0</td>
<td>8.8</td>
<td>16.9</td>
<td>15.8</td>
<td>14.4</td>
</tr>
<tr>
<td>Spain</td>
<td>18.0</td>
<td>21.0</td>
<td>15.2</td>
<td>11.7</td>
<td>9.4</td>
</tr>
<tr>
<td>Italy</td>
<td>31.8</td>
<td>23.9</td>
<td>17.2</td>
<td>14.1</td>
<td>11.6</td>
</tr>
<tr>
<td>12 EU countries</td>
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<td>9.5</td>
<td>7.4</td>
<td>7.1</td>
<td>7.3</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>12.3</td>
<td>11.2</td>
<td>8.8</td>
<td>7.3</td>
<td>6.2</td>
</tr>
<tr>
<td>Others</td>
<td>4.1</td>
<td>2.1</td>
<td>1.7</td>
<td>1.2</td>
<td>1.5</td>
</tr>
<tr>
<td>Africa</td>
<td>19.4</td>
<td>19.9</td>
<td>28.0</td>
<td>33.2</td>
<td>35.9</td>
</tr>
<tr>
<td>Algeria</td>
<td>11.6</td>
<td>11.7</td>
<td>14.3</td>
<td>14.8</td>
<td>13.3</td>
</tr>
<tr>
<td>Morocco</td>
<td>1.1</td>
<td>3.3</td>
<td>6.6</td>
<td>9.1</td>
<td>11.0</td>
</tr>
<tr>
<td>Tunisia</td>
<td>1.5</td>
<td>3.5</td>
<td>4.7</td>
<td>5.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Others</td>
<td>0.7</td>
<td>1.4</td>
<td>2.4</td>
<td>4.3</td>
<td>6.6</td>
</tr>
<tr>
<td>Asia</td>
<td>2.4</td>
<td>2.5</td>
<td>3.6</td>
<td>8.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Turkey</td>
<td>1.4</td>
<td>1.3</td>
<td>1.9</td>
<td>3.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Cambodia, Laos, Vietnam</td>
<td>0.4</td>
<td>0.6</td>
<td>0.7</td>
<td>3.0</td>
<td>3.7</td>
</tr>
<tr>
<td>Others</td>
<td>0.6</td>
<td>0.6</td>
<td>1.0</td>
<td>1.9</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Source: INSEE, 1990
During the 20th century, the nature of the foreign workforce varied according to the major events of French and world history. As Table 1 shows, the figures for the last quarter of the 20th century show the immigrant population as a stable percentage of the total population. This is due to the fact that, at the political level, immigration for work was drastically curtailed following the economic crisis of the 1970s and, at the legal level, significant numbers acquired French nationality.

Whereas, before the First World War and during the 1920s, immigrants came almost exclusively from elsewhere in Europe, after the Second World War migrants began to come from those countries that were linked to France by colonialism: the Maghreb, Asia and Africa. The ratio of European to non-European migration was thus gradually reversed during the century. In 1962, of the total foreign population in France that year, 78.7% were of European origin, whereas this figure had dwindled to only 50.4% in 1990.

Immigrants and foreigners in France

The population census of 1999 provides figures on the basic categories in French society.

Under the legal definition, an individual is either French (by birth or by naturalisation) or a foreigner. ‘Immigrants’ are those who are either defined as foreigners or as citizens by naturalisation. The term immigrant is not therefore a legal classification, but a sociodemographic one. There is no method in France for enumerating minority populations according to cultural or other characteristics, since the children born to immigrant parents – the ‘second generation’ – are not classified as immigrants.

To sum up, a foreigner is someone who lives in France, but does not have French nationality. An immigrant, whether naturalised or not, is defined according to ‘an invariable characteristic which is his/her place of birth’ (INSEE, 2000a). Acquisition of French nationality does not affect this for the purposes of enumeration.

While these are the parameters of the official classification system, social reality imposes another, in which distinctions are made according to the visibility of groups, both physical and symbolic. In other words, colour, name and religion are, in fact, as important as legal status when establishing the place of immigrant groups in the social hierarchy.

Refugees and asylum seekers

From the 1970s onwards, the countries of Europe have closed their borders to economic migrants. But the growing crises in Third World countries and, subsequently, the fragmentation of the Soviet bloc have resulted in increasing numbers of asylum seekers attempting to enter Europe. To meet this new situation, the European Community (EC) has begun to establish joint policies and agreements relating to asylum, although several European states have derogated from sections of these to protect their sovereignty.
In France, those who are granted asylum are either defined as political refugees under the Geneva Convention and come within the purview of the Office Français de Protection des Réfugiés et Apatrides (OFPRA) or are defined as asylum seekers, suffering from threats or degrading treatment (not necessarily instigated by the authorities), who are the responsibility of the Minister of the Interior.

Since the large increase in asylum applications, the right to asylum has been interpreted more strictly, mainly out of concern to control their entry. For instance, out of 38,749 applications submitted to OFPRA in 2000, only 5185 were granted refugee status (17.1%; Bulletin du Dictionnaire Permanent des Etrangers, 2002). As for applications for territorial asylum (which is not the equivalent of ‘exceptional leave to remain’), less than 3% of these were granted in 2000: ‘Thus, a new group of people living in a legal no man’s land is appearing: those who cannot obtain refugee status but cannot be expelled for humanitarian reasons’ (Wihthol de Wenden, 2002).

The evolution of immigration policies in France

Before the Second World War, private companies mainly organised the immigration of the workforce they needed. From 1945 onwards, the state took on a more direct role in controlling migration through various agencies. These were the Office National d’Immigration (ONI), OFPRA and the Direction des Populations et des Migrations (DPM). Until the early 1970s, however, most immigrants came as workers whose presence was judged to be ‘temporary’ and who were therefore viewed in that light (Sayad, 1991). Because of this, their social conditions were also judged according to their ‘temporary’ nature.

The crisis of the 1970s and the subsequent economic recession revealed how illusory this temporary notion was. ‘Temporary’ had become ‘settled’, as demonstrated by the failure of the ‘politiques d’aide au retour’ and the extent of family reunification. ‘Integration’ became the watchword of immigration policies. In 1989, the Haut Conseil à l’Intégration was established to coordinate and produce statistics on immigration and integration. Its first report sets out to define the French model of integration. This model puts forward a number of firm basic principles: the ‘participation’ of immigrants in society, ‘individual equality before the law’, ‘secularism’ and ‘the exclusion of minority logic’.

Other issues were passed over: the right to vote for foreigners, the place of Islam in society, and so on. In the event, the policy that resulted avoided all these issues; it consisted of targeting ‘difficult’ urban areas and aimed at containing problems. For a long time, immigration policy restricted itself to controlling the numbers of those attempting to enter. However, towards the close of the 20th century, two major issues, which had been politically downplayed and ignored, surfaced: the reality of discrimination and the reality that the immigrant population was ageing.
The reality of discrimination

Although xenophobia and discrimination against ethnic minorities are important factors in the history of migrant communities in France, they have often been concealed behind more creditable universalist views. A poll carried out in 2000 by the Société française d’étude de marché et d’opinion (SOFRES, the market research institute) revealed that 59% of French people still believed that there were ‘too many immigrants in France’ (Courtois, 2000). However, this is not just an expression of ‘ordinary’ popular prejudice; in a crisis, it is mobilised by national populist political parties whose programmes are mainly based on the rejection of immigrants. During the presidential elections in May 2002, for example, the Front National leader got through to the second round of voting after winning 17.4% of the votes in the first ballot.

The major democratic parties have sometimes been ambiguous on immigration. Public institutions are also known to have practised institutional racism, for example by not applying their own rules, discriminating against ethnic minorities in the provision of services, not keeping to quotas, and so on (Wieviorka, 1998). Lastly, the state itself is now being scrutinised for discriminating against foreigners by reserving particular occupations in the civil and public services to those of French nationality or by rejecting all but French qualifications for certain occupations in the private sector (Math and Spire, 1998).

The situation has improved partly through anti-discrimination campaigns in businesses, schools and the like. But the pressure on these issues from within the EU itself (for example through Article 14 of the European Convention on Human Rights) and from researchers, activists and trade unionists fighting against racism has revealed how urgent it is to deal with racial discrimination, which constitutes a major curb on integration (Haut Conseil à l’Intégration, 1998). As a result, a number of measures have been undertaken, including setting up Groupes d’Etudes et de Lutte contre les Discriminations (GELD, groups to study and fight against discrimination), Commissions Départementales d’accès à la Citoyenneté (CODAC, local commissions promoting access to citizenship) and the introduction of the ‘numéro vert 114’, a free telephone number for people who are subject to or witness racial discrimination.

The ageing of immigrants

In the 1990s, various reports, statistics and projections confirmed the ageing of the French population. The proportion of people aged 60+ has increased regularly, representing 21.3% of the population in 1999, whereas the proportion of those aged under 20 has conversely decreased, representing only 24.6% of the population in 1999. The projections to 2050 are worrying. In 2000, the proportion of people aged 60+ represented 20.6% of the total population; by 2050, this is projected to rise to 35.1%. In 2000, those aged 65+ represented 16% of the total; by 2050, this is projected to rise to 29.2% (INSEE, 2001). These forecasts feed into social and political discussions on the retirement system, the needs of the elderly for services, health care, and so on.
### TABLE 4  Distribution of immigrants by age and country of origin (%)  

<table>
<thead>
<tr>
<th></th>
<th>0–14</th>
<th>15–24</th>
<th>25–34</th>
<th>35–44</th>
<th>45–54</th>
<th>55–64</th>
<th>65+</th>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Portugal</td>
<td>2.3</td>
<td>12.8</td>
<td>25.5</td>
<td>26.5</td>
<td>20.2</td>
<td>9.4</td>
<td>3.4</td>
</tr>
<tr>
<td>Spain</td>
<td>0.7</td>
<td>2.5</td>
<td>12.4</td>
<td>14.8</td>
<td>16.0</td>
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<td>13.1</td>
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<td>11.7</td>
<td>32.6</td>
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<td></td>
<td></td>
<td></td>
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<tr>
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<td>21.9</td>
<td>22.9</td>
<td>15.0</td>
<td>7.1</td>
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<td>7.4</td>
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<td>4.7</td>
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<td>26.3</td>
<td>16.8</td>
<td>12.5</td>
<td>11.3</td>
</tr>
<tr>
<td>Others</td>
<td>10.7</td>
<td>16.9</td>
<td>33.2</td>
<td>24.0</td>
<td>9.5</td>
<td>3.3</td>
<td>2.2</td>
</tr>
<tr>
<td><strong>Asia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Turkey</td>
<td>13.7</td>
<td>24.8</td>
<td>20.1</td>
<td>20.8</td>
<td>9.5</td>
<td>2.3</td>
<td>8.2</td>
</tr>
<tr>
<td>Cambodia, Laos, Vietnam</td>
<td>6.3</td>
<td>22.6</td>
<td>24.0</td>
<td>21.6</td>
<td>10.2</td>
<td>7.6</td>
<td>7.7</td>
</tr>
<tr>
<td>Others</td>
<td>15.7</td>
<td>15.1</td>
<td>29.8</td>
<td>21.3</td>
<td>8.6</td>
<td>4.5</td>
<td>5.1</td>
</tr>
<tr>
<td><strong>America, Pacific region</strong></td>
<td>14.6</td>
<td>14.5</td>
<td>25.3</td>
<td>23.0</td>
<td>10.7</td>
<td>4.8</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Total immigrants</strong></td>
<td>5.7</td>
<td>10.8</td>
<td>18.3</td>
<td>20.7</td>
<td>15.8</td>
<td>12.1</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Total population</strong></td>
<td>19.0</td>
<td>15.0</td>
<td>15.2</td>
<td>15.2</td>
<td>10.0</td>
<td>10.5</td>
<td>14.8</td>
</tr>
</tbody>
</table>

Source: INSEE, 1990
In this situation, migration could serve a practical function as a demographic regulator. That the steady ageing of the population was a reality did not come as a total surprise. Yet – somewhat paradoxically, given that France is the country with the oldest record of immigration in Europe – the ageing of the immigrant population did. Indeed, from the 1970s, the attention of both politicians and researchers was focused on the problems of the young, the second generation (Temime, 2001). That this group’s parents were growing old was completely overlooked. Hence, many immigrants were getting older, but remaining outside the remit of the social services and institutions dealing with this age group (Gallou, 2001).

The analysis of the immigrant population by age clearly shows its special features. Middle-aged people are more numerous, since they arrived as adults. The age structure of this population also depends on the lapse of time since the various migrations. Migrants from elsewhere in Europe are represented most strongly in the oldest age group, whereas the most recent immigrants are less numerous. But it is the ageing of the latter – those of non-European origin – which seems to be considered a new and unforeseen phenomenon.

The following elements are clear:

■ This ageing also concerns immigrants from the Maghreb, with its particular historical relationship with France.

■ The presence of immigrants was long seen as temporary and they were not supposed to grow older while in France.

■ Their careers and social status have been vitiated by numerous difficulties. Also, at a time of economic restructuring, it is difficult for them to take retirement as it comes too soon for most.

■ Of these immigrants, 20% have remained single as they have grown older, living far from their families in migrant workers’ hostels. They no longer work, but have to live in structures that do not suit their needs.

At present, we do not have any qualitative or quantitative studies on the 75% of this age group who live outside hostels, mainly with their families.
### TABLE 5  Unemployment rate of immigrants by sex and country of origin (%)

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 EU countries</td>
<td>9.2</td>
<td>10.4</td>
</tr>
<tr>
<td>Of which</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>7.6</td>
<td>8.8</td>
</tr>
<tr>
<td>Italy</td>
<td>8.9</td>
<td>16.2</td>
</tr>
<tr>
<td>Portugal</td>
<td>8.6</td>
<td>9.9</td>
</tr>
<tr>
<td>Algeria</td>
<td>29.0</td>
<td>39.3</td>
</tr>
<tr>
<td>Morocco</td>
<td>32.5</td>
<td>36.7</td>
</tr>
<tr>
<td>Tunisia</td>
<td>23.9</td>
<td>39.6</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>28.9</td>
<td>35.8</td>
</tr>
<tr>
<td>Turkey</td>
<td>33.1</td>
<td>42.5</td>
</tr>
<tr>
<td>Southeast Asia</td>
<td>15.7</td>
<td>35.2</td>
</tr>
<tr>
<td>Other countries</td>
<td>15.9</td>
<td>22.6</td>
</tr>
<tr>
<td>Total</td>
<td>20.5</td>
<td>24.3</td>
</tr>
</tbody>
</table>

Source: INSEE, 1995

### TABLE 6  Unemployment rate by nationality and age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
<th>%</th>
<th>Number</th>
<th>%</th>
<th>Number</th>
<th>%</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>15–24</td>
<td>500,484</td>
<td>24.7</td>
<td>1,882,592</td>
<td>10.5</td>
<td>351,058</td>
<td>7.3</td>
<td>2,674,134</td>
<td>11.1</td>
</tr>
<tr>
<td>25–49</td>
<td>41,015</td>
<td>38.9</td>
<td>254,032</td>
<td>22.8</td>
<td>80,969</td>
<td>21.9</td>
<td>376,016</td>
<td>23.7</td>
</tr>
<tr>
<td>50+</td>
<td>4134</td>
<td>15.2</td>
<td>36,158</td>
<td>9.2</td>
<td>18,454</td>
<td>12.0</td>
<td>58,750</td>
<td>10.2</td>
</tr>
<tr>
<td>Total</td>
<td>541,499</td>
<td>25.4</td>
<td>2,076,624</td>
<td>11.2</td>
<td>432,027</td>
<td>8.4</td>
<td>1,050,150</td>
<td>11.8</td>
</tr>
</tbody>
</table>

Source: INSEE, 1998

### TABLE 7  Average yearly income of households according to country of origin (1991)

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Single person</th>
<th>Couple with child(ren) under 25</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average income (francs)</td>
<td>Average income (francs)</td>
</tr>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Spain</td>
<td>84,000</td>
<td>161,000</td>
</tr>
<tr>
<td>Portugal</td>
<td>93,000</td>
<td>146,000</td>
</tr>
<tr>
<td>Algeria</td>
<td>79,000</td>
<td>124,000</td>
</tr>
<tr>
<td>Morocco</td>
<td>80,000</td>
<td>138,000</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>64,000</td>
<td>130,000</td>
</tr>
<tr>
<td>Turkey</td>
<td>98,000</td>
<td>115,000</td>
</tr>
<tr>
<td>Southeast Asia</td>
<td>82,000</td>
<td>152,000</td>
</tr>
<tr>
<td>Total France</td>
<td>105,000</td>
<td>188,000</td>
</tr>
</tbody>
</table>

Source: INED (with INSEE), 1992
Some characteristics of immigrant populations

Labour market, training and unemployment

Because of the strong historical link between modern immigration and work, ‘the rate of participation of immigrant men in the labour force is slightly higher than the national average’; 67.7% compared with 62.3% (INSEE, 1995). They are overrepresented in the 40+ and 50+ working populations, but the participation rate for women is lower than the national average, particularly for those from the Maghreb (37.8% for Moroccans; 40% for Algerians). The average participation rate in the labour force among immigrant women is 55.7%. Immigrants are represented or overrepresented in certain sectors, such as the construction, car and service industries.

Immigrants work mostly in the private sector (71% compared with 56% of the total working population in 1995) and, as a result, are more likely to be in temporary employment and have less labour protection. Nor do they seem to benefit from promotion as does the wider population. In 1993, for instance, only 17% of those born in the Maghreb benefited economically from having continued their education, as compared with 44% of French male workers aged 25 to 59 (INSEE, 1993). Labour market conditions are such that immigrants also have a significantly higher unemployment rate, as Table 5 demonstrates.

In January 1999, 441,000 immigrants were unemployed. The immigrant population represents 8.1% of the working population, but immigrant unemployment represents 14.4% of total unemployment. All ages taken together, the rate of unemployment of 19.7% of immigrant men is superior by 9.5 points to that of the total for all men. The same pattern characterizes the rate of female unemployment, which rises by 23.1% for immigrants (INSEE, 2000b).

Income and transfers

The income of immigrants is mainly dependent on their economic activity in the labour market and is lower than the national average. Family benefits represent around one-quarter of household income for all non-European immigrants.

Regional location and accommodation for immigrants

Most of those who come as migrant workers live in urban areas such as Ile de France, Provence–Alpes–Côtes d’Azur and Rhône–Alpes regions. Because of their lower incomes and various factors relating to ‘integration’, most immigrant couples are tenants (54%), with many in social housing (23%). Private rented accommodation is often more expensive and more segregated. In 1990, immigrant couples owning their own homes were mostly of European origin (Italians, 64.7%; Spanish, 52.6%; compared with Algerians, 19.4%; Moroccans, 17%). Just over 4% of Algerian married men live alone in hostels. Around 41% of the Algerian community occupy social housing compared with 11.5% of Italians.
Some 39% of Tunisians are in social housing, with a figure of just below 17% for the Spanish community or 23.5% for the Portuguese. Less than 2% of Portuguese live in hostels compared with 6.5% of Algerians and just under 4% of Moroccans.

Historically, one of the special features of immigrant housing in France was the building of migrant workers’ hostels (FTM) from the late 1950s onwards. There are now more than 700 FTM, half of them managed by the Société Nationale de Construction pour les Travailleurs (SONACOTRA) and half by various state-aided associations. The issue of immigrants, mainly from the Maghreb and ‘without any family’, growing old in these hostels, in conditions that are no longer suitable for their age or status, was one of the factors that triggered the realisation that the immigrant population in general was ageing. In 1999, 30% of those living in FTM were aged over 56 (Charbit, 1999). A five-year plan has been put in place to turn such hostels into accommodation for a younger and more transient population. However, the issue of immigrant elders still living in hostels is yet to be resolved.

Family profiles

The demographic profile of immigrant families shows the regulating role that immigration can play in French demography. In more than 12% of the 14 million couples living in France, there is at least one immigrant partner. These couples have a higher percentage of children aged below 25 than other couples in France. The average for Moroccan and Tunisian families is 2%; for Turkish families, just under 2%; slightly less for those from Cambodia, Laos and Vietnam; for Portuguese families, 1.4%; and for Italians, Spanish and other European nationalities (similar to the figure for French families), under 1%. Most of these children were born in France and have French nationality. On the other hand, immigrant households have roughly the same distribution of those 60+, although, as might be expected, the earliest groups of migrants (Spanish, Italian and other European groups) have the highest distribution and that for Maghrebins is somewhat lower. The French population falls between the two.

Languages

In France, there is no policy of accommodating immigrants’ languages as recognised minority languages. French language teaching to immigrants is encouraged, but not as a consistent matter of policy. It is the experience of ‘total immersion in the French language’ and the succession of French-speaking generations within families that have enabled the first generation of immigrants to manage linguistically. However, there are still large numbers of illiterate immigrants, which results in difficulties when dealing with officialdom.
Modes of social relationships

The forms and extents of social relationships among the various immigrant groups depend on various factors. For the particular groups we are interested in, the most developed social relations are of a family type, extending to a community network. There are, however, internal differences; people from Southeast Asia have more of a community network whereas men from the Maghreb foster their social relationships in cafes and bars. Formal associations, such as community or religious ones, are not really developed among immigrants. ‘Less than one migrant out of ten belongs to an organisation which is identified as a community association’ (Tribalat, 1996). However, it does not mean that because only a small number belong to religious associations, religion does not play an important role in immigrants’ lives. This role may not consist of regular religious practice and observance (which remains generally the province of a minority), but of serving as a vehicle for identity, memory and sense of belonging.

The survey that produced these figures only looked at immigrants below the age of 60, yet we can surmise that interest in religious practice and observance may increase with age and is perhaps more significant among the elders we are concerned with in this report.

The social welfare system and the legal context

The social welfare system is dense, complex and vast. It encompasses social security, supplementary old age schemes, unemployment benefit, social aid and a basic guaranteed income. The organisation of social security is based on the principle of national equality and mutual protection. It protects workers and their families against risks likely to reduce or end their earning ability. It bears health care costs, ensures the payment of social insurance benefits, compensates workers for industrial accidents and occupational illnesses and pays out pensions, old age allowances and family allowances.

Foreign elderly in the social welfare system

Access to the compulsory social security system for foreigners living in France is dependent upon their remaining in the country. An Act of 11 May 1998, while maintaining this as the condition of access to welfare benefits, did make a few positive alterations to the social welfare system for foreigners. It created a ‘retired’ card for foreigners who have lived in France by removing the residence condition formerly necessary to receive an old age pension and lifted nationality as a condition of access to non-contributory benefits. But a number of practical difficulties remain: some relevant aspects of the statute are ambiguous, which can lead to court cases for resolving disputes; some organisations persistently refuse to grant certain benefits, frequently arguing that the residence permit produced does not comply with the standards; and administrative procedures may be overly complex.
<table>
<thead>
<tr>
<th>Country</th>
<th>Men</th>
<th>Women</th>
<th>No religion</th>
<th>Non-practising Occasional</th>
<th>Regular</th>
<th>No religion</th>
<th>Non-practising Occasional</th>
<th>Regular</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algeria</td>
<td>15</td>
<td>6</td>
<td>15</td>
<td>38</td>
<td>21</td>
<td>26</td>
<td>12</td>
<td>29</td>
</tr>
<tr>
<td>Morocco</td>
<td>27</td>
<td>10</td>
<td>10</td>
<td>29</td>
<td>23</td>
<td>39</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Portugal</td>
<td>23</td>
<td>41</td>
<td>7</td>
<td>35</td>
<td>44</td>
<td>14</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Southeast Asia</td>
<td>14</td>
<td>17</td>
<td>32</td>
<td>23</td>
<td>33</td>
<td>11</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>Spain</td>
<td>14</td>
<td>29</td>
<td>17</td>
<td>43</td>
<td>33</td>
<td>6</td>
<td>9</td>
<td>29</td>
</tr>
<tr>
<td>Turkey</td>
<td>36</td>
<td>22</td>
<td>8</td>
<td>25</td>
<td>36</td>
<td>31</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>35</td>
<td>31</td>
<td>8</td>
<td>20</td>
<td>33</td>
<td>39</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>France</td>
<td>20</td>
<td>26</td>
<td>22</td>
<td>41</td>
<td>30</td>
<td>7</td>
<td>17</td>
<td>33</td>
</tr>
</tbody>
</table>

Source: INED (with INSEE), 1992
Other drawbacks are inherent in the Act itself:

- **The resident card for the retired person.** This solves the administrative problems for retired foreigners leaving and re-entering, but creates other problems. For instance, those who fall under the scheme are not allowed to work in France for more than one year and lose their welfare rights.

- **The basic old age pension.** This can now be claimed by foreigners, but the administrative procedures involved are extremely complex and involve different health and social welfare professionals.

- **The Couverture Maladie Universelle (CMU, comprehensive health insurance).** The universal nature of this health cover is in fact limited by several conditions: funding limits exclude some people; the justification of a regular situation for foreigners (who have to have a regular permit to stay [or status] in the country) ‘stable residency’, and so on.

- **Low pensions.** Foreigners may find it difficult to make enough contributions to the social security system to receive a pension at the full rate and their supplementary pensions may also be smaller.

- **Sickness benefit.** A retired foreign worker who returns to his/her home country loses his/her health insurance benefit.

- **Family benefit.** For those from countries that have signed bilateral conventions with France (mainly in the Maghreb and Africa), the sums paid in benefit for children who have stayed in the country of origin have been cut, over 20 years, to one-tenth of their previous level (GISTI, 1997).

- **Freezing of war pensions.** The pensions of many thousands of soldiers from the Maghreb, recruited by France during both world wars or the Indochina campaigns, have been frozen since 1961.

### State of health and morbidity

**Health of the foreign population**

There are no epidemiological statistics or statistics of morbidity allowing us to isolate precise indicators about the health of foreign and immigrant populations. However, correlating different studies reveals, for example: the existence of pathologies linked to bad housing conditions, such as higher levels of lead poisoning; the incidence of tuberculosis is about six times higher in the foreign population than in the French population; the existence of pathologies linked to nutritional deficiencies can also be detected; there is a recurrent neglect of oral health; and diseases of the respiratory tract are more frequent among immigrants, accounting for 15% of immigrant hospitalisation (Gliber, 1997). A survey carried out in free health care centres by CREDES indicates that their foreign patients suffer more from gastric disorders than do French patients (11.8% compared with 6.9%; CREDES, 1993). Florence Flot notes that the proportion of those with HIV/AIDS among the foreign population is stable (between 13 and 14%), but that there is an increased incidence among those coming from sub-Saharan Africa. This has risen from 20% in 1989 to 37% in 1995 (cited in Gliber, 1997).
<table>
<thead>
<tr>
<th>Average number of GP consultations</th>
<th>French</th>
<th>Total foreigners</th>
<th>Southern Europeans</th>
<th>Maghrebins</th>
<th>Other Africans and Asians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>6.6</td>
<td>4.6</td>
<td>5.7</td>
<td>3.7</td>
<td>3.2</td>
</tr>
<tr>
<td>Children (under 18)</td>
<td>6.1</td>
<td>3.7</td>
<td>3.8</td>
<td>3.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Men (18–59)</td>
<td>3.9</td>
<td>3.1</td>
<td>3.9</td>
<td>2.4</td>
<td>3.5</td>
</tr>
<tr>
<td>Women (18–59)</td>
<td>7.0</td>
<td>5.7</td>
<td>6.1</td>
<td>5.5</td>
<td>4.8</td>
</tr>
<tr>
<td>Elders (60+)</td>
<td>10.1</td>
<td>9.2</td>
<td>9.2</td>
<td>3.1</td>
<td>not given</td>
</tr>
<tr>
<td>Average number of dentist consultations</td>
<td>1.4</td>
<td>1.1</td>
<td>1.1</td>
<td>1.3</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Source: INSEE, 1991
Martina Gliber has pointed out the disproportionate representation of foreigners in industrial accident figures. In 1991, they formed 6.8% of paid workers, but accounted for 13.1% of accident victims. In the construction and public works sector, where almost one wage earner in five is a foreigner, 30.2% of those who suffered permanently incapacitating accidents were foreigners.

Service usage patterns

The use of health services

According to a number of studies, immigrants do not use health services as much as the native population, although the poor quality of their health has been noted by observers. Migrants mainly resort to emergency services or their GP (Penet, 2001: 28). These two health care systems have the advantages of being simple to access and quick and efficient in their responses. All the elderly are entitled to access these services freely, but many immigrants resort to such institutions only in cases of real emergency.

On average, French people see their doctor seven times per year, foreigners five times, people from the Maghreb less than four. French elderly see their doctors about three times more than elders from the Maghreb. We should also note that foreigners are less likely than French people to have supplementary insurance cover for their medical expenses (59% compared with 87%); naturalised citizens fall midway between the two, with 75% having supplementary cover (CREDES, 1993). The expenditure of sickness benefits on foreigners is, on average, lower than that on French people. People from the Maghreb, Africans and Asians are, on average, three to four times more likely to lack supplementary cover, even where they have health insurance.

Social and economic barriers to service use

- **Cost.** For example, the monthly cost of medical care in a retirement home is approximately €915, yet the monthly income of some, especially those living in hostels, may be no more than €610 (Desrumeaux, 1998: 14).

- **Communication difficulties.** These can make accessing information about services and dealing with administrative procedures extremely difficult, even though people’s rights depend on them.

- **Home helps.** Their services are impossible to obtain for immigrants who live in furnished hotel accommodation because they cannot give proof of a permanent domicile. For those who live in hostels, the help with, for example, preparation of meals may well be unsuitable both because of cultural dietary requirements and because some care assistants are reluctant to enter hostels. Toufik Ftaïta (1999: 53) shows how certain services, such as home helps, are viewed by many immigrants as a luxury they cannot allow themselves.
**FIGURE 1** Organisation of care services and funding

<table>
<thead>
<tr>
<th>Provision</th>
<th>DDASS (regional social services)</th>
<th>DRASS (health services)</th>
<th>Local bodies</th>
</tr>
</thead>
<tbody>
<tr>
<td>DDASS</td>
<td>Direction départementale des affaires sanitaires et sociales (departmental social services)</td>
<td>Direction régionale des affaires sanitaires et sociales (regional social services)</td>
<td>town hall funds</td>
</tr>
<tr>
<td>COTOREP</td>
<td>funds</td>
<td>Conseil Général funds</td>
<td>Conseil Général</td>
</tr>
<tr>
<td>Social aid</td>
<td>social aid</td>
<td>carers</td>
<td>CCAS funds</td>
</tr>
<tr>
<td>Supplementary benefit</td>
<td>home helps independent</td>
<td>independent living allowance</td>
<td>living allowance</td>
</tr>
<tr>
<td>Disabled adults' allowance</td>
<td>living allowance dependency</td>
<td>hospital</td>
<td>medical aid</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sources of funding</th>
<th>Pension and provident fund</th>
<th>Social welfare system</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAF</td>
<td>Caisse d'allocations familiales (child benefit office)</td>
<td>social security funds</td>
</tr>
<tr>
<td>CPAM</td>
<td>Caisse primaire d'assurance maladie (local health insurance department)</td>
<td>all insurance</td>
</tr>
<tr>
<td>CRAM</td>
<td>Caisse régionale d'assurance maladie (regional health insurance department). Finances social and medicosocial actions in favour of elders</td>
<td>widows' benefits</td>
</tr>
<tr>
<td>Mutual insurance company</td>
<td>funds</td>
<td>Social security</td>
</tr>
<tr>
<td>Office for elders</td>
<td>home care</td>
<td>Industrial accident payouts</td>
</tr>
<tr>
<td>Hostel restaurant</td>
<td>home help service</td>
<td>Disability benefits</td>
</tr>
<tr>
<td>Public transport</td>
<td>pensions</td>
<td></td>
</tr>
</tbody>
</table>

**Glossary**

- DDASS: Direction départementale des affaires sanitaires et sociales (departmental social services)
- DRASS: Direction régionale des affaires sanitaires et sociales (regional social services)
- COTOREP: Commission technique d'orientation et de reclassement professionnel (committee for the training and qualification of disabled persons). Evaluates the disability of the applicant
- Conseil Général: (general council) In charge of organising the gerontological diagram
- CCAS: Centre communal d'action sociale (local council social work office). Analyses the social needs of the whole population
- CAF: Caisse d'allocations familiales (child benefit office)
- CPAM: Caisse primaire d'assurance maladie (local health insurance department)
- CRAM: Caisse régionale d'assurance maladie (regional health insurance department). Finances social and medicosocial actions in favour of elders
- Social security: Provides all insurance, widows' benefits, industrial accident payments and disability insurance
Cultural characteristics and their impact on need

Most migrants come from rural areas where resorting to a doctor is unusual. Some 90% of geriatric institutions are occupied by women, which is in contradiction with their spatiocultural reference points (UNAFO, 1995). Consequently, the activities undertaken there are not necessarily suited to immigrant elders. As Pitaud explains, old age and death fall within the sphere of private, intimate experience.

What comes under the remit of the geriatricians (the professionalisation and institutionalisation of old age and death) is disregarded, not because they [Maghrebin elders] do not want, or cannot, benefit from geriatric services, but above all because ‘growing old and dying are intimate aspects of the domestic private sphere’.

But retirement homes, like sheltered accommodation, give immigrants neither the welcoming sense of a family home, nor even that of the migrant workers’ hostels where shared experiences create a sense of solidarity. Moreover, there are certain specific cultural practices of the Maghreb, as Samaoli et al. (2000) demonstrate, affecting the intimacy of the body (washing, and so on) that make it difficult for such people to live comfortably in an institutional setting.

Service providers

Organisation of health and social care for the ageing population

The distribution of services and benefits is carried out by a plethora of organisations. Figure 1 provides an overview of the organisation of care services and funding.

Health institutions and services

We do not have any precise data on the presence of immigrants in residential and health institutions except for certain intermediary services such as migrant workers’ homes and social residences, which number more than 700 and house 130,000 people. ‘Anticipations show that half of the residents in those homes will be aged more than 55 years in 2008’ (Desrumeaux, 2001).

However, the reasons for entering them are linked to: the absence of alternatives; deterioration in, or lack of, family ties; isolation; issues regarding medical services. Certain sociological studies indicate financial and cultural difficulties when entering such institutions. In addition, the currently low numbers of dependent elders among populations from the Maghreb and Asia should also be mentioned along with the ageing of the population generally.

Health institutions include: regional, local and general hospitals; psychiatric centres; institutions specialising in short- and long-term, follow-up and rehabilitation care; and home care. These frequently employ welfare workers, adult educators and medical and psychiatric assistants.
Social workers

As of January 1998, there were 800,000 social workers with various specialities working in social or medicosocial institutions and services for the disabled, the elderly or people with social difficulties. Such institutions include those for adults with social difficulties (CHRS); those for mothers and children; those not registered as social aid; and those for elders such as retirement homes and sheltered housing. These frequently employ medical and psychiatric assistants and coordinators.

Associations

In France, there are estimated to be around 2000 associations dedicated to the public good (all French associations are legally bound to be registered, but the lists of them are often not up to date). New associations are constantly being formed. The associations involved in social work mainly take one of two forms; they function either as institutional managers or undertake direct care. Associations are thus responsible for around 55% of social work activity (Espace social européen, 1990, cited in Wihthol de Wenden and Leveau, 2001). This sector is made up of professional organisations.

Details of immigrant and migrant workers’ organisations come under the same legal requirements as other associations, but lists of them rapidly become outdated as this is a constantly changing area. However, Catherine Wihthol de Wenden (2002) has estimated their approximate number. She notes that there are some 850 associations of people from the Maghreb (including 350–450 NGOs; 100–180 independent adult organisations; 180–200 for young people and women; and approximately 30 multicultural associations fighting racism and dedicated to sociocultural life). She adds that there are ‘250 organisations of refugees from South East Asia, set up by the community, and 1,000 to 1,100 organisations for welcome and mutual aid’.

It is difficult to form a typology of the organisations. As well as the more dynamic youth groups, there are associations for older people which are often based on two fundamental concerns. These revolve around religion and places of prayer and are complemented by those which concentrate on community links, friendliness and solidarity. Yet, as we have seen in the INED (1992) survey, this network for elders is not really developed in France. It lacks political and logistical support and finds it difficult to expand in a wider social context dominated by individualism.

However, alongside this unofficial network, lies another whose purpose it is to assist immigrants. It is made up of diverse professional bodies and includes: the network of reception offices established by a ministerial circular in the early 1970s; the managers of immigrant workers’ hostels within UNAFO; social workers dealing with immigrant families (ASSFAM); the Inter-Service Migrants’ Network (specialising in interpreting and translation); and the Association of Social Assistance for Migrants (SSAE). There are also more militant organisations which provide migrants with aid of various types (for example, GISTI, ASTI, Pastorale des Migrants, CIMADE). Most of these networks were created during the migration period to meet the problems faced by many migrant workers and their families. They cover the different areas that are affected by immigration: social, legal, housing, training,
health, education, cultural dynamics, and so on. The professionals involved in these networks have, in a sense, traversed the same journey as the workers; now they are moving on to dealing with the problems raised by their ageing.

Conclusion

Despite its long history, it has taken a long time for migration to be regarded as a legitimate aspect of French society. This backwardness has resulted in the social reality of migration being misconceived in a number of ways.

- The settlement of successive waves of migrant workers had consequences, such as ageing, which have not been politically or socially anticipated.

- A formal and legalistic model of integration was imposed from the top down, which took little account of the aspirations of minorities, the historical specificities of migrants from former colonies and which denied the vote to non-EC foreigners.

- A gradual extension of legal regulation and provision occurred which, however, took no account of difficulties in accessing such provision and understanding regulations (for example, lack of information, poor command of French) or the particular requirements of immigrant groups for adaptations to service provision, care and support services.

However, in the last few years, people have become aware that the immigrant population is an ageing one. In many institutions, in many communities and regions, studies and reports on the issue have been carried out. Work on ageing is now in progress, but our understanding and knowledge of this field still need to be improved, notably in those areas targeted by the MEC project: social care, health and housing. We must assess the gaps that exist between expectations and needs, as expressed by those concerned, and what can be offered to them both inside and outside institutions and other facilities.
The percentage of foreigners currently living in Germany is relatively high – around 8.9% of the total population. The majority arrived during the past 40 years as so-called ‘Gastarbeiter’ (guestworkers) from Turkey or Southern Europe. There is also a heterogeneous group of asylum seekers and refugees from various war zones, although it is assumed that most of these will eventually return to their native countries. Also to be considered in this context are immigrants of German origin, from Central and Eastern Europe or the former Soviet Union, who have full citizenship but serious language and integration problems. Because of the nature of the legislation on immigration and citizenship, official statistics and administrative data only differentiate between Germans and foreigners and not between ethnic groups.

In relation to minority elderly care, it was for a long time wrongly assumed that most of the foreign workforce (the guestworkers) would return to their native countries after a few years and, thus, except for pension benefits, Germany would have no responsibility for their care. Moreover, the overall ageing of the population and related demographic changes were, until recently, not considered a matter of urgency in political or public discussion.

That social security benefits are granted to everyone in Germany, regardless of ethnic origin and independent of fees paid, leads to the illusory assumption that all those in need of these benefits receive them equally. Hence, there has been a failure to collect information on the group-specific use of such benefits, which also applies to ethnic minorities.

It is only over the past few years that the problems of care for older people in general, and for elderly immigrants or those from ethnic minorities in particular, have received greater attention. There have been a number of recent government reports and research studies on this topic, mostly case studies. Common to all of them is the complaint of a lack of data. Data on matters of health, nursing care, social services, and so on are poor – the fairly recent Federal Health Monitoring System is, for instance, still incomplete and the Long-term Care Insurance statistics are only just being compiled. The situation is further complicated by the ways that foreigners, naturalised immigrants and German citizens are differentiated, and the impossibility of differentiating immigrants according to their country of origin.
FIGURE 1  Age structure of the German population (1999 and 2050)

Source: Statistisches Bundesamt, 2000: 14
The European Union (EU) Council Directive 2000/43/EU of 29 June 2000 ‘implementing the principle of equal treatment between persons irrespective of racial or ethnic origin’ (Official Journal of the EU Nr. L 180: 22) oblige member states to provide legal protection for persons where they suffer discrimination on the grounds of their racial or ethnic origin in the context of access to and provision of goods and services. To date, German law, under the civil code, does not grant the persons in question the protection they would be entitled to according to the directive.

Demographic situation and change

The German population is one of the most rapidly ageing in the EU; it also has one of the highest age levels. Figures show that, in 1999, 22.4% of the population were 60+. It is projected that, by 2050, this figure will be 35.8%. At the same time, the birth rate is falling; it has long been insufficient to maintain the population level. At present, a birth rate of 2100 babies per 1000 women would be necessary to keep the population level constant, but for decades this rate has been as low as 1400 per 1000 women. If the birth rate stays this low – which is to be expected given the trend since the 1970s – the German population will, at least on a long-term basis, significantly decrease and get older. See Figure 1.

Moreover, life expectancy is rising. Male babies born in 1997 could expect to live to 74; females to 81 years of age. Since 1970, this is an increase of seven years in average life expectancy. Added to this is the increase in the elderly population, as those born in the ‘baby boom’ years of the 1950s and 1960s will soon reach pensionable age. The ratio between the number of people aged 60+ and those aged between 20 and 59 is expected to increase from the current 0.4% to around 0.8% in 2050.

Migration statistics also show that, in the past, major changes took place in the total net migration to Germany. Main immigrant groups and their reasons for immigration varied as well. In the 1960s, for example, the recruitment of a foreign workforce was the prevailing reason for immigration, causing in turn the family reunifications of the 1970s. In the 1980s and 1990s, German repatriates from Eastern Europe, foreign asylum seekers and civil war refugees were the predominant immigrant groups. In 1992, a record figure of 780,000 more people (both foreigners and Germans) entered Germany than left the country. Since then, this number has decreased and, in 1999, it only accounted for about 200,000 persons. See Figure 2 overleaf.

Based on the present legislative situation, realistic projections estimate, until 2050, an average positive total net migration to Germany of about 200,000 persons per year. Although immigrants to Germany have a younger age structure than the current population, their number is not nearly high enough to affect the ageing and decreasing of the present German population.
FIGURE 2  Migration balance in the past

Note: Balance of migration across the German borders until 1990 refers only to the former West Germany (without migration from the former German Democratic Republic). Numbers are in thousands.
Source: Mai, 2001: 39
Ethnic composition of Germany: foreigners/ethnic minorities

As already mentioned, official statistics do not differentiate between people’s ethnic origins, but between Germans and foreigners in general.¹ At the end of 2000, there were 7.3 million foreigners living in Germany – 8.9% of the whole population. Of these foreigners, 3.7% (272,000 people) were asylum seekers whose asylum proceedings had not yet been legally completed. In 1997, approximately one-third of foreigners had lived in Germany for over 20 years, about half for more than 10 years. About one-fifth were born in Germany, but had the citizenship of their parents. Thus, contrary to expectations when this workforce was recruited, a substantial number of guestworkers did not return to their country of origin after a few years and will not return in the future. Thus, around 66% of Turks and Greeks, 71% of Italians and 80% of Spanish have lived in Germany for 10 years or longer.²

The largest – but not most homogeneous – group are the Turks, some 2.4% of the whole population and numbering almost 2 million, followed by people from the former Yugoslavia (0.8% of the total) and Italy (0.7%). Other nationalities, especially those from other continents, constitute considerably smaller (mostly younger and more heterogeneous) populations. Asians form 1% of the total, Greeks 0.4%, Croatians 0.2%, Africans 0.3% and Poles 0.3%.

The majority of the foreigners in Germany live in the West of the country and in cities. The age structure of the foreign population is younger than the German population. Within the foreign population, women are on average younger than men, but, in contrast to the German population, there are more older men than women among the foreign population. This difference in age structure is perhaps one reason why, hitherto, so little attention has been paid to the topic of minority elderly care. In 1997, only 3.2% of foreigners, but 16% of Germans, were aged 65+. For every 100 Germans aged between 20 and 60, there were 41 Germans aged 60+, whereas this ratio among the foreign population was, and still is, as low as eight people aged 60+ to every 100 20–60 year olds. When the figures are broken down by country of origin, those aged 60+ form 10% of the immigrant population originating from elsewhere in the EU; 6.6% of the Polish population and from the former Yugoslavia; and 4.5% of Turks. The percentage of older people of Asian or African origin is even lower. Overall, those 60+ constitute some 8.7% of the total foreign population. In contrast, those aged between 18 and 35 from all migrant backgrounds form some 35.5% of the total foreign population.

¹ There is one exception: some small ethnic minorities settled in Germany (national minorities) are officially registered due to their culture being protected by the state. Such groups are the Frisians, the Sinti and Roma, the Danish minority in Schleswig-Holstein and the Slavonic ethnic group of Sorbs in Saxony. However, these groups are only differentiated in special surveys and not in other statistics. One can only speculate about the actual overall number. Another 30,000 or so are picked up at the borders each year.

² This does not mean, however, that all of these people would have a right of unlimited residence or a permanent work permit.
<table>
<thead>
<tr>
<th>Population aged 60+</th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germans per 1000</td>
<td>19,180.30</td>
<td>18,305.60</td>
<td>22,407.90</td>
</tr>
<tr>
<td>% of the German population</td>
<td>26.80</td>
<td>27.20</td>
<td>36.20</td>
</tr>
<tr>
<td>Foreigners per 1000</td>
<td>1307.80</td>
<td>1999.20</td>
<td>2859.50</td>
</tr>
<tr>
<td>% of the foreign population</td>
<td>13.50</td>
<td>18.20</td>
<td>24.10</td>
</tr>
<tr>
<td>% of the total population</td>
<td>6.40</td>
<td>9.80</td>
<td>11.30</td>
</tr>
</tbody>
</table>

Source: Deutscher Bundestag, 2000a: 118
Projections

The prognoses available assume that the proportion of older people in the foreign population will stay below that of the German population. Nevertheless, it is expected to increase to 24.1% by 2030.

Various studies have come to similar conclusions, showing that a high proportion of immigrants are expected to remain permanently in Germany. Experience shows that many of those (still) intending to return to their country of origin, nonetheless do stay in Germany. Furthermore, a considerable number intend to ‘commute’ between Germany and their native country. According to a number of studies (see Mehrländer et al., 1997; Marplan, 1998; Zentrum für Türkeistudien, 1999), the primary motives for remaining in Germany are:

- family relations
- support and family/social networks
- the health care system
- financial reasons.

Selection of minorities to be analysed

For the MEC project, three minorities have been analysed in more detail: Turks, Italians and Russian-speaking immigrants, most of whom are German nationals.

The Turks are the largest group of foreigners in Germany and demonstrate substantial cultural and religious differences to the German population. Many Italians, although they come from another EU state and so might not be expected to have difficulties, are relatively poorly integrated (see Granato, 1997). Finally, Russian-speaking immigrants constitute a heterogeneous group: recent repatriates, who have German citizenship but diverse sociocultural backgrounds, Jewish refugees and immigrants of Russian, Kazakh and other nationalities. At this point, only a first account of the development of the age structure of these three minorities can be given.

‘In 1997, a total of about 499,500 immigrants aged 60 years or older were living in Germany. The largest group consisted of about 96,000 immigrants of Turkish nationality, followed by about 51,000 Italians’ (Zentrum für Türkeistudien, 1999: 17). As previously stated, in 1997, those aged 65+ constituted about 3.2% of the total foreign population. As of 31 December 2000, out of the total Turkish population, those aged 18–35 constituted 35.1% of that population (around 705,800 persons), while those 60+ constituted 7.1% (around 142,800 persons). In relation to the Italian population in Germany, those aged 18–35 constituted 32% of the total Italian population (some 198,200 persons), while those aged 60+ accounted for 10.2% of it (around 62,900 persons). The percentage of those aged 60+ in the Turkish and Italian populations is still relatively small in comparison with, say, the Spanish or the Greeks, but the total number of the elderly is, and will continue to be, much higher among the Turks and Italians.
### TABLE 2  Number of repatriates 1990–99 by country of origin

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Poland</th>
<th>Former USSR</th>
<th>Former Czecho slovakia</th>
<th>Romania</th>
<th>Former Yugoslavia</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>397,075</td>
<td>133,872</td>
<td>147,950</td>
<td>1708</td>
<td>111,150</td>
<td>961</td>
<td>1434</td>
</tr>
<tr>
<td>1991</td>
<td>221,995</td>
<td>40,129</td>
<td>147,320</td>
<td>927</td>
<td>32,178</td>
<td>450</td>
<td>991</td>
</tr>
<tr>
<td>1992</td>
<td>230,565</td>
<td>17,742</td>
<td>195,576</td>
<td>460</td>
<td>16,146</td>
<td>199</td>
<td>442</td>
</tr>
<tr>
<td>1993</td>
<td>218,888</td>
<td>5431</td>
<td>207,347</td>
<td>134</td>
<td>5811</td>
<td>120</td>
<td>45</td>
</tr>
<tr>
<td>1994</td>
<td>222,591</td>
<td>2440</td>
<td>213,214</td>
<td>97</td>
<td>6815</td>
<td>182</td>
<td>43</td>
</tr>
<tr>
<td>1995</td>
<td>217,898</td>
<td>1677</td>
<td>209,409</td>
<td>62</td>
<td>6519</td>
<td>178</td>
<td>53§</td>
</tr>
<tr>
<td>1996</td>
<td>177,751</td>
<td>1175</td>
<td>172,181</td>
<td>14</td>
<td>4284</td>
<td>77</td>
<td>20</td>
</tr>
<tr>
<td>1997</td>
<td>134,419</td>
<td>687</td>
<td>131,895</td>
<td>10</td>
<td>1777</td>
<td>34</td>
<td>16</td>
</tr>
<tr>
<td>1998</td>
<td>103,080</td>
<td>488</td>
<td>101,550</td>
<td>16</td>
<td>1005</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>1999</td>
<td>104,916</td>
<td>428</td>
<td>103,599</td>
<td>11</td>
<td>855</td>
<td>19</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: Bundesministerium des Innern, 2001

### TABLE 3  Comparison of foreigners with the German population  
(Western Germany 1997)

<table>
<thead>
<tr>
<th></th>
<th>Foreigners from traditional countries of recruitment</th>
<th>Germans (average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age in years</td>
<td>38.5</td>
<td>47.6</td>
</tr>
<tr>
<td>Household size: number of persons</td>
<td>3.1</td>
<td>2.5</td>
</tr>
</tbody>
</table>

#### Educational level

<table>
<thead>
<tr>
<th></th>
<th>Foreigners from traditional countries of recruitment</th>
<th>Germans (average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No degree</td>
<td>29%</td>
<td>4%</td>
</tr>
<tr>
<td>Primary education abroad</td>
<td>27%</td>
<td>n/a</td>
</tr>
<tr>
<td>Secondary education abroad</td>
<td>9%</td>
<td>n/a</td>
</tr>
<tr>
<td>Secondary school 'Hauphschule'</td>
<td>22%</td>
<td>46%</td>
</tr>
<tr>
<td>Secondary school 'Mittlere Reife'</td>
<td>8%</td>
<td>25%</td>
</tr>
<tr>
<td>Matriculation/high school diploma</td>
<td>6%</td>
<td>23%</td>
</tr>
</tbody>
</table>

#### Professional status

<table>
<thead>
<tr>
<th></th>
<th>Foreigners from traditional countries of recruitment</th>
<th>Germans (average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>51%</td>
<td>63%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>11%</td>
<td>6%</td>
</tr>
<tr>
<td>Currently not in employment</td>
<td>38%</td>
<td>31%</td>
</tr>
</tbody>
</table>

| Average living space in m² | 76.5 | 94.0 |
| Less than one room per person | 37% | 7%   |

Note: The figures refer to those aged 16–64 except for the average age entry which refers to persons aged 16+

Source: Statistisches Bundesamt, 2000: 570
The third minority focused upon are the Russian-speaking immigrants of German origin from the former Soviet Union. Here it is important to note that these repatriates are not, according to the German Immigrants Act (Article 116 GG), to be considered an ‘ethnic minority’, but as Germans by legislation who can easily obtain German citizenship. Their numbers are increasing (see Table 2) and they are relevant to this study because the majority of them have grown up in wholly different cultural environments, despite their parents’ or grandparents’ connection with German culture. Many had been forced to resettle in the Asiatic parts of the Soviet Union. It is this group’s problems of integration and language that make it an appropriate object of study.

Additionally, the age structure of the repatriates makes them of interest to the MEC project. For example, of those arriving in 1999 (a total of 104,916 individuals), some 10.7% were aged 60+ (11,193 individuals), while 12.6% (13,214 persons) were aged 45–60 and 32.6% (34,221 persons) were aged 25–45.

Socioeconomic profile of the foreign population

Official statistics offer little information on the socioeconomic composition and situation of the foreign population in general or of specific groups. But there are a plethora of separate research results available. Tables 3 and 4, based on a standardised survey, the Socioeconomic Panel, list a number of indicators applying for the moment to foreigners aged 16–64 years. Table 5 adds a few indicators from the so-called Welfare Survey 1998, differentiating first between Eastern and Western Germany, the latter being further broken down into German citizens – including naturalised migrants – and those without German citizenship.

Level of education and employment

Table 3 shows that foreigners from the traditional countries of workforce recruitment, Turkey, Italy, Greece, Spain and the former Yugoslavia (here we refer only to those aged 16+), are on average younger than their (West) German counterparts. They live in households with more occupants than do Germans (3.1 compared with 2.5 persons respectively), but their apartments are nevertheless smaller than those of German households. Some 37% of foreign households have less than one room per person, whereas this is so for only 7% of German households.

Secondary and higher education have each been completed by about one-quarter of the German population between 16 and 64 years of age, whereas only 8% of foreigners have completed secondary education and 6% higher education. More than seven times as many foreigners (29%) do not have a degree as Germans. This is one of the main causes of high unemployment among foreigners (according to the EU survey definition), which is about twice as high as for Germans.

3 A special subgroup are the Jewish immigrants from the former USSR, about 125,000 people in sum of the years 1990–2000.

4 In Eastern Germany, the percentage of repatriates and foreigners is lower than in Western Germany.
<table>
<thead>
<tr>
<th></th>
<th>1 Longitudinal cohort</th>
<th>2 Longitudinal cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Good German language skills</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>42</td>
<td>46</td>
</tr>
<tr>
<td>Second generation</td>
<td>86</td>
<td>89</td>
</tr>
<tr>
<td>Women</td>
<td>35</td>
<td>40</td>
</tr>
<tr>
<td>Turks</td>
<td>30</td>
<td>31</td>
</tr>
<tr>
<td><strong>Interethnic friendships</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>unavailable</td>
<td>48</td>
</tr>
<tr>
<td>Second generation</td>
<td>unavailable</td>
<td>60</td>
</tr>
<tr>
<td>Women</td>
<td>unavailable</td>
<td>46</td>
</tr>
<tr>
<td>Turks</td>
<td>unavailable</td>
<td>35</td>
</tr>
<tr>
<td><strong>Willingness to stay permanently</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>39</td>
</tr>
<tr>
<td>Second generation</td>
<td>34</td>
<td>54</td>
</tr>
<tr>
<td>Women</td>
<td>27</td>
<td>38</td>
</tr>
<tr>
<td>Turks</td>
<td>26</td>
<td>35</td>
</tr>
<tr>
<td><strong>Self-identification as Germans</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Second generation</td>
<td>15</td>
<td>19</td>
</tr>
<tr>
<td>Women</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Turks</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

*Note: The second generation consists of those born in Germany, but who have a foreign passport. This group was too small for a longitudinal analysis in 1984–89 and, therefore, people going to school in Germany were also included.

*Source: Statistisches Bundesamt, 2000: 576*
The employment rate of the foreign population is lower, especially among women, who are much less likely to be employed in the formal economy than their German counterparts.

Language skills and aspects of integration

With regard to language skills, Table 4 depicts a considerable increase in self-evaluated competence among foreigners between 1984 and 1993, a trend which does not continue at the same rate up to 1997. As would be expected, most of the second generation have good German language skills, whereas foreign women in general, and Turkish men and women in particular, still lag behind in this respect. However, some empirical results show that the third generation, now mostly of school age, lag behind their parents – following a process of ‘self-ethnicisation’ (see Deutscher Bundestag, 2002: 247).

Foreign women and Turks of both sexes claim to have proportionately fewer friends of other nationalities. All in all, only 48% of all the foreigners taking part in the survey report interethnic friendships, a percentage that does not increase over the years. Even among the second generation, only two-thirds have such contacts, indicating considerable problems of integration. And only one-third of the second generation consider themselves German. In the other groups surveyed, less than one-sixth of interviewees identified themselves as such in 1997, although there was an increase over the years. Nevertheless, the percentage of those intending to remain in Germany – which also clearly increased between 1984 and 1997 – is as high as 68% among the second generation; about half of those from other groups expressed a wish to stay in Germany permanently.

Objective and subjective indicators of well-being

With regard to general living conditions – income, housing, standard of living and vocational status – divisions emerge between Germans, repatriates and foreigners (see Table 5 overleaf). Conditions are poorest in relation to income, household facilities and employment status for the foreign population, although there is less of a discrepancy in the figures relating to illness, disability and single-person households. Symptoms of anomie are, however, more frequent among repatriates and especially among the foreign population.

Household composition and social networks

The Mikrozensus survey of 1998 also demonstrates that older foreigners more frequently live in larger households (of three or more persons; 28.2%) than do Germans aged 60+ (11.3%). This generates the prevalent belief (or illusion) of care for the elderly being provided within the family. Some 56.6% of Germans aged 60+ cohabit or live just with their spouse compared with 48.7% of foreigners. Only 23% of foreigners aged 60+, but 32% of Germans, live in single households. Some 7.6% of foreigners aged 60+ living in single-person households are divorced or living separately from their spouses; some 10.8% are widowed. This compares to 4.5% of those in single-person households among the German 60+ population who are separated or divorced and some 23.5% of those widowed.
### TABLE 5 Welfare gaps and problems 1998 (%)

<table>
<thead>
<tr>
<th>Objective problems</th>
<th>Total</th>
<th>Total</th>
<th>Of whom repatriates</th>
<th>Without German citizenship</th>
<th>Eastern Germany</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income in the lower decile</strong>*</td>
<td>10</td>
<td>7</td>
<td>19</td>
<td>22</td>
<td>14</td>
</tr>
<tr>
<td><strong>Less than one room (excluding kitchen) per household member</strong></td>
<td>9</td>
<td>8</td>
<td>23</td>
<td>32</td>
<td>8</td>
</tr>
<tr>
<td><strong>No bathroom, toilet and central heating</strong></td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td><strong>Insufficient standard of living</strong></td>
<td>7</td>
<td>6</td>
<td>16</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td><strong>No vocational qualification</strong></td>
<td>15</td>
<td>15</td>
<td>24</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td><strong>Living alone/no close friends</strong></td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Chronically ill or disabled</strong></td>
<td>10</td>
<td>10</td>
<td>5</td>
<td>10</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subjective problems</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Often alone</strong></td>
<td>16</td>
<td>15</td>
<td>18</td>
<td>27</td>
<td>16</td>
</tr>
<tr>
<td><strong>Recurring fear and anxiety</strong></td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td><strong>Often unhappy or depressed</strong></td>
<td>12</td>
<td>12</td>
<td>14</td>
<td>17</td>
<td>15</td>
</tr>
</tbody>
</table>

* Individuals whose income level falls within the lower decile of the income scale, evaluated by household size and the respective ages of the individual household members, compared to the average income in Germany

Source: Statistisches Bundesamt, 2000: 564
Such figures imply that a certain percentage of foreigners move in with their children or return to their native country after losing their spouse. Most experts believe that fewer elderly foreigners than Germans live in care homes – an assumption that cannot, however, be proved statistically.

A higher percentage of foreigners aged 60+ also live in households of two or three generations (29.7% compared with 13.5% of Germans aged 60+). Of these, some 6% of foreigners live in households that encompass three generations – grandparents to grandchildren – compared to 1.8% of Germans aged 60+. This suggests that, as the age structure of the foreign population is relatively 'young', their family ties are perhaps stronger.

The structures of mutual support and family networks between the generations of the foreign population do not differ basically from those of the German population (see Figure 3 overleaf). However, we should note the following: ‘Elderly foreigners, especially those elderly labour migrants and repatriates who are tradition-oriented, primarily expect support from their own children’ (Deutscher Bundestag, 2000a: 122).

Health

Assessing the social and health situation of foreign minorities, and especially of the elderly among them, is made more difficult by a lack of information: ‘Comparative studies on the distribution of illnesses between foreign and German senior citizens, such as those carried out in Great Britain, do not exist in Germany’ (Gerling, 2001: 55). Nonetheless, we can conclude from the data available that the state of health of the foreign population (from infant mortality up to the chronic illnesses of the elderly) is poorer than among Germans. This results to a great extent from the foreign population’s poorer housing and more strenuous working conditions. In addition, the foreign population more often suffers from mental disorders, often caused by their specific situation as migrants. The poorer health of foreigners is also demonstrated in their own evaluations of their state of health, expressed in the national survey findings of 1996 and regional survey results for Hamburg of 1997. Thus, 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 total foreign population were 5.6 and 40.5 respectively. Among Turks in Hamburg, the percentages were even lower, with only 3.1% describing their health as ‘very good’ and only 26.8% describing it as ‘rather good’. Those describing their health as poor, however, were some 17.6% of Turks, 23.2% of Yugoslavians, but only 3.6% of Germans. The percentage of all foreigners describing their health as ‘poor’ was 19.6. In the national survey of 1996, 12.4% of Italians described their health as very poor, as did 14.6% of those from the former Yugoslavia.

According to the Hamburg survey, ‘Of the elderly migrants, 62% are receiving medical treatment. The corresponding figure for the Germans is only about 46%. Only 2% of the foreigners get professional help, one-tenth of the German figure’ (Zentrum für Türkeistudien, 1999: 34). See Table 6 overleaf.
FIGURE 3 Support received and given by elderly foreigners

<table>
<thead>
<tr>
<th></th>
<th>Portugal</th>
<th>Turkey</th>
<th>Yugo slavia</th>
<th>Italy</th>
<th>Poland</th>
<th>Iran</th>
<th>Total foreigners</th>
<th>Germany</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good</td>
<td>2.8</td>
<td>3.1</td>
<td>8.6</td>
<td>13.1</td>
<td>8.0</td>
<td>3.9</td>
<td>5.6</td>
<td>14.7</td>
</tr>
<tr>
<td>Rather good</td>
<td>63.0</td>
<td>26.8</td>
<td>32.5</td>
<td>63.9</td>
<td>45.5</td>
<td>66.2</td>
<td>40.5</td>
<td>61.4</td>
</tr>
<tr>
<td>Rather poor</td>
<td>25.9</td>
<td>52.5</td>
<td>35.8</td>
<td>18.9</td>
<td>42.0</td>
<td>27.3</td>
<td>40.4</td>
<td>20.3</td>
</tr>
<tr>
<td>Poor</td>
<td>8.3</td>
<td>17.6</td>
<td>23.2</td>
<td>4.1</td>
<td>4.5</td>
<td>2.6</td>
<td>19.6</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Source: Gerling, 2001: 58
Service delivery and utilisation

Health and elderly care

‘The health care situation of migrants is demonstrably marked by substantial shortcomings. This can be evidenced not only in the state of medical care, but also in the field of nursing care’ (Habermann, 2001: 73). This applies both to the general supply of health and nursing care services and to specific services created to meet the particular needs of this population group. The comment above must nevertheless be seen in the context of the overall situation in Germany – that is, state spending in these fields cannot be described as poor in comparison with international standards. But there are some definite quantitative deficiencies, such as the lack of networked services and the shortage of nursing staff. But there is, too, some definite overcapacity, for example, in fixed health institutions, although there are considerable regional differences.

Benefit payments in the German health and nursing care system are primarily financed within the framework of two social security systems. Elderly care (institutional, partly institutional and non-institutional) and social welfare are, in the first place, financed by the municipalities. Depending on the sector in question, services are provided by private suppliers, state or municipal agencies or by large charitable institutions. These have more or less divided up the ‘lucrative’ social consulting market between themselves. Client organisations, including those of ethnic minorities, are at best significant as suppliers of self-help or as information and counselling services, although their importance in these areas is not to be underestimated.

There is practically no representative information available on patterns of service usage by minorities in spite of their prevailing need for and entitlement to such services. The data generated in the process of accessing and utilising services do not differentiate between nationalities. Distinguishing between Germans and foreigners is only possible in the field of social welfare – but, again, not according to individual nationalities.

Income support

The share of income support recipients per 100 foreign residents is in all parts of the country significantly higher than that of native Germans, with a difference in affluence increasing from the South of the republic to the North. Additionally, the uneven distribution of the foreign population in Germany, which, moreover, follows a distinct settlement pattern; the larger the number of residents in a particular area, the higher the percentage of foreigners of the whole residential population.

Statutory Long-term Care Insurance was only developed in the past decade, while the statutory health insurance has already existed for 100 years.
Utilisation of services

There is no corresponding information available to show gaps in service provision or failure to utilise them in spite of entitlement and need, either for Germans or foreigners. Also unavailable are data on the use of hospital services, doctors, elderly care (stationary or ambulatory), sheltered housing, and so on. Such figures and rates are only available on a representative basis for the whole population, and since they would not contribute to an understanding of the specific issue of minority elderly care, they will not be presented here (see, however, the more extensive country report).

Only by putting together some qualitative studies, regionally-limited investigations and single surveys is it possible to draw up any picture of how foreign minorities take up relevant social services and benefits – and, even then, the necessary differentiation between different nationalities is limited. However, the conclusion to be drawn from all these pieces of information is unambiguous and unanimously confirmed in the relevant literature. Despite their greater needs and their generally worse social situations, the foreign population, and foreign elderly in particular, use health, nursing and elderly care services less than does the native population.

Barriers to service access

There are numerous obstacles faced by elderly foreigners in relation to the German care system – and the complicated social system as a whole – leading to their exclusion from services that are intended to be generally accessible, resulting in care gaps. These obstacles have been widely discussed in the literature and examined in numerous studies. Communication problems resulting from cultural and language barriers hinder, for instance, the provision of medical care and information. They can complicate the establishing of case histories, as well as diagnosis, therapy and rehabilitation. Wrong diagnoses may lead to multiple examinations or to illnesses becoming chronic. Providers of both stationary and ambulatory care lack the necessary intercultural skills needed to ensure adequate and properly targeted health care for migrants. The frequent early retirement from paid work, as well as the dangers of isolation among the increasing number of elderly migrant women who have never been employed, can lead to problems not only of poverty, but also of mental health and well-being, with which society increasingly has to come to terms. Chronic illnesses of old age that lead to a need for long-term care can occur among migrants as young as 50 years of age – considerably younger than usual.

The diverse health hazards and strains endured in the course of migration often find expression in acute illnesses and the early signs of physical wear. Known facts are the relatively high sickness rate and early retirement from working life due to health problems. Early retirement rates show that disability at an early age, between 40 and 50 years, strikes foreigners more frequently than the average of the population. (Deutscher Bundestag, 2000a)
Other factors that militate against migrants accessing social and health care provision can include: a lack of understanding or knowledge on the part of service providers responding to the religious, cultural and gender-specific needs of migrants; a middle-class bias against a population that is both ‘different’ and largely working class; possibly even certain preconceptions about the elderly and their needs, which are compounded by cultural biases.

Service providers

The extensive social security system, paid for through compulsory insurance, covers almost the entire German and foreign population and is supplemented by special systems and private insurance. Hence, less than 0.5% of the population is not covered by any health insurance at all.

In principle, everybody is equally entitled to receive the system’s services if in need. The only exceptions to this rule are illegal immigrants,6 asylum seekers, individuals with a tolerated stay and those with entitlement only to temporary residence (granted for exceptional purposes, especially to war refugees). These latter groups are only entitled to services defined under the Law for Asylum Seekers’ Assistance and not according to the Federal Social Assistance Act. Essentially, these people receive medical assistance ‘for the treatment of acute illnesses and states of pain only’.

According to the available information, ethnic minority organisations, in addition to lobbying and encouraging self-help and self-organisation, focus mainly on providing information and counselling. It is exceptional for such an organisation to offer other services. Besides, the debate on provision in Germany clearly aims at establishing the concept of intercultural openness and providing culture-sensitive services in all institutions of health and elderly care rather than at establishing ethnically-specialised provider organisations.

Growing demand: an example

Projections show that elderly foreigners’ need for services will significantly increase in the future. Accordingly, ‘the number of elderly migrants living in institutions for elderly care will increase. With an estimated share of 1.5% [of all those in homes for the elderly] (1994), elderly migrants living in homes for the elderly are so far underrepresented’ (Zentrum für Türkeistudien, 1999: 35). Table 7 overleaf reflects, along with the estimated future need for institutional care of elderly migrants, the changes awaiting society in coping with this matter.

6 In the past decade, more than 100,000 illegal residents have been caught each year within the German borders; one can only speculate about the actual overall number. Another 30,000 or so are picked up at the borders each year.


<table>
<thead>
<tr>
<th></th>
<th>Aged 65+</th>
<th>Aged 80+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1,327,900</td>
<td>220,500</td>
</tr>
<tr>
<td>Prognoses for future need</td>
<td>5.0%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Need for institutional care</td>
<td>66,395</td>
<td>73,034</td>
</tr>
</tbody>
</table>

Source: Zentrum für Türkeistudien, 1999: 35
Conclusion

The bodies responsible for social and health services need to ensure that their planning takes sufficient account of citizens from migrant backgrounds. Some relevant model projects are already in operation. The federal government supports, for instance, the following projects:

- improving the provision of nursing care by starting mobile care services with multilingual staff
- courses for carers from migrant families
- initial and further training of foreign helpers in home care
- information courses for care professionals on the situations of migrant families
- language courses for ambulatory service staff
- promotion of professions in elderly care to the foreign population.

In terms of disease prevention, the aim is to inform migrant families on health issues, mobilise their potential for self-help and encourage them to obtain professional qualifications. The federal government’s commissioner for foreigners’ issues has set up a working group, ‘Migration and Public Health’, which publishes a series of practical leaflets on relevant topics, supports projects that are already running and distributes information on them.

In respect of elderly care, the following are required:

- intercultural openness and culture-sensitive care
- ‘user-friendly’ care for the elderly within a framework more strongly orientated towards the ageing of society as a whole
- support for returnees and commuters
- further training and qualifications for professional and voluntary helpers
- hiring of intercultural professionals
- creating services with an ethnic emphasis in care institutions
- promotion of family support systems
- specific ethnic services as part of non-institutional elderly care
- more research and data provision on the topic
- networking of voluntary work for the elderly and for migrants

(see Beauftragte der Bundesregierung für Ausländerfragen, 1999; Deutscher Bundestag, 2000a: 218ff., 2000b: 280; Zentrum für Türkeistudien, 1999: 38ff.).

Intercultural openness is a strategic concept adopted by some official authorities, representatives of migrant organisations and German expert forums. Emphasis within specialist discussion and thinking has, in recent years, shifted from the approaches of ‘employing native speakers as professionals’ and ‘cooperating with migrant projects’ – important as these still are – towards ‘intercultural further training’ and ‘intercultural openness as a function of organisation and management’. Yet migrant organisations make little effort, apart from providing information and counselling for the elderly, to open their projects to mainstream social care (see Bundesgemeinschaft der Immigrantenverbände at: http://www.bagiv.de/broschuere_1.htm).
The concepts of intercultural openness and culture-sensitive care are based on the assumption that the labelling of most problems as ‘culture-bound’ can serve to further exclude migrants. Recent studies on migration repeatedly point out that discussing ‘the other’ without at the same time examining one’s own state and structures is counterproductive. Culture-specific expectations and perceptions, in the intercultural context of care, require continuous individualisation in the care process itself. Because the intercultural context of care includes diverse nationalities and ethnic groups, it can be of only limited value to gather knowledge of specific cultures. It seems, therefore, important to focus more on the attainment of general competencies in intercultural communication, thus building a solid structural basis for successful intercultural care (for more details, see Habermann, 2001).

The concept of intercultural openness and culture-sensitive elderly care aims at enabling all elderly people living in Germany, regardless of their social, ethnic or cultural background, to gain access to the institutions of elderly care and to find there culture-sensitive, professional treatment based on experience. Culture-sensitive care is expected to empower persons in need of nursing care to live according to their individual requirements, values and cultural and religious preferences. This includes, among other things, the following:

- information, consultation and health education for migrants
- a need- and biography-orientated care relationship in which the planning of the care process is undertaken in dialogue with the persons needing care as well as their families
- in the foreseeable future, the parallel establishment of institutions specially targeted at migrants, with staff who speak their languages
- efforts to train foreign language speakers as qualified employees, as well as to sensitise German trainees to cultural issues, and further training of staff already employed in these sectors
- in addition to the provision of knowledge, the creation of forms of learning in which experiences can be reflected upon and intercultural competence developed
- political, professional and financial support for institutions and associations engaged in intercultural openness in relation to stationary and ambulatory care
- recognition of migrants’ own organisations as a potential resource; taking them into consideration in making political decisions and allocating funds
- opening existing networks and committees to migrant organisations.

To open up the social services to an intercultural approach in this way requires an external stimulus as well as continuous monitoring, and is thus a task for management. It is a process that demands commitment both at management level and at the operational level of an organisation. In other words, it needs to become part of ‘company culture’. The most important target groups for the implementation of intercultural openness in elderly care are the public providers and social administrators, the private providers and charitable associations. It must also be integrated into the primary and further training sector. Nevertheless, intercultural openness is not just a task for the social services, but for all of society.
The Netherlands

Bing Teng, Annemarie Peeters
and Norma Schuijt-Lucassen

Introduction

Like the other MEC project reports, this one seeks to identify the factors that
determine the quality of care provided to minority ethnic elderly people.
Based on the full country profile report, it uses available statistics and research
on minority elderly care in the Netherlands. However, in a number of areas,
data are unavailable on ethnic minority elders.

In this report, the definition of ethnic minorities refers to those minority
groups defined as target groups under the government’s integration policy.
These target groups include all those living in the Netherlands who were born
in Turkey, Morocco, Surinam, the Netherlands Antilles, Aruba, Greece, Italy,
the former Yugoslavia, Portugal, Spain, Cape Verde Islands and Tunisia, as
well as their children living in the Netherlands. In addition to this, Moluccans,
refugees, Roma and gypsies also fall within the target groups.\(^1\) These target
groups are characterised by their low socioeconomic status.

The context of migration in the Netherlands

To an increasing extent, the Netherlands is becoming a country of immigration.
Three dominant types of migration can be distinguished:

- **Migration as a consequence of the colonial past and present.** Dutch history
encompasses colonial rule in Indonesia, Surinam, Aruba and the Netherlands
Antilles. The latter two still have a constitutional relationship with the
Netherlands, as they are part of the kingdom of the Netherlands.

- **Economic migration of workers.** Although economic migration has a longer
history in the Netherlands, substantial numbers of migrant workers have
come to the Netherlands since the late 1950s and early 1960s. Among the
earliest were people from Mediterranean countries such as Italy, Greece
and Spain who, because of economic conditions in their countries of origin,
came to the Netherlands mostly on an individual basis. They were followed
by migrant workers from Turkey and Morocco.

\(^1\) To clarify, in some cases people from these ethnic minority groups have Dutch nationality.
The economic situation in the Netherlands in the 1960s created a demand for labour which gave rise to a more ‘proactive’ recruitment policy. Male guestworkers from Turkey and Morocco were recruited for work, mainly in the industrial sector. At first, their stay in the Netherlands was meant to be temporary. For a variety of reasons, the anticipated return migration never happened and, since the 1970s, women from Morocco and Turkey have joined their husbands as part of family reunification.

- Refugees and asylum seekers. In origin, this is a very varied group. It includes refugees from Latin American countries and Vietnam who came in the 1970s and early 1980s respectively. In later years, refugees and asylum seekers came to the Netherlands from, among other countries, the former Yugoslavia and China as well as from the Middle East and the African continent.

The background to their migration influences the current social position of the various groups within Dutch society. It is, for instance, conceivable that, because migrant workers initially came temporarily to the Netherlands for economic reasons with the intention of returning to their countries of origin, this has hindered their integration. In this respect, they differ substantially from those who came to the Netherlands as part of colonial migration. However, as time has passed by, returning ‘home’ has proved to be a dilemma for many migrant workers. Migration data show that only a very small proportion of migrants returns to their countries of origin. Circumstances such as having children in the Netherlands, uncertainties about financial arrangements (such as benefit and pension rights), socioeconomic prospects in the country of origin and uncertainty about the possibilities of returning to the Netherlands in the future all hinder their return. For example, in 1995, only 2% of Turks and 5% of Moroccans aged 50–65 actually went back.

Ethnic minority policy

Since the late 1980s, immigration has increased substantially, not only because of increasing numbers of asylum seekers, but also because of family reunification and family formation. As a consequence, in the political arena as well as in public opinion, the issue of ethnic minorities is becoming more and more important. The current government, which took office in 1998, places great stress on its ‘integration policy’ which emphasises the incorporation of migrants into Netherlands society. Since a substantial number of those from ethnic minorities (generally of non-white origin) lag behind socioeconomically, their current social position can be characterised as one of deprivation, which coincides with a high prevalence of complex minority problems such as high unemployment, racial tension and discrimination and, among certain groups, an above average crime rate. Given these problems, public discomfort and political concern over the issue of ‘foreigners’ are currently growing. Hence, current integration policy focuses strongly on migrants settling down within Netherlands society.

A shift in the nature of integration policy can be detected in recent decades. In the early 1980s, the recognition that the majority of migrants were unlikely to return home led to an acceptance that a policy on ethnic minorities was needed which incorporated a twin strategy of socioeconomic assimilation.
and cultural pluralism. This policy was aimed at the maintenance of cultural traditions without denying equal opportunities for social and political advancement. It placed strong emphasis on the promotion of ‘ethnic community development’ by making various resources available to communities. Ideologically, this approach was in keeping with the social (and political) structures that, for most of the 20th century, characterised Netherlands society. Social and cultural pluralism constituted the dominant ideological basis of policy on minorities, which emphasised guarantees of a substantial degree of autonomy for each cultural (or religious) grouping. Within this policy framework, minority groups were conceived as ‘new’ cultural blocs in need of social emancipation.

But, since the beginning of the 1990s, a complex combination of socioeconomic trends, including a large increase in immigration, structural economic changes resulting in a greatly decreased need for blue-collar labour, the restructuring of the ‘traditional’ welfare state and growing public unease have led to a growing awareness of the problematic nature of the current situation concerning certain minority groups. The policy response has been to replace the culturally liberal approach of the past with a problem-orientated approach. The emphasis on groups maintaining their own cultural identities has shifted towards an emphasis on their acceptance of certain key norms and values of western democratic society. The yardstick of ‘active citizenship’ has become the binding sociopolitical concept of current integration policy.

Current integration policy falls into three categories: the active incorporation of foreigners into civil society; education strongly aimed at facilitating labour participation; and anti-discrimination measures. Alongside an increasingly restrictive policy on the admittance of new migrants (especially asylum seekers), general policy towards ethnic minorities is becoming increasingly stringent in character. Recognition of their civil rights is accompanied by more and more emphasis on their obligations; for example, to learn the Dutch language; to engage in education so as to broaden their prospects in the labour market; and to comply with the key norms and values of ‘civil society’. This approach is categorised as a ‘social contract’ between the migrant and the ‘receiving society’. Characteristic of the changing policy is the increasing use of sanctions against minority ethnic individuals who do not fulfil their obligations arising from the social contract.

The target groups of the integration policy are largely those ethnic minority groups whose socioeconomic position is weak: Turks, Moroccans, Surinamese, Antilleans and refugees and asylum seekers. Emphasis is laid particularly on those in the younger age groups because of their potential in the labour market. The issue of ethnic minority elders is a much lower priority for integration policy and is more or less delegated to the domain of the Ministry of Health, Welfare and Sports.

2 For a major part of the 20th century, Netherlands society was structured along the lines of the various religious and ideological groups (Catholic, Protestant, Humanist, and so on) which were referred to as ‘pillars’. This structure was also reproduced at the level of the social and political institutions, which reflects the social climate of recognition of cultural pluralism in which the relative autonomy of each pillar was highly valued.
FIGURE 1  Ethnic minorities by age, 1999 (%)  

Source: CBS, 2001a, b
Demographic trends

Projections indicate that, between 1995 and 2015, the total number of ethnic minority people will double to over 2 million. In recent years especially, the number of newcomers has increased greatly. The following provides an insight into the most prevalent demographic trends in the Netherlands.

Throughout the western world (as well as in Japan), a trend towards population ageing is discernible, and the Netherlands is no exception. Due to the increase in life expectancy and the birth explosion during the post-war reconstruction period, there has been a sharp increase in the number and percentages of persons in older age groups. The oldest group consists mainly of women, who account for 63% of 75–84 year olds and 74% of those aged 85+ (de Klerk, 2001). The proportion of men aged 80+ is expected to rise from 1.9% of the total population to 6.6% in 2050, while the proportion of women aged 80+ will increase from 4.4% to 8.9%.

The size and composition of the Dutch population is changing because of immigration. From 1995–2001, the number of non-western minorities in the Netherlands increased by more than 30%, while the number of western minorities increased by about 5%. The number of Turks, Moroccans, Surinamese and Antilleans aged 50+ is low compared to the indigenous population. But although the proportion of ethnic minority elderly is comparatively low, it is evident that the numbers are on the rise.

Future projections

The increase in the number of older people is strongest in relative terms among the Antilleans and the Surinamese. The number of elderly Turks and Moroccans is also expected to grow, but comparatively less. It is estimated that, by 2005, there will be around 125,000 non-western elders in the Netherlands. This figure does not include Indonesian elderly. At present, there is already a substantial group of Indonesians aged 50+; the figure has risen above 110,000.

Distribution of the ethnic minority population

The number of ethnic minority people as a proportion of the population varies considerably between the provinces. Whereas 93% of people in Friesland are of indigenous Dutch origin, the percentage is significantly lower in North Holland (76%). Minorities – non-European minorities in particular – are concentrated in North and South Holland. They are clearly underrepresented in the northern and eastern provinces, but are overrepresented in the larger cities. Reasons for this include the availability of industrial work, which has attracted a substantial number of migrant workers, and the availability of a wide range of educational services.

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3 The division into ‘western' and ‘non-western' minorities is a statistical distinction based not on geographic but on economic characteristics. Indonesians belong to western minorities.
Refugees and asylum seekers

Another category of migrants is that of refugees and asylum seekers. Between 1992 and 1994, applications from asylum seekers more than doubled. In 1994, the admissions policy was tightened, leading to a decrease in requests for asylum in 1995. Nevertheless, the number of asylum seekers increased from almost 23,000 in 1996 to almost 43,000 in 1999. The total number of naturalisations in the first years of the 1990s increased, peaking in 1996. This is due to the fact that, between 1992 and 1997, it was possible to maintain one's original nationality in addition to obtaining Dutch nationality, but this situation changed in 1997. After that date, applicants had to renounce their original nationality in order to attain Dutch nationality. It is striking that 80% of those who became Dutch nationals in 1998 and 1999 had been in the Netherlands for less than 10 years.

Socioeconomic position

In what follows, we present some information on the socioeconomic position of ethnic minority elderly. Although there are major differences between the various ethnic groups, they all lag behind mainstream society in socioeconomic terms.

Education

Turkish and Moroccan elderly generally have low levels of education, particularly the women. A high proportion is illiterate. Older Surinamese and Antilleans, who are significantly better educated than their Turkish and Moroccan counterparts, hardly differ from the Dutch elderly in this respect. This can be attributed to the fact that a proportion of Surinamese and Antilleans emigrated to the Netherlands to gain educational qualifications in addition to their already high level of education.

In general, the elderly have a lower educational level than younger people, whose education levels will increase with each new generation. It is unlikely that the elderly will, at this stage, improve their education, making this group more vulnerable.

Employment

About 80% of Turkish and Moroccan employees work in lower status occupations, mainly in the industrial sector (for which they were originally recruited) and also in the agricultural sector, mostly in horticulture. A high proportion of Surinamese and Antilleans works in the public sector and in health care. Turkish and Moroccan workers are overrepresented in unskilled and semi-skilled occupations and have little or no occupational mobility. Surinamese and Antillean elders have more often managed to improve their labour position over the course of their careers.

For Turkish and Moroccan men, work was the most important reason for coming to the Netherlands in the 1960s and 1970s and, until the end of the 1970s,
their participation in the labour market was higher than that of the Dutch and their unemployment rate was much lower. However, today a substantial proportion of Turkish and Moroccan men is long-term unemployed.

Income

Elderly persons from ethnic minorities are concentrated in the lower income categories due to low labour force participation and the overrepresentation of those in employment at the bottom of the occupational structure. The majority of those qualifying for the state pension among ethnic minorities also do not have full pension entitlements, since they did not come to the Netherlands until later in life. Low labour participation rates have an indirect effect on pension build-up, which can also be disrupted by periods of unemployment or disability. A large proportion of ethnic minorities is dependent on some kind of benefit, and disability is the most common cause of inactivity in the labour market. Many Turkish and Moroccan men are on national assistance, indicating long-term unemployment.

Turkish women, in particular, do not receive an income from employment or benefits. They work in the household and are financially dependent on their partners. The picture is different for Surinamese women due to their high labour participation rates and the high proportion of single-person households. They are more likely to have an income of their own. Many elderly find their incomes inadequate. Approximately 80% of Turkish and 60% of Surinamese and Antillean elders consider their incomes to be low or much too low.

Partner status and household composition

Partner status and household composition are strong indicators of practical and emotional support, both given and received. They are also important factors in determining financial status. There are, however, some major differences in partner status and household composition between the different ethnic groups. Ethnic minority households, especially in the Turkish community, are in general larger than those of the indigenous population. The majority of Turks aged 55+ live in multiperson households. The majority of Surinamese elderly, however, live in one- or two-person households. One-third of Surinamese women live alone and single-parent families are common.

A particular aspect of many households of ethnic minority elders is the big age difference between partners, especially among Moroccan and Turkish couples. Almost 40% of Moroccan men have a partner who is more than 10 years younger and over 30% have a partner who is five to nine years younger. The percentages for the Turkish community are slightly smaller, but still high – 20% and 30% respectively. These age differences can cause major disadvantages for women. Men’s lower life expectancy means that they are more likely to receive care and support from their younger wives until they die. For a woman, caring for a partner can become a considerable burden, with no one to take care of them when they become old and need help in their turn.
Housing situation and living conditions

Ethnic minority elders live in homes of a poorer quality than the rest of the population, as do younger members of minority communities. In general, they have to share their homes with more people. This applies especially to Turkish and Moroccan elders, who usually continue living with others until late in life. The homes of Antillean and Surinamese elders are often of better quality than those of the Turkish and Moroccan elderly, but poorer than those of the general population.

The homes of Turkish and Moroccan elders are more likely to be in the social rented sector and fewer are owner-occupied. Overall, members of ethnic minorities are less likely to express a positive opinion about their housing situation than the rest of the population, mainly because of the lack of space and rooms in their homes. The elderly in the population at large are more likely to live in a house that is accessible without stairs; members of minority communities are less likely to live in single dwellings than the general population. Ethnic minorities are more likely to live in apartment buildings with all the rooms on one floor. One advantage of living in cities is the high level of services that can be provided. Because minorities more often live in urban areas, they have better access to different kinds of services such as shops, medical services and public transport than in rural areas.

Integration

For integration into a society, knowledge of its language is one of the most important factors. Turkish and Moroccan elders have difficulties with the Dutch language. In many situations where knowledge of Dutch is indispensable, they are forced to rely on others; in most cases, their better educated children. This also appears to be true for many Surinamese and Antillean elderly. Although a large proportion of them are better educated than their Turkish and Moroccan peers, there is still a relatively large group whose command of the Dutch language is only rudimentary.

In addition, elderly Turks and Moroccans have made little progress towards adapting to the host community's social environment and its values during their time in the Netherlands. Elderly persons from these groups have generally remained ‘foreigners’, but the length of time they have spent in the Netherlands means that they have also become, to a certain extent, foreigners in their countries of origin (de Klerk and Timmermans, 1998). Turkish and Moroccan elders have barely integrated into Dutch society, although the integration of elderly Surinamese and Antilleans is much further advanced.

Turkish and Moroccan elders have hardly any social contact with Dutch people but, instead, associate mainly with members of their own groups. Antilleans, however, associate more frequently with the indigenous population. Levels of participation in clubs and associations among ethnic minority elderly are extremely low. If they do belong to clubs, these consist, for the most part, of those from the same cultural-ethnic background.
Take-up of health and care services

Health

According to Tesser et al. (1998), there seems to be a discrepancy between objective and subjective viewpoints on the health status of minority ethnic groups. According to objective assessments, their health status does not appear to be worse than that of indigenous elderly people, but their subjective views about their health are very negative. The discrepancy may be to do with the psychosomatic nature of the majority of complaints affecting Turkish and Moroccan elderly people. It is suggested that at least some of their complaints could arise from their more general dissatisfaction with the social situation in which they find themselves. Stress factors arising from the dilemmas surrounding the return to their countries of origin and what help they can expect from their children could also play a role. Another explanation could be that the way in which Turks and Moroccans describe their complaints is different from that of the Dutch population. Among Surinamese elderly people, there is a much greater correlation between subjective and objective health indicators (de Klerk and Timmermans, 1998).

Poor health status is often correlated with unfavourable working circumstances and the stress of living as a migrant worker. Physical overloading in a job can cause back trouble, while working with harmful substances can lead to lung and respiratory problems. Stress can cause mental problems which, in turn, can give rise to hypertension, gastric trouble, insomnia, and so on. Turkish elders are more likely than indigenous people to report that they suffer from one or more chronic illnesses. Turkish and Moroccan people more frequently report high blood pressure, diabetes, joint, mobility and gastric problems; Surinamese elders more often suffer from somatic disorders such as diabetes and high blood pressure.

Unfortunately, little is known about the mental health status of ethnic minorities. The available data are neither extensive nor up to date and there are major doubts about their validity.

A recent study carried out in Rotterdam found lower mortality indices among Moroccan elderly, probably because they are less likely to die of cancer, which is also the case for older Turks (Denktas, 2000). They also suffer less frequently from heart and cardiovascular disease, which is probably correlated with their diet in which polyunsaturated fatty acids and carbohydrates predominate. The food of the Surinamese contains more saturated fat, hence they are at greater risk of diabetes and high blood pressure. In comparison with the general population of Rotterdam, their mortality rates are a little higher.
Take-up of care services

According to Tesser et al. (1998), elderly members of minorities face the same problems of day-to-day functioning as indigenous elderly people and their need for professional care can therefore be assumed to be comparable. To date, however, the take-up of care services by elderly members of minorities is extremely low. Specific needs and desires, related to cultural preferences and traditions, play an important role in the take-up of care facilities. If no allowance is made for this, there is a great risk that the provision of care services will not reach minority elders (de Klerk and Timmermans, 1998).

Visits to the GP, medical specialists and hospital

Ethnic minorities in general, and Turkish and Surinamese elderly in particular, visit a GP comparatively more often than the indigenous population. Their first contact with a medical specialist or hospital mostly comes through a GP referral. It is striking that, despite their health status and frequent visits to the GP, members of ethnic minorities are not seen by medical specialists and do not gain admission to hospital more frequently.

Use of medicine

Specific recent data about the use of medicine by different ethnic groups are unavailable. Health surveys show, however, that Turkish elders take medicine more frequently, and of different kinds, than do the Dutch population. They use painkillers more often and remedies for gastric disorders, joint problems and colds. Dutch elderly are more likely to take medicine for cardiovascular diseases than Turkish elderly. Unfortunately, there are no data about the use of medicine by other groups.

The health care policy framework

The Netherlands health care system aims at providing preventative and curative mental and physical care. A distinction is made between:

1) public health care, which aims at public prevention and is carried out by municipal services;
2) primary health care, which is patient-orientated, general and has free access;
3) secondary health care, which is patient-orientated and includes specialised care and inpatient services accessible only by referral, usually by a GP.

The health care system is underpinned by complex legislation and is highly regulated. It includes detailed standards and complex planning procedures, particularly with regard to secondary care. Policy and planning for primary health care have been delegated to the municipal level within certain boundaries. The most relevant legislative programmes are:

- Act on hospital facilities (WZV). The Act regulates the planning standards, procedures and obligatory monitoring of specialised and medical inpatient services. It covers the planning of general and psychiatric hospitals, nursing homes and certain specialised hospitals. Nursing homes for somatic and psychogeriatric patients are of particular relevance to the care of the elderly.
In addition, day nursing care in nursing homes is provided on the basis of this Act. The planning standards for nursing homes are mainly based on the number of those aged 70+. By law, the planning authority is the provincial administrator, but the minister has to give final approval.

- **The health insurance system.** The health insurance system is a mixed system of public and private insurance and also a mixture of voluntary and compulsory systems. There are no age restrictions. About 9 million inhabitants (including co-insured partners and children) are covered by the Public Health Insurance Fund, while private insurance schemes cover about 6 million inhabitants. Whether a person belongs to the Public Health Insurance Fund or has private health insurance depends on his/her income. The Public Health Insurance Fund is compulsory for all persons with an annual income of up to €31,000. Employees with an income above this limit, as well as the self-employed, have to pay for their own private health insurance through private companies. Both the public and private schemes cover the medical expenses of primary and secondary health care.

- **Act on exceptional medical expenses (AWBZ).** This Act was established to cover the expenses of ‘uninsurable’ medical risks such as may arise from serious illness or long-term disability, most notably mental illness requiring prolonged nursing and care or congenital physical or mental handicap. These are expenses that virtually no one is in a position to bear without help from the state or elsewhere. It is obvious that the elderly population, given its relatively higher incidence of chronic illness and disability, is an important target group for this scheme. This Act is part of the general legislation concerning care provision and is not exclusively aimed at the elderly population. The aim originally was to offer insurance covering long-term care facilities for the chronically (physically as well as mentally) ill. Policy changes turned this into basic insurance covering exceptional medical expenses for every citizen. The scheme is, as stated above, a substantial element in the provision of care for the elderly. The insurance is compulsory. The premium is paid by employers and consists of a fixed percentage of income.

These insurance schemes and legislative systems, together with the health care system in general, are currently the topic of fierce debate. At one level, this is the result of obvious malfunctioning. Long waiting lists indicate that the supply of care is substantially lagging behind demand. Also, the strongly centralised and overregulated legislative structure has led to excessive bureaucratisation and to institutional inertia. Lastly, the anticipated ageing of the Netherlands population has generated an increasing awareness of the necessity for reviewing the current system.

The current rethink (‘the modernisation debate’) began in the 1990s and has resulted in some ad hoc adaptations. The most important trends within modernisation policy are described below:

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4 According to the AWBZ, no services are provided, but the following treatments and services are financed: long-term stay in rehabilitation clinics and mental hospitals, residential care in nursing homes and homes for the elderly, day care in nursing homes, psychiatric help provided by regional institutes for community mental health care (RIAGG) and non-clinical psychiatric care, home helps and district nursing.
A major shortcoming of the long-term care system has always been the fact that the various types of care were financed under different funding schemes and regulated under different policy programmes and authorities at various administrative levels. Under modernisation, all long-term care services would come under the AWBZ.

In the Netherlands care system, strong emphasis is placed on controlling expenses. This is underpinned by a regulation-orientated and centralised approach in which planning is largely supply-orientated. Under modernisation, this will be replaced by a more demand-orientated approach. However, at present, this is hardly any more than a point of departure for further policy development. More operational policies and planning mechanisms are still under development.

Linked to the pursuit of a more demand-orientated system is the decentralisation of administration. Tasks and responsibilities concerning service planning are being allocated to regional authorities (i.e. regional health insurers). Given the intrinsic relationship between care, housing (the formal responsibility of the municipalities) and social care, the regional health insurers are supposed to adjust their planning in relation to the other relevant policy agencies.

It should be remembered that the process of modernisation is still in its early stages and, to a large extent, the trends described above have still to be made operational. An important factor impeding decisive policy formation is a certain amount of dissension among the major policy making agencies in parliament as well as in the Ministry of Welfare and Health.

Services for the elderly

The health care system

*Nursing homes*

These provide residential facilities for patients who need extensive nursing care without extensive specialist treatment – known as CLSM (continuous, long-term, systematic and multidisciplinary) care. Besides residential care, an increasing number of nursing homes also provide ‘day nursing’ in small outpatient units. Although the nursing homes are not intended exclusively for the elderly, about 90% of the available beds are occupied by this group. Three types of nursing home can be distinguished: those for physically incapacitated patients; those for psychogeriatric patients; and those of a ‘mixed’ nature.

*Psychiatric hospital care*

This is provided by ambulatory services; in psychiatric wards in general hospitals (short-term admissions); and in psychiatric hospitals. Some of these services are fairly specialised, for example, the treatment of drug addicts. Psychiatric hospitals mainly provide residential psychiatric mental health care for the population of a large catchment area. Two-thirds of psychiatric hospitals also provide psychiatric day care facilities. Outpatient services usually deal with the diagnostic stages before admission and some follow-up care for discharged patients.
Although a distinction is made in mental health care between psychiatric care and care for psychogeriatric patients or those with learning disabilities, many psychiatric hospitals also have separate wards and units for these kinds of patients. The in-service treatment aims at short-term admissions, but many patients remain for long periods.

General hospitals
These provide secondary health care. In the Netherlands, general hospitals are acute hospitals providing specialised medical, diagnostic and curative care. Beds are explicitly not intended for long-term patients. The emphasis is generally on somatic health care, although there are usually a few psychiatric patient beds. General hospitals cater to the whole population, however the elderly constitute a significant number of patients, accounting for over one-quarter of all admissions and over one-third of occupied beds. The admission rate for the total population in 1986 was 10.6%; for the elderly population, it was 22.9%.

Community mental health care
The regional institutes for community mental health care (RIAGG) perform a wide range of outpatient services, varying from psychiatric follow-up care and psychotherapy to paediatric group therapy or collective prevention programmes for high risk groups. Their most important service for the elderly is the ‘social (psycho-) geriatric service’, which has several functions, including preventative activities, diagnostic and curative roles and support for the psychogeriatric patient living at home, with his/her family or receiving domiciliary care services. The agency is the regional coordinator and access point for psychogeriatric day care and nursing home facilities.

The social care system
Homes for the elderly
These are residential facilities that provide living accommodation and services for those elderly who, for social, psychological or physical reasons, cannot remain independently at home. Homes for the elderly provide small apartments for single elderly and married couples. Housekeeping tasks such as cleaning and preparing meals are performed by the staff. Social activities and therapeutic facilities are also available. A small ward is often available for sick persons, which offers intensive nursing care on a temporary basis. However, homes for the elderly are not intended as treatment centres. In recent years, several additional functions have been made locally available to those elderly still living independently who can, if they wish, use the home’s social and therapeutic facilities. Often such homes are involved in organising voluntary activities, for example, preparing the meals for the ‘meals-on-wheels’ service. Sometimes sheltered housing has been built adjacent to the homes, thus integrating services and facilities.

Home or district nursing
This is provided by private, non-profit, district nursing organisations. Again, home nursing is intended for the whole population, but the majority of clients are elderly. These organisations work at regional, local and sub-local levels and a merger with home help organisations has taken place.
This concentrates a wide range of service provision into one organisation. The work of the district nurse includes a broad range of activities, including preventative tasks (for example, prenatal and postnatal care, screening and nutrition advice) as well as home nursing for discharged hospital patients and the bedridden. Although district nursing is not aimed at any specific age group, the elderly are an important part of their clientele.

**Home help service**

The function of this service is to assign ‘domestic help and personal support and care to any person … who is prevented by illness, convalescence, frailty, disability, bereavement, psychosocial disturbances or interpersonal problems from performing those tasks which are a normal part of the homemaker’s routine’. The programme can also include ‘counselling or educational components. … In principle home help is available to all independent households including families with or without children, people living alone, one-parent families, the elderly, and chronically ill or disabled people’ (WVC, 1986). A wide variety of activities and tasks are performed by the home help service, including housework, laundry, preparation of meals and shopping.

**Community service centres**

In many city centres and local communities, multipurpose service centres have been developed. Their main function is to accommodate several voluntary activities and professional services. Many elders still living independently use the centres as a meeting place. Most health centres in which GPs, district nurses and social workers collaborate as a team are in such community centres. The centres are usually owned and managed by a municipal organisation or agency. Financial resources come from municipal budgets. Access to the service centres is free, although small charges for certain activities can be made. Hardly any data are available about the functioning of the centres, but they are believed to be important as a meeting place for elders living independently and as a base from which much voluntary care is organised. It is estimated that 12% of elders use community service centres (Klaasen-van den Berg Jeths and Kraan Jetten, 1985).

Other services relevant to the elderly are listed below:

- **Social work** (not aimed exclusively at elders).
- **Social cultural work**. In many districts, small centres perform functions for the elderly similar to those of the community service centres, but on a smaller scale. These serve as meeting points and for organising voluntary activities.
- **Social consultant**. Provision of social consultants is a relatively new innovation. They can give information about services, tax and legal matters and are an important resource for many elders who cannot handle bureaucratic procedures and form-filling.
- **Municipal social support service**. This is intended to carry out social assistance tasks, however a number of other functions have been brought under its remit. For instance, it often employs the social consultants and workers in community service centres. It can also provide resources for certain kinds of help or expenses.
Minority elderly services

The Dutch system shows an explicit preference for general over specific services. For some minority elderly groups – the ‘first generation migrants’ – the development of specifically targeted services is felt to be desirable. Here we should mention the efforts of the Netherlands institute for care and welfare (NIZW) which is the most important institute in the field of innovating new approaches to care and welfare. Since the early 1990s, the NIZW has been carrying out an extensive programme aimed at improving service accessibility for minority ethnic elders. It has developed a number of new methods and approaches for the provision of care and welfare. Currently, strong emphasis is being put on developing concepts of multicultural services.

Another impetus to the development of targeted services is that, in the larger cities in particular, many providers of health and social care are now being confronted with the ageing of the minority elderly population. Their experience of ‘not being equipped’ to meet these groups’ needs has led to a growing awareness that social care provision needs to be adapted and has resulted in the development of many new forms and approaches to minority elderly care, often of an experimental nature. Frequently, such innovations focus on ‘linking’ minority ethnic elders and the respective service providers. Examples include new ways of providing information, such as through the introduction of elderly advisors whose role it is to guide and support minority elderly in the care system. There have also been some developments in culturally-specific care provision, such as a home care scheme for Chinese elderly in Rotterdam and residential care for Surinamese elderly in the Hague.

Some tentative conclusions

Demographic trends

Between 1997 and 2015, it is estimated that the total ethnic minority population of the Netherlands will double to around 2.5 million people (14.8% of the total population; de Klerk and Timmermans, 1998). This is also an ageing society. Between 2000 and 2030, the proportion of the population aged 55+ will rise from 23% to 35%. During this period, the potential labour force (those aged 15–64) will decrease as a proportion of the population from 58% to 47%.

The ageing of the population also applies to ethnic minorities. However, there are differences between the various groups in the rate and degree of their ageing. The proportion of elderly among the Indonesian population, who have mostly been resident in the Netherlands for a long time, is comparable to that of the population as a whole, as is this community’s rate of ageing. Among groups that come within the government’s integration policy, the increase in the numbers of older people is greatest among the Antilleans and the Surinamese. The number of older people in the Turkish and Moroccan communities is also expected to grow, but to a lesser extent in the short and medium term. It is estimated that, in total, there will be around 125,000 non-western elders in the Netherlands in 2005.
Socioeconomic position, integration and incorporation

Socioeconomic position and degrees of integration and assimilation differ between the various ethnic minority groups. In general, the Indonesians, with their relatively long residence in the Netherlands, are comparable in income, education, level of unemployment and housing with the mainstream population, although many of the first generation have maintained their cultural identities. On the other hand, among the Turks and Moroccans (the major communities of migrant workers), education levels are generally low, their occupations are low status and poorly paid, unemployment is high and their incomes are lower. As a consequence, their housing and living conditions are usually far below average. Regarding their position in the labour market, the Surinamese and Antilleans come midway between the Dutch population, on the one hand, and the Turkish and Moroccan population, on the other. It is worthy of note, however, that Surinamese and Antillean women in the 35+ age group occupy a position in the labour market that is generally higher than that of their Dutch contemporaries. The educational performance of schoolchildren and students from these ethnic minority groups shows similar patterns. The Surinamese and Antilleans occupy an intermediate position between the Turks and Moroccans, on the one hand, and the Dutch population, on the other.

Integration and incorporation into the society and cultural background of a ‘new’ country of residence is strongly facilitated by a command of its language. Not surprisingly, those who come from countries with colonial links to the Netherlands do not usually have problems with this aspect. Far more problematic is the situation of the Turks and Moroccans, especially the older age groups (the first generation migrants who generally came as guestworkers). In line with this, social interaction between them and the native population is generally lower compared to such interaction between the Surinamese/Antilleans and the native population.

Health and service take-up

In respect of the health situation among the various groups, there seems to be a discrepancy between objective health status and self-assessments of health among older Turks and Moroccans. Viewed objectively, their health indicators do not appear to be worse than those of the Dutch population, but their subjective evaluation of their health is far more negative. For the Surinamese and Antillean groups, however, both subjective and objective health assessments are more closely correlated with each other.

As for the take-up of services and care provision, this is extremely low among minority elders. Particular needs and wishes, related to culturally-specific preferences and traditions, play a major role in the take-up of care facilities. If no allowance is made for this, there is a risk that minority elders will not make use of such provision (Tesser et al., 1999).

5 The question arises as to whether this may be due to an ethnic-related bias in the conceptualisation and use of the measures and indicators commonly used. This is a topic that deserves the attention of the MEC project.
Vulnerable groups

The empirical data presented in this summary of the full Netherlands country profile, as well as mainstream official statistics, tend to focus on larger groups, specifically the target groups of the government’s integration policy. More differentiated data, for instance on gender, are not usually collected on a systematic basis. Mention must therefore be made here of specific groups that are in a highly vulnerable social position. This would include those living ‘illegally’ in the Netherlands such as asylum seekers without refugee status – those without residence permits are deemed non-existent by the political administrative system. Another ‘vulnerable group’ is comprised of single older women, especially of Turkish and Moroccan origin, who may be socially isolated, lack economic resources and are often not self-sufficient. Much the same can be said of those in less numerous minority communities, often from non-industrialised countries, who came in search of better economic prospects.

The policy response

Integration policy is increasingly focused on the proactive integration of members of minority ethnic groups. More stringent regulations and conditions are being imposed on minority ethnic persons to encourage them to adapt to the social, economic, cultural and political values and standards of the Netherlands – in other words, to a western lifestyle. As a consequence, there is an explicit preference for general provision and policy measures over specific ones designed to meet particular cultural needs. Nevertheless, with respect to first generation ethnic minority elders, it is recognised that specific provisions and measures are appropriate. However, central government (specifically the Ministry of Health, Welfare and Sports) plays only a limited role in developing appropriate health and social services for minority elders. Any ‘innovative practices’ tend to originate at the local level and are often initiated by local care organisations and minority associations.

Barriers hindering service use by elderly ethnic minorities

Ethnic minority elders have to face a dilemma over care provision in their old age. Their cultural backgrounds and traditional family lifestyle lead them to assume that their children will take care of them should they need help. This attitude hinders them from getting information on what professional help is available and how to get it. But often the reality is that their children, who have been born and grown up in the Netherlands and have adopted its lifestyle and values, may be unable or unwilling to take care of their parents in their old age. Another important factor in the failure to use services is a lack of familiarity with them, particularly those social services aimed at helping the elderly to live longer in their own homes, for example, meals-on-wheels, day care facilities and community centres. Apart from lack of familiarity, however, another barrier to service use is the need to comply with rules and procedures. This is also a barrier for those Dutch elders of low socioeconomic status, but causes even greater difficulties for minority elders because of the language problem. This is particularly true for the Turkish and Moroccan communities. To cope with this, elders may need to rely on others – their children, relatives or other members of their community.
Finally, it has to be recognised that service provision for elders often doesn’t correspond with the special demands and wishes of the elderly from minority groups. Cultural differences are not sufficiently taken into account. For example, Muslim elders cannot make use of meal facilities unless they can be sure that the preparation of such food has satisfied their religious requirements. Also, the type of food offered may satisfy mainstream tastes, but not necessarily theirs.

However, even when elders have surmounted the administrative requirements to make use of social and welfare service provision, the language barrier still hinders them from taking part in the social life of the wider community. Special attention needs to be paid to measures that will stimulate and encourage the social integration and participation of minority elders in institutional settings.
We are now all equal, or rather, there is an attempt at making us all equal precisely in matters where we should maintain our differences, and we differ in matters where we should be equal. We differ in terms of rights and economic conditions, as well as in terms of social respect. And it is in these matters that we should be equal. We differ in terms of cultural origins, and this difference should be maintained, however there is an attempt at making us all the same by adhering to a single cultural model. (Fundació Alfonso Comín, 1998: 178–9)

The concept of multiculturalism does not yet exist in Spain. Foreigners other than technical experts, the highly skilled, professionals or well-off retired people looking for warmer climes belong to a group that is not necessarily unified by nationality, culture or religion. What links them is that they personify what has become known as ‘the problem of immigration’, sometimes spoken of as an ‘avalanche’ or ‘invasion’, which merely serves to distance the human problems involved. Such is the situation that immigration has this year become the third most important issue of concern to Spaniards after unemployment and terrorism, according to the results of an enquiry carried out by the Spanish Centre for Sociological Research (CIS, 2002).

A large proportion of Spaniards associates the problem of racism with countries beyond Spanish borders, in spite of the fact that about 15% of Spaniards admit that they would not like to have Moroccans, black Africans or Latin Americans as neighbours (CIS, 1996). Unlike the concept of racism that existed in the past, which was based on specious biological arguments, modern racism, masquerading behind cultural differences, is based on the so-called incompatibility of the ‘host’ society with its foreign population (Espelt and Javaloy, 1997). However, differences characterising foreigners with high purchasing power are not questioned although they may come from other cultural or religious backgrounds. Rejection and discrimination seem to be a reaction to poverty rather than to being different.
### TABLE 1  
**Age structure of the Spanish population (2000–30)**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2000</th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–14</td>
<td>5,882,438</td>
<td>14.7%</td>
<td>6,362,062</td>
<td>15.0%</td>
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<tr>
<td>15–24</td>
<td>5,667,133</td>
<td>14.2%</td>
<td>4,221,422</td>
<td>10.0%</td>
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<td>25–34</td>
<td>6,786,046</td>
<td>16.9%</td>
<td>6,041,120</td>
<td>14.3%</td>
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<tr>
<td>35–44</td>
<td>6,061,121</td>
<td>15.1%</td>
<td>7,150,666</td>
<td>16.9%</td>
</tr>
<tr>
<td>45–54</td>
<td>4,916,760</td>
<td>12.2%</td>
<td>6,165,898</td>
<td>14.5%</td>
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<td>55–64</td>
<td>4,015,540</td>
<td>10.0%</td>
<td>4,841,110</td>
<td>11.5%</td>
</tr>
<tr>
<td>65–74</td>
<td>3,863,266</td>
<td>9.6%</td>
<td>3,709,103</td>
<td>8.7%</td>
</tr>
<tr>
<td>75–84</td>
<td>2,266,893</td>
<td>5.6%</td>
<td>2,890,894</td>
<td>6.8%</td>
</tr>
<tr>
<td>85+</td>
<td>662,476</td>
<td>1.7%</td>
<td>977,039</td>
<td>2.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>40,121,673</td>
<td></td>
<td>42,359,314</td>
<td></td>
</tr>
</tbody>
</table>

Source: INE, 2000
Historical perspective

Among most developed societies, it is generally held that the ageing of the population and immigration are currently the two major sociological issues demanding most attention. Both are the focus of this study. The decrease in the birth rate, the inclusion of women in the workforce, advances in medical science, healthier lifestyles and public health measures have all helped to increase life expectancy significantly. Whereas, in the poorest parts of the world, life expectancy is barely 50 years, those born in a country such as Spain can expect to live into their eighties. The second issue affecting developed countries is that of migration. Over the last decade, migration to Spain has progressively increased. Due to improved economic standards, Spain, a country of emigration during the first half of the 20th century, has become a country of immigration. However, the number of immigrants in Spain is still comparatively lower than in other countries, possibly because immigration is a more recent phenomenon.

Although some have argued that it is essential for Europe to close its doors to immigration, it must not be forgotten that Spain, Italy, Germany and Denmark will be the first EU countries to record a significant population decrease in the near future. The population of Spain will begin to decrease in 2014 as a result of the low birth rate (1.15 children per woman). Spaniards will live longer, but will certainly be fewer in number (by 2025, 22% of the population of Europe will be 85+). In the light of this, it seems obvious that Europe will have to open its doors to immigrants, as it will need the labour force and the social security and pension contributions in order to keep the economy in balance. In fact, in the first quarter of 2002 in Andalusia, one in three people registered with social security were foreigners. Moreover, the immigrants of today are the parents of the Spaniards of tomorrow, for Spain is no longer a country of transit, but a destination for immigrants. This is reflected in the increase of 42.9% in the immigrant population over the last five years.

While levels of the foreign population (around 165,289 people in 1975) showed only a gradual increase throughout the 1980s and early 1990s, the rate of increase had begun to accelerate by 1996. Thus, by 1997, there were 609,813 foreigners resident in Spain; by 2000, this had risen to 895,720; and, by 2001, to 943,225.

In April 2002, there were 1,243,919 foreigners resident in Spain. If to this sum we add the estimated number of illegal immigrants – obviously difficult to ascertain, but which, according to a number of sources, is estimated at between 200,000 and 300,000 – the immigrant population represents around 3.5% of the total population in Spain. Of the immigrant population, around 469,000 are from EU countries and around 784,000 are from non-EU countries. Some political sources estimate that there may be at least 2,250,000 immigrants living in Spain by the year 2025.

The gypsy population must not be overlooked when considering discrimination in Spain. Although they have been part of Spanish life, culture and tradition for over five centuries, gypsies have a lower life expectancy than the rest of the Spanish population, due partly to their living conditions which have a detrimental effect on their health. Gypsies aged 55+ are few in number and have been little researched.
### TABLE 2  Age structure of the foreign population (2000)

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–15</td>
<td>102,269</td>
<td>11.4</td>
</tr>
<tr>
<td>16–24</td>
<td>111,005</td>
<td>12.4</td>
</tr>
<tr>
<td>25–44</td>
<td>161,111</td>
<td>50.7</td>
</tr>
<tr>
<td>45–64</td>
<td>453,983</td>
<td>18.0</td>
</tr>
<tr>
<td>65+</td>
<td>67,302</td>
<td>7.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>895,720</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: INE, 2000

### TABLE 3  Foreign minority residents (2001)

<table>
<thead>
<tr>
<th>Minority groups</th>
<th>Number</th>
<th>% of total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Europe</td>
<td>378,887</td>
<td>40.2</td>
</tr>
<tr>
<td>Total Africa</td>
<td>278,162</td>
<td>29.5</td>
</tr>
<tr>
<td>Morocco</td>
<td>214,223</td>
<td>22.7</td>
</tr>
<tr>
<td>Total South America</td>
<td>135,085</td>
<td>14.3</td>
</tr>
<tr>
<td>Argentina</td>
<td>10,127</td>
<td>1.1</td>
</tr>
<tr>
<td>Venezuela</td>
<td>8323</td>
<td>0.9</td>
</tr>
<tr>
<td>Total Asia</td>
<td>78,062</td>
<td>8.2</td>
</tr>
<tr>
<td>Philippines</td>
<td>13,447</td>
<td>1.4</td>
</tr>
<tr>
<td>Total North and Central America</td>
<td>71,225</td>
<td>7.6</td>
</tr>
<tr>
<td>Cuba</td>
<td>19,673</td>
<td>2.1</td>
</tr>
<tr>
<td>Mexico</td>
<td>4739</td>
<td>0.5</td>
</tr>
<tr>
<td>Oceania</td>
<td>904</td>
<td>0.1</td>
</tr>
<tr>
<td>Stateless</td>
<td>900</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>943,225</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: INE, 2001
Although gypsies have Spanish nationality and theoretically enjoy the same rights as any Spaniard, they are underprivileged and barred from many aspects of mainstream society. They are victims of prejudice, resulting in their marginalisation and social exclusion. This is reflected in their social and economic conditions, described in greater detail later in the chapter, and which include characteristics such as being younger, having bigger families, suffering greater unemployment and underemployment and lacking skills. Discrimination is particularly severe in relation to housing; neighbours often coerce gypsies to abandon their homes in particular areas (Comisión Europea contra el Racismo y la Intolerancia, 1999).

Demographic trends

Ethnic immigrant minorities resident in Spain

Currently, the greatest number of foreign nationals living in Spain (that is, legal immigrants) are those who come from Europe (40% of all foreign residents). Although there has been some increase in the numbers of immigrants from Eastern Europe (Rumania, Bulgaria and Russia), the majority are from the EU, and this group is not the focus of this study. Having chosen to live in Spain for its favourable climate or for other reasons, this group does not experience the same health problems and the social and economic discrimination that affect the most underprivileged ethnic minorities living in Spain. The second largest group of foreign nationals comes from Africa (29.5%); mainly Morocco (22.7%), followed by Algeria and other countries of sub-Saharan Africa (Gambia, Senegal and Nigeria). In third place are those from the Americas (21.9%); mostly from South America (14.3%). This group has increased in the last few years, with a clear growth in the numbers of people from Ecuador, Peru, Colombia, the Dominican Republic and, most recently, Argentina. Lastly are nationals from Asia (8.2%), who come mainly from China and the Philippines.

The age of foreign nationals living in Spain is noticeably young, the majority being between 25 and 44 years of age (see Table 2). However, those 65+ represent 7.5% of the total immigrant population (INE, 2000).

Moroccan immigrants are the most significant foreign minority group in Spain and account for 1.5% of the total population. They live mostly in Catalonia (37.9%), in Madrid (16.4%) and in Andalusia (14.8%), tending to live on the outskirts of urban areas. They represent 22.4% of foreign workers registered with social security on 31 December 2000, with 22.7% living as residents, according to the latest figures from Spain’s National Institute of Statistics (INE).

The Moroccan population is young – much younger than other ethnic groups (69% of Moroccans are aged 16–44; see Table 4 overleaf) – and has low levels of education. At the other extreme, numbers of those aged 55+ are low, accounting for less than 5% of the Moroccan total. The number of Moroccan women in Spain is lower than the number of men, although in recent years there has been an increase in female immigration. However, the percentage of women 55+ is greater than that for men, probably because of women’s higher life expectancy.
### TABLE 4  Age structure of Moroccan population (2000)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–15</td>
<td>40,246</td>
<td>20</td>
</tr>
<tr>
<td>16–24</td>
<td>34,459</td>
<td>17</td>
</tr>
<tr>
<td>25–44</td>
<td>104,718</td>
<td>52</td>
</tr>
<tr>
<td>45–64</td>
<td>18,451</td>
<td>9</td>
</tr>
<tr>
<td>65+</td>
<td>1908</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>199,782</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: INE, 2000

### TABLE 5  Age structure of Latin American population (2000)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Latin America</th>
<th>%</th>
<th>Ecuador</th>
<th>%</th>
<th>Colombia</th>
<th>%</th>
<th>Peru</th>
<th>%</th>
<th>Others</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–15</td>
<td>11,329</td>
<td>9</td>
<td>2097</td>
<td>7</td>
<td>2716</td>
<td>10</td>
<td>2462</td>
<td>9</td>
<td>4054</td>
<td>9</td>
</tr>
<tr>
<td>16–24</td>
<td>17,833</td>
<td>14</td>
<td>5442</td>
<td>18</td>
<td>3374</td>
<td>14</td>
<td>3777</td>
<td>14</td>
<td>5240</td>
<td>11</td>
</tr>
<tr>
<td>25–44</td>
<td>77,609</td>
<td>59</td>
<td>20,688</td>
<td>67</td>
<td>15,038</td>
<td>61</td>
<td>16,376</td>
<td>59</td>
<td>25,507</td>
<td>54</td>
</tr>
<tr>
<td>45–64</td>
<td>18,966</td>
<td>15</td>
<td>2552</td>
<td>8</td>
<td>3110</td>
<td>13</td>
<td>4217</td>
<td>15</td>
<td>9087</td>
<td>17</td>
</tr>
<tr>
<td>65+</td>
<td>4793</td>
<td>4</td>
<td>99</td>
<td>0.3</td>
<td>464</td>
<td>2</td>
<td>1056</td>
<td>4</td>
<td>3174</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>130,530</td>
<td>100</td>
<td>30,878</td>
<td>100</td>
<td>24,702</td>
<td>100</td>
<td>27,888</td>
<td>100</td>
<td>47,062</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: INE, 2000
Immigration from Morocco is primarily for economic reasons. Moroccans usually carry out work of low social status, requiring few qualifications: farmhand, builder’s assistant, industrial worker, and so on. They have little job security and are mostly single men who live in cheap, shared accommodation. They usually cannot afford to own a car and thus have to travel on foot, by bus or other forms of public transport.

Latin American immigrants make up the second most numerous group, with 135,085 legal residents in March 2001. If, however, the figures are examined for each country individually, none reaches even one-third of the Moroccan level. Before 1996, the largest group was Argentinian, but there has been a significant change in recent years. Most now come from Ecuador, Peru and Colombia.

The Ecuadorian population in Spain has increased significantly in recent years. In 1997, there were just over 4000 Ecuadorian residents in Spain, but by 2000 there were almost 40,000. Ecuadorians currently account for 3.4% of the total immigrant population; 44.3% of them are men and 55.7% women. This gender balance is in contrast to the Moroccan population, as noted above. The age of Ecuadorian immigrants is noticeably young. Most are aged between 25 and 44; those 65+ account for only 0.3% of this group. Ecuadorians account for 0.07% of Spain’s total population. Most live in Madrid (88.7%), mainly in the city and, to a lesser extent, in the greater metropolitan area. They live mainly in the older parts of the city and tend to gather in the more popular districts where there are more flats available.

Peruvians are the second largest Latin American group. In 2000, there were 27,800 Peruvians living in Spain (3.1% of the immigrant population). Of these, 38% were men and 62% were women; again, a great gender imbalance. Their numbers have not increased very much in recent years and they represent 0.07% of the national population. The age of this population is similar to that of Ecuadorians and Colombians (see Table 5), although the 65+ age group is larger.

The Colombian population has increased by 16,290 in recent years. This increase is primarily reflected in the regional community of Madrid, where Colombians are the third largest ethnic minority group after Ecuadorians and Moroccans. Figures for 1999 show the age structure of this community as typically young, consisting mainly of people aged between 25 and 44. Although those 65+ were the smallest age group, they represent a higher proportion of the Colombian population than do their Ecuadorian peers of the Ecuadorian population. Colombians account for 0.06% of the national population. In 2002, they accounted for 2.8% of all immigrants; 30% of them were male and 70% were female, an even greater gender imbalance than among the Ecuadorian and Peruvian populations.
<table>
<thead>
<tr>
<th>Resident foreigners by autonomous community (AC) (2000)</th>
<th>Europe</th>
<th>North and Central America</th>
<th>South America</th>
<th>Asia</th>
<th>Africa</th>
<th>Oceania</th>
<th>Stateless</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catalonia</td>
<td>55,482</td>
<td>15,220</td>
<td>30,473</td>
<td>22,908</td>
<td>90,633</td>
<td>196</td>
<td>84</td>
<td>214,996</td>
</tr>
<tr>
<td>Madrid</td>
<td>49,366</td>
<td>21,422</td>
<td>41,634</td>
<td>16,817</td>
<td>33,183</td>
<td>192</td>
<td>371</td>
<td>162,985</td>
</tr>
<tr>
<td>Andalusia</td>
<td>61,944</td>
<td>5738</td>
<td>10,127</td>
<td>7622</td>
<td>46,686</td>
<td>177</td>
<td>134</td>
<td>132,428</td>
</tr>
<tr>
<td>East Spain: Community Valenciana and Murcia</td>
<td>57,020</td>
<td>4017</td>
<td>12,085</td>
<td>6076</td>
<td>30,324</td>
<td>76</td>
<td>219</td>
<td>109,817</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>45,183</td>
<td>5766</td>
<td>8133</td>
<td>7733</td>
<td>10,578</td>
<td>35</td>
<td>166</td>
<td>77,594</td>
</tr>
<tr>
<td>North Spain: Asturias, Cantabria, Galicia Navarra, Basque Country</td>
<td>30,805</td>
<td>8816</td>
<td>14,794</td>
<td>3098</td>
<td>11,184</td>
<td>130</td>
<td>45</td>
<td>68,872</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>34,110</td>
<td>1744</td>
<td>3086</td>
<td>1489</td>
<td>5266</td>
<td>64</td>
<td>13</td>
<td>45,772</td>
</tr>
<tr>
<td>North Central Spain: Aragon, Castilla Leon and La Rioja</td>
<td>17,770</td>
<td>4631</td>
<td>6602</td>
<td>3299</td>
<td>15,460</td>
<td>19</td>
<td>62</td>
<td>47,843</td>
</tr>
<tr>
<td>South Central Spain: Castilla la Mancha and Extremadura</td>
<td>6478</td>
<td>1886</td>
<td>3431</td>
<td>1430</td>
<td>13,073</td>
<td>11</td>
<td>34</td>
<td>26,343</td>
</tr>
<tr>
<td>Ceuta and Melilla</td>
<td>360</td>
<td>59</td>
<td>39</td>
<td>491</td>
<td>4604</td>
<td>0</td>
<td>21</td>
<td>5574</td>
</tr>
<tr>
<td>Total</td>
<td>361,437</td>
<td>69,434</td>
<td>130,530</td>
<td>71,015</td>
<td>261,250</td>
<td>902</td>
<td>1152</td>
<td>895,720</td>
</tr>
<tr>
<td>Errors in AC</td>
<td>2919</td>
<td>135</td>
<td>126</td>
<td>52</td>
<td>259</td>
<td>2</td>
<td>3</td>
<td>3496</td>
</tr>
</tbody>
</table>

**Note:** For the purposes of summarisation, ACs located in the same geographical area have been grouped together despite disparities in the spread of immigration among them. Figures corresponding to Ceuta and Melilla, Spain’s enclaves in North Africa, are represented as one, given their proximity, resulting in shared social characteristics of mixed race minorities and the fact that both are destinations for citizens from the same neighbouring regions.

**Source:** INE, 2000 and authors’ extrapolation
Settlement patterns

The autonomous communities (ACs) of Spain which attract the highest number of immigrants are Catalonia, Madrid and Andalusia. Immigrants opt for these areas because it is easier to find work; Madrid and Barcelona are the largest cities in Spain and Andalusia offers agricultural work. Madrid has a preponderance of Latin Americans, Barcelona of Africans and, in Andalusia, Malaga has the largest number of immigrants from the EU, while Almeria attracts immigrants from African countries (mainly Morocco). See Table 6.

The gypsy population in Spain is roughly double that of non-EU immigrants. Over 40% of gypsies live in Andalusia, followed by Madrid and Catalonia. The age structure of the gypsy population is similar to that of non-EU immigrants; there are high numbers of children and young people (63% of gypsies are under 25) and a low number of elderly (slightly over 2%). Numbers of young people are proportionally much higher than for the rest of the Spanish population and numbers of the elderly much lower. The age structure of the gypsy population has significant demographic and developmental consequences, since this community will grow at a faster rate than the rest of the population. The gypsy birth rate is over twice that of the rest of the population. Over 50% of the gypsy population is made up of men, in contrast to the rest of the population in which women are slightly more numerous than men.

The socioeconomic situation of ethnic minorities

Work

Those immigrant minorities without financial resources who wish to live in Spain have four options open to them: 1) to apply for a work permit; 2) to apply for a study permit; 3) to request family reunification; and 4) to request a tourist visa. Of foreign workers in Spain, 61% come from countries that belong to the developing world. Those who contribute the largest number of immigrant workers, with the exception of other European countries, are Morocco, Ecuador, China, Peru, the Dominican Republic, Colombia, Cuba, Argentina and the Philippines (Ministerio de Trabajo y Asuntos Sociales, 2000). Over half of these workers are male (65.3%) and 34.7% are female. They work mostly in service industries (46.53%). Far fewer are attracted to agriculture (10.5%), construction (8.65%) and industry (6.75%). However, agriculture and construction are the sectors that immigrants first approach when they still have no legal status in the country and thus do not register in official statistics. It can be legitimately assumed that agriculture and construction are the sectors with the highest concentration of illegal immigrants. The greatest concentration of foreign workers, having labour registration papers and contributing to social security, is to be found in Madrid, Catalonia and Andalusia. One of the factors that determines their position in the labour force is their level of education.

Of the immigrant population, almost all are of working age, since it is usually the active younger members of the family who emigrate. Employment is the key to integration, essential for obtaining decent accommodation
and for ensuring a better education for their children. Moreover, having a job guarantees the immigrant’s chances of staying in the country. However, rates of covert or illegal employment, inactivity and unemployment are much higher among members of these minorities.

Foreign workers aged 55+ represent 4.4% of all foreign workers. There is a higher percentage of working males aged 55+ than female, although the difference is minimal. Most in this age group who are still working are categorised as self-employed; a large proportion of them do domestic work or work as home helps.

Most of the Spanish population aged 65+ has ceased to participate in the labour market, except for a small minority (1.6%, approximately 118,500 people) who remain actively working. Most are men under 70 and, like immigrants and gypsies, almost two out of three are self-employed, usually setting up one-man, independent businesses, largely in the private sector or occasionally employing others (INE, 2001).

Gypsies, with their high birth rate and lower life expectancy, are a young population of whom 50% are of working age. Few gypsies have professional qualifications. That section of the population that would be the main beneficiary of active training and employment policies (those aged 16–25) can be estimated at approximately 100,000 people (20–25% of the gypsy population). The rates of underemployment or hidden employment are much higher in the gypsy community than in the rest of the Spanish population. Most gypsies are self-employed, involved in informal, unregulated family concerns (hawking, urban rubbish collecting, seasonal work), a situation that is currently undergoing radical transformation and regularisation. The percentage of gypsies in what, in their terms, is not considered to be ‘traditional’ employment, such as construction, public works or the civil service, is approximately 10–15%.

Clearly such a situation leaves much to be desired when set against the policies for professional training and employment developed by various administrative bodies. It is true that such policies have not been adapted to the specific needs of the gypsy community and that their excessive rigidity allows little margin for the tailoring of such policies to individual characteristics. Hence, it is legitimate to claim that gypsies have not had the same degree of access to the diversity of training schemes as other citizens. At the same time, training projects that have specifically targeted the gypsy community have, in general, had little success in achieving improved employment rates.

This can partly be explained because, according to the cultural parameters of many gypsies, having a ‘profession’ is understood as ‘earning one’s living’ in a variety of occupations. These are all carried out by the different members of the family and are often of a seasonal nature – very different from the concept held by many of what employment entails. In addition, there is a traditional resistance to working for someone else, as well as other cultural habits that are difficult to transform over a period of a few years (Fresno, 1999).

As Table 7 overleaf shows, among those who live below the poverty threshold, the proportion of households headed by inactive people (for example, retired people, widows, the disabled) is higher among the Spanish population
than among the Spanish gypsy or the immigrant populations. In contrast, among the heads of families who are in a position to work (potentially active people), the sector of the population in Spain with the highest rate of unemployment is the gypsies, and the joint rate of unemployment and underemployment is alarmingly high in both the gypsy and the immigrant populations. On the other hand, according to the same source, while in 4.7% of poor Spanish households, at least one member does not have social security, figures rise sharply to 11.2% in gypsy households and 26.6% in those of immigrants.

Housing conditions

The nature and quality of housing are undoubtedly two of the defining features of the social situation of the immigrant population. Along with difficulties in employment and health, the struggle for basic housing represents one of the major problems facing this group. The nature and quality of housing can ease or hinder integration into wider society. The main problem is the lack of basic rented accommodation available to immigrants, who may be discriminated against as tenants. People often have to live in shanty dwellings in decaying and marginal urban areas in the larger cities; they may be evicted even from building sites, stores or dwellings which do not have the most basic elements of safety or hygiene. At present, there are large numbers of people who are homeless or forced to live in poor or overcrowded accommodation. Most of them are gypsies or immigrants. By contrast, owner-occupancy is the most common form of tenancy among the mainstream population, with approximately four in five Spaniards owning their own homes. Only 4% of Spanish homes lack basic facilities (Pérez, 2002).

Of gypsy homes, however, 10% are shanty dwellings, caves or similar and 17.2% are either in a state of extreme deterioration or are unfit for habitation, which would indicate that a high percentage of the gypsy population is in poverty. It is not only gypsies who suffer housing problems, since over 38% of immigrants also live in inadequate accommodation, according to the OPI (Permanent Immigration Observatory, 2000). However, the desire of immigrants to return home is closely linked to their accommodation situation, since they tend to spend as little as possible on rent so as to invest any savings in buying houses or businesses in their countries of origin. In order to save as much as possible, immigrants tend to live in small flats with others of the same nationality, leading to overcrowding. This changes when, at a later stage in the migration process, family reunification begins to take place. It then becomes necessary to find larger accommodation for all the family members. However, this does not always lead to an improvement in living conditions since, in some instances, immigrants may leave a shared flat and resort to a shanty dwelling.

For immigrant ethnic minorities, therefore, housing is a problem to which no solution has yet been found and which condemns them to be concentrated in decaying urban areas, either in city centres or in the suburbs. They are then socially rejected by the other inhabitants of the neighbourhood and their presence may lead, because of the racism with which their presence is viewed, to a decrease in local property values.
### TABLE 7  Heads of households unemployed and underemployed living below the poverty threshold (1996) (%)

<table>
<thead>
<tr>
<th></th>
<th>Spanish general</th>
<th>Spanish gypsy</th>
<th>Immigrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inactive</td>
<td>44.0</td>
<td>24.1</td>
<td>18.1</td>
</tr>
<tr>
<td>Unemployed</td>
<td>39.5</td>
<td>46.8</td>
<td>29.7</td>
</tr>
<tr>
<td>Underemployed</td>
<td>12.5</td>
<td>35.2</td>
<td>37.8</td>
</tr>
<tr>
<td>Total unemployed and underemployed</td>
<td>52.0</td>
<td>82.0</td>
<td>67.5</td>
</tr>
</tbody>
</table>

*Note: People living below the poverty threshold are those whose incomes fall below 50% of the average net disposable income. 22.1% of Spanish people were living below the poverty threshold, which represents 19.4% (8,509,000) of Spanish households (EDIS et al., 1998: 159).*  
*Source: Gómez, 1998: 355*

### TABLE 8  Illiteracy rates among the poorest aged 16+ (1996) (%)

<table>
<thead>
<tr>
<th></th>
<th>Spanish general</th>
<th>Spanish gypsy</th>
<th>Immigrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete illiteracy</td>
<td>8.9</td>
<td>25.7</td>
<td>14.4</td>
</tr>
<tr>
<td>Functional illiteracy</td>
<td>45.3</td>
<td>63.5</td>
<td>43.6</td>
</tr>
<tr>
<td>Total</td>
<td>54.2</td>
<td>89.2</td>
<td>58.0</td>
</tr>
</tbody>
</table>

*Source: Gómez, 1998: 354*
Education levels

Illiteracy, both absolute and functional, is much higher among immigrant ethnic minorities than among the rest of the population. According to the report on the social integration of immigrants who participated in social promotion programmes in Spain in 1999 (a total of 4245 registered cases), 26% of immigrants have obtained secondary school qualifications. This group is closely followed by those who have completed elementary school education or, for those from Islamic countries, the Muslim equivalent (25.8%); those with no formal qualifications (13.8%); those with primary school education (10.1%); university graduates (9.2%) and diploma holders (5.6%; IMSERSO, 1999).

These figures are comparable to the figures obtained in another research project carried out in Andalusia on a sample of 1819 immigrants (OPAM, 2001). Results showed that, with respect to age, 2.1% of women aged 55–64 have no qualifications, 1.1% have studied up to primary school level, while 1% have elementary schooling. However, 1.4% of males aged 55–64 are university graduates, almost the same proportion as those who have no qualifications (1.3%).

When we look at the poorest sectors of the population in Spain, gypsies have the highest illiteracy rate; a staggering 89% of those living below the poverty threshold, as previously defined, being either functionally or completely illiterate. That is to say, nine out of 10 gypsies living below the poverty threshold are either completely or functionally illiterate. This makes it even harder to combat poverty levels and their repercussions in terms of social exclusion.

Among gypsies over 18 years of age, especially women, there is a very high level of total and functional illiteracy, above 50% among residents in almost all communities. Few gypsies of the older generation have attended school regularly. However, full attendance in schools is currently being achieved for gypsy boys and girls, although there is still a high rate of absenteeism, dropout and failure.

Knowledge of the language

Knowledge of the language is essential for an immigrant to manage in a new society, although this condition is not always fulfilled. Those who find Spanish most difficult are Africans and Asians. Among the 5320 registered immigrants in Spain from Africa processed by the OPI in 1999, 33.6% have an understanding of Spanish, but speak it with difficulty; 6.8% neither understand nor speak Spanish; while 26.8% claim to understand and speak it correctly and 19.8% of this figure write it as well. A sample study carried out in Andalusia shows that, of the immigrants tested, 40.24% find it difficult to speak Spanish; 26.4% can understand it, speak it and write it; 20% can speak it correctly; but 13.5% neither speak nor understand it. Mastery of the language is better among the young. However, men aged 65+ neither speak nor understand the language. The great majority of women can understand, speak and write the language; the exceptions are those under 18 and those 65+. Gypsies have no problem with the language as they have been Spanish for centuries.
Health and social needs

The health problems of immigrant minorities are usually the result of their poorer and more precarious living conditions. Poor nutrition, lack of rest, bad housing and the type of work they do all mean that illnesses such as tuberculosis, hepatitis, infestation with lice and parasites, and so on are prevalent among certain groups of immigrants. Moreover, recovery from these conditions takes longer or may be incomplete. Health information is often haphazard, lacking or insufficient and immigrants tend only to go to the doctor in cases of extreme urgency, often attempting to get assistance first from social services. Health problems can often stem from the unsanitary conditions in which people may have to live and, on occasion, from the cultural influence of certain practices that are not conducive to disease prevention, but which derive from their traditions, economic conditions or religious beliefs (Solas and Ugalde, 1997).

In general, people living clandestinely in Spain and working in the black economy do not have recourse to social and health services other than those provided by the emergency services (almost 30% make use of this form of health provision). The main problems are not to do with sudden accidents or injuries, but with the ongoing lack of adequate access to health care. Another problem arising from reliance on the emergency services is that, although they resolve specific problems, there is no follow-up care.

Furthermore, when the patient’s residency is irregular (illegal), immigrants do not attend public health centres for fear of their presence being made known to the police. This can be observed in Ugalde’s 1997 study comparing Spanish and Moroccan workers in the construction industry. Of Moroccans in the study, 33% did not access health services as they did not have appropriate legal papers or were not covered by social security in contrast with only 6% of Spaniards. The second reason for not seeking health care was the fear of losing one’s job, a reason given by 27% of Moroccans. However, no Spaniard in the sample considered this to be an issue. In addition, lack of money limited access for 7% of Moroccans, and 10% claimed that they had had negative experiences on previous visits to health centres, whereas none of the Spaniards cited these reasons.

Given this situation, religious and non-governmental organisations (NGOs) have, in the past, taken on the provision of such services and still do so in certain circumstances. As a result of all these factors, it is difficult to ascertain with accuracy the current state of health of the immigrant population, although there are some indications that can throw light on the situation. For example, headaches, chest pains, nausea, general discomfort, stomach pains and injuries were among the most frequently cited symptoms suffered by a group of Moroccan construction workers (Ugalde, 1997: 63–4).

The gypsy population also suffers from specific health problems. Gypsies are on average smaller in stature than the Spanish population, indicating lower levels of nutrition. A high percentage of children grow up without adequate vaccinations and are exposed to illnesses that have been almost eradicated elsewhere. In some cases, deficient nourishment and malnutrition as well as a higher level of involuntary accidents and injuries, such as burns, falls, fractures, wounds and food poisoning, can be observed.
Gómez (1998) highlights a number of factors that negatively affect the health of the poorest groups of gypsies and immigrants, such as eating habits and the consumption of alcohol and drugs. Of gypsy and immigrant households living below the poverty threshold, 21.6% and 15.1% respectively have a deficient diet, while this ratio decreases to 4.2% of Spanish households having a similar economic deficit. In terms of the consumption of alcohol, variations between the three groups are reduced, with gypsy households having the highest ratio yet again; 5.1% of households registered have at least one member affected by problems related to alcoholism as opposed to 4.5% of immigrant households and 4% of Spanish households. In terms of drug consumption, again gypsy households are worst affected (10.4%), then immigrant households (3.8%), closely followed by the poorest Spanish households (4%).

Service delivery

The legislative framework

The Spanish state is structured on three levels: national, regional and local. The concept of ‘regional communities’, which was first set out in the Constitution of 1978, is a response to Spain’s complex multinational reality. The Constitution reflects the desire for self-government among the 17 ACs within the Spanish state. In accordance with this, responsibility for social services and health has been transferred to the ACs. The national government retains exclusive responsibility over nationality, immigration, emigration, legislation concerning foreign nationals and rights of asylum.

Social services come under the purview of the Ministry of Social Affairs. While the national government establishes the basic regulatory framework, each AC is then responsible for developing rules and procedures compatible with this. There is, therefore, no general social services legislation common to the whole country; each AC has its own legislation.

The Foreign Nationals Act, 8/2000 (Article 14) states that foreign residents have the right of access to social services under the same conditions as Spaniards. It is recognised that both have access equally to general and specialised social services. Nevertheless, it is also accepted that foreigners, whatever their administrative status, have the right of access to general social services, from which it may be deduced that illegal immigrants do not have the right of access to specialised social services. However, in practice, whatever their administrative status, immigrants are allowed access to specialised social services when essential on a discretionary basis. That this should be so is reason enough to give impetus to changing the relevant legislation, so that the specialised social services accorded to immigrants are not given simply at the discretion of temporary professionals, managers or politicians, but as a recognised right.

Similarly, health care in Spain falls under the purview of the social security system so that, as with the social services, the state establishes the basic legislative framework, while each AC develops its own regulations in accordance with that.
Article 12 of the Foreign Nationals Act establishes the principle that health care be available to all, but defines those who are eligible as ‘all those Spanish nationals and foreign residents within the national territory’. Foreign residents are deemed to be only those who have a residence permit; those without permits are left without cover. Therefore, those immigrants who have not regularised their status according to the law do not have the right to health protection or health care.

According to international, national and regional legislation, an illegal or non-regularised immigrant only has the right to essential emergency treatment. An immigrant whose status is irregular cannot claim the right to health care on the grounds of contributions paid since, by definition, the payment of contributions means that the claimant is already registered with social security.

As with social services, what happens in reality is that all immigrants, regardless of their administrative status, are able to access health care. In fact, some of the ACs have reached agreements with NGOs and immigrant associations to ensure that the entire population, without distinction, has access to health protection and health care. This situation could force a change in the current legislation which, although it is not strictly applied, does not recognise the right to health care for all.

Finally, it is worth noting that although the legislative framework in relation to health, social services, the elderly and immigrants is fairly comprehensive, there is no legislation at any level of government that takes into account the elderly of minority communities.

Current status of the health system

Health centres in Spain can be divided into two main groups:

- **Primary health care centres** provide the first level of health care. They deal with preventative care, the curing of disease, rehabilitation and health awareness. There are different types of primary health care centres, depending on the level of service they provide and the size of the municipality in which they operate.

- **Specialised health care centres** provide technical and human resources for diagnosis, treatment and rehabilitation which, because of their specialised nature or characteristics, cannot be provided by primary care. These centres can be either outpatient clinics or hospitals and are divided into four broad areas according to their purpose: general; short-stay specialist (medical-surgical and surgical, children’s, maternity and maternity-infant); long-term specialist (geriatric and chronic); and psychiatric. Specialised geriatric services represent 13.4% of the total number of hospitals in Spain and account for 6.7% of the beds available in all hospitals.

While this report was being produced, there was a change in the organisation of competencies concerning the health system in Spain. While this in no way affects the information offered, it is important to mention it as it may have an effect in the future on the subject of this study. The functions and services of the National Institute of Health (INSALUD) are to be transferred to those ACs which have not formerly enjoyed these responsibilities: Aragón, Asturias, the Balearic Islands, Cantabria, Castilla-La Mancha, Castilla-León, Extremadura, La Rioja, Murcia and Madrid.
These hospital centres are divided into public and non-public. There are 20% more non-public hospitals than public and, among the non-public hospitals, the largest number belongs to the private, non-charitable sector. However, in terms of beds available, the situation is reversed and there are twice as many beds in the public sector. Not-for-profit hospitals are the only ones that provide services free of charge.

If we look at the three ACs of Andalusia, Madrid and Catalonia, Catalonia has the largest number of hospitals (2.9 per 100,000 inhabitants), above the national average (2.0); Madrid falls below the average (1.5) and Andalusia is even further below (1.2). As far as available beds are concerned, both Catalonia (4.9 per 1000 inhabitants) and Madrid (4.0) are above the national average (3.9), whereas Andalusia (3.0) is again below it.

Ethnic minorities and the health system

The immigrant population

The health information available to immigrants is often poor or insufficient; they will mainly visit a doctor in an emergency and usually prefer to make use of the social resources open to them such as NGOs or immigrant associations. Here they can obtain information about how to access health care.

According to the organisation Red de Situación de la Integración Social de los Inmigrantes (Network for the Social Integration of Immigrants), which studied the health care given to immigrants and refugees using the network in 1999, most users (81.2%) made use of the social security system (being either formally registered, accounting for 62.8%, or not) compared to those who used NGO services (7.9%) and those who declared that they did not know where to go (3.1%; IMSERSO, 1999).

Although health problems may sometimes be caused by their own cultural practices and beliefs and adherence to traditional healing methods (compounded by the lack of financial resources to access effective modern health care), these problems stem far more from shocking housing conditions and insecure, often dangerous, occupations.

During 2000, figures were recorded in Andalusia on the health care given to the immigrant population. The numbers of immigrants who applied for primary health care (50.1%) and secondary hospital health care (49.9%) are similar. In terms of hospital health care, while admissions to hospital only account for 7.3%, the figures for hospital emergencies are very high (92.7%). Such high figures are probably due to the previously mentioned fact that an illegal or non-regularised immigrant only has the right to essential emergency treatment; furthermore, it is easier for someone who is not familiar with the normal procedure to go straight to a hospital’s emergency services. It can also be assumed that they access health services only when absolutely necessary. In fact, Almeria, where the large numbers of migrant workers from developing countries do extremely hard physical work in agriculture and horticulture, is also the province with the highest percentage of health care usage (64.5%), particularly of the emergency services. Almeria is followed by Granada with a much lower percentage.
Among the measures initiated by the Andalusian administration to facilitate immigrants’ access to health care is the provision of a ‘health folder’. This contains all the documentation that they will be issued with while registered with the public health system. It also contains information about the nature of the Andalusian health system, advice on how to access various health services via health centres, hospitals and emergency services and how to obtain temporary recognition of the right to health care. The folder also contains the patient’s ‘portable’ medical record and a list of addresses and telephone numbers of NGOs and trade unions that promote immigrants’ use of health services. It even includes a leaflet with the schedule of vaccinations for children and adults. This information is currently being translated into English, French, Arabic and Russian. The health folder also provides the health professional with a useful registration and follow-up document on an individual’s care record, regardless of where that care may have taken place or whether the individual is illiterate or not.

As part of Andalusia’s integrated plan for immigrants’ health care, a health care guide is being produced, aimed at professionals (doctors and nurses) in the primary health care system. This guide will describe the characteristics of the immigrant population in Andalusia and outline specific guidelines for action in relation to the different population groups.

In Catalonia, despite the fact that universally available health care was established as one of the guiding principles of its health system, immigrants’ access to health facilities is still highly restricted. The Department of Health and Social Security has set out a health programme for the immigrant population for 2001 which aims to identify and respond to the specific problems of immigrant communities and to encourage them to use the health system.

A study carried out in 1998 in the regional community of Madrid asserts that immigrants tend to enjoy good health in the months following their arrival. The longer they stay, the more likely they are to fall ill or to experience accidents at work. The most common complaints, in order of frequency, are: joint and muscle problems (closely related to living and work conditions); psychosomatic complaints, with symptoms such as headaches, tiredness and gastrointestinal problems which are closely linked to the sense of vulnerability, separation from the family and the general stress of being a migrant; and respiratory illnesses, made worse by overcrowding.

There are no indications of any noticeable differences in the epidemiological profile of the immigrant population compared to the native population, nor has there been any significant introduction of tropical diseases. However, the fact that figures on this are not statistically significant does not lessen the difficulties for health personnel who may come across a rare or tropical condition of which they have had little experience.

In general, workers in the ‘black’ economy, living clandestinely, have no other means of contacting the public health system except through the emergency units of hospitals (almost 30% use this route). The main problem does not usually stem from the accident itself or the immediate injuries, but from the lack of adequate access to the health care system as a whole. While emergency care can deal with a specific acute condition or trauma, there is no possibility of follow-up care.
Moreover, illegal immigrants whose status has not been regularised do not readily make their way to public health centres for fear of repatriation. In this context, it has always fallen (and often still does) to NGOs or religious organisations to take on the responsibility for caring and for providing information on the social and health resources available.

**The gypsy population**

What marks out this population as socially rejected and marginalised is its poverty and deprivation, its lack of education, its difficulty in entering the labour market and, in particular, its poor health and quality of life. Life expectancy for the gypsy population is, even today, below the Spanish national average. A high percentage of children still grow up without proper vaccinations and exposed to illnesses, such as tuberculosis, that have been practically eradicated among the majority population. In some cases, low levels of nutrition or even malnutrition have been detected. Gypsies also suffer a higher level of accidents and involuntary injuries from burns, falls, car accidents, fractures, wounds, food poisoning, and so on.

Until the end of the 1980s, few gypsies had social security cover and most had to resort to local charities or other institutions if they needed medical attention. In the last decade, there has been an increase in health cover for gypsies; the Universal Health Aid Act 1989 guarantees universal access to health services. Since then, a number of social service agencies have processed requests from gypsy families to attend their local health centres, hospitals and clinics.

However, the gypsy population does have a different attitude to health and illness from the rest of the population. They show little interest in preventative action and appear to have little collective awareness of the importance of appropriate health education. Hence, when gypsies require medical attention, their case is usually urgent, with symptoms needing to be dealt with as quickly as possible. In addition, most gypsy men and women associate good health with an absence of illness and a lack of pain and medication, which means that they are not concerned with their own health care until they feel ill, are in pain or become incapacitated. This limits their understanding of health as an integrated phenomenon that involves a comprehensive biological, psychological, social and preventative approach. It also leads to a general impression that maintenance of good health depends on the health care system and that individuals, families and ultimately the community in general have hardly any role in preventing illness. Such a situation can lead to a kind of dependency on health institutions which prevents gypsies from using them in the intended way.

In this context, it has been observed that they may use the emergency services excessively by not using the primary health care services initially. This is a consequence of a series of difficulties, some related to the community itself and some to the inflexibility of public services and to a mutual lack of understanding. There are cultural differences with the dominant society which provoke rejection and resistance in the gypsy community. They do not readily adapt to a situation that they do not understand and with which they do not identify. They may not understand the workings of institutions but, even when they do, they are loath to adhere to the rules.
They lack an awareness of their rights as citizens and find it difficult to deal adequately with bureaucracy. They do not consider health and social services a right granted by society, but rather a source of immediate and specific benefits; there is no intercultural dialogue. However, the gypsy community is gradually beginning to understand and to accept the role of health centres. The administration is also becoming more aware of its responsibility to fulfil its obligations and adapt its services to the specific needs of this population.

It is clear, given all these issues, that public health centres have insufficient resources to meet demand and offer little specific training covering the wide variety of health services. There is also a lack of integrated, all-embracing programmes that could promote a broader understanding of health and contribute to the integration of ethnic minority groups generally. Finally, there is difficulty in understanding different value systems and there is no intercultural dialogue.

The health indicators of the gypsy population are poor, so gypsy associations are making significant efforts to promote health awareness among the community. The general secretariat of gypsy associations (ASGG) in particular is working to facilitate the community’s access to mainstream health resources through setting up mediation services. In addition, it is carrying out an awareness campaign, offering training and technical advice aimed at public and private institutions and at gypsy associations.

The social services

Social services legislation in Spain distinguishes between community social services and specialised social services. The former is the doorway to the system; it is decentralised and so closer to the individual client and it is on a par with primary health care. Generally speaking, the entire population in Spain may benefit from community social services, although most municipalities lay down local registration as a condition of use. Specialised social services are intended for specific sectors of the population such as the elderly, the disabled, immigrants, children, and so on, and are equivalent to secondary levels of health care.

Social services for the elderly have increased consistently. Current geriatric policies and programmes, developed by the Institute of Migration and Social Services (IMSERSO) in response to the needs of the elderly, include a wide range of services such as the provision of home helps, telephone assistance, daytrips, short-term stays in residential care, programmes of organised holidays and spa treatments, day centres, residential care centres, and so on.
Social policy for the immigrant population

The social integration plan for immigrants is one of the national strategies directed at the immigrant population and was developed by IMSERSO through its subdirectorate on the social promotion of migration and programmes for refugees. Its aims are wideranging and include encouraging the integration of immigrants and refugees and supporting the activities of administrative bodies and social organisations to this end. The aim of the plan is to: eradicate discrimination; promote good relations based on democracy and tolerance; ensure a supportive legal environment and social stability; dismantle the barriers to integration; campaign against the exploitation of foreign workers; and mobilise society against racism and xenophobia.

Another significant advance was the setting up, in 1994, of the permanent immigration observatory programme (OPI) to gather and analyse data systematically in order to draw up a policy for dealing with the issue of immigration in a sustained way. The OPI is a government agency which depends on and is located at IMSERSO. It is a centralised information system that receives data from different regional centres, such as the Andalusian permanent immigration observatory (OPAM). At present, the OPI is phasing in its units in the different communities and provinces. Its main aim is to extend and consolidate these units for the current stage and the next one.

The integrated immigration plan is being developed in Andalusia. It aims to encourage the full integration of the immigrant population in relation to work, society and at the personal level, to ensure that immigrants have access to basic services such as health care, education, housing, social services and legal aid. The plan will promote and develop strategies to guarantee this access and will assess the quality of the goods and services supplied to the immigrant and Spanish populations. It will promote an understanding of the immigration process through research and through training the personnel who work with immigrants. It will encourage social awareness of the positive aspects of immigration, together with a rejection of racism, xenophobia and discrimination. Finally, it will assist with improving the living conditions and infrastructure in immigrants’ countries of origin through a series of measures known as ‘development cooperation’ in order to tackle the root causes of migration.

The regional immigration plan (2001–03) of Madrid is being developed along the same lines. It too promotes and facilitates the full integration of the immigrant population into society and aims to rationalise and make the best use of resources. A series of programmes is to be developed dealing with such matters as information and primary reception in municipal social service centres; social care centres for immigrants; temporary and transitory emergency reception centres; help in finding accommodation; help for immigrant nomadic minorities; help and training for immigrant women; help for victims of sexual exploitation and vulnerable young women; social and labour support programmes co-financed by the European social fund; and help for the disabled and the elderly. The plan’s strength lies in its introduction of new and significant financial aid. There is even one programme, again with a financial element, aimed specifically at sectors of the immigrant population such as the disabled and the elderly.
Social policy for the gypsy population

Spain is currently implementing several aid projects for gypsies, demonstrating that the authorities have begun to tackle the problems of the gypsy population, although not as vigorously as needed. The greater part of the aid comes from the government, but gypsy associations manage its distribution.

In Andalusia, the AC with the largest number of gypsies, a number of aid projects are in place for the education of gypsy children and for helping to solve the problems of the gypsy community. Plans have been introduced for gypsy development and for the integration of the gypsy community. Another programme aims at promoting tolerance of social difference through intercultural teaching materials, a day of celebration of Andalusian gypsies and an international day to promote the elimination of racial discrimination.

In Madrid, the main assistance from the social services falls under one of four headings: personal, financial, ‘in kind’ or a combination of all three. Contributions ‘in kind’ include permanent homes intended mainly for the elderly and the physically and mentally disabled; shelters; specialised centres, and assistance and services for elderly people. This would include home helps, day centres, centres for the elderly, aid programmes for ethnic minorities, and so on.

As regards the use made of these facilities by the gypsy community, they tend not to take advantage of services offered ‘in kind’ and have difficulty in using to the full the personal opportunities available. This is mainly because gypsies find it hard to relate to ‘the authorities’, they do not know these services are available to them and, furthermore, few others in their community have made use of them. As a result, it is financial assistance that is most requested.

The Catalan regional community has the third largest gypsy population. It has recently signed an agreement with the Ministry of Labour and Social Affairs (December 2001) for joint financing of projects for the social support and integration of those gypsies who come under the resettlement programme. Its main objective is to combat exclusion by putting an end to shanty dwellings and improving the precarious housing of some gypsy families.

The work done by associations like the Gypsy General Secretariat Association and the Romany Union is extremely important in furthering the integration of the gypsy community. Many of these associations act as intermediaries between the community and public social services; others develop direct action programmes to meet the needs of the gypsy population. They may also offer information services, training, guidance and analysis to advance the objectives of gypsy associations and non-gypsy groups working in the area. They also initiate campaigns, disseminate information and promote their distinctive cultures.

The gypsy minority is, without doubt, deeply rooted in Spain. Of all the minority groups, it has also made the greatest progress in achieving social recognition, in spite of the discrimination from which it still suffers.
Conclusion

It is clear from the data gathered thus far that immigration is a relatively new phenomenon in Spain and that it will continue to increase. For example, over the last five years, the number of immigrants has doubled, yet the capacity of the health and social services in Spain is at saturation point. Hence it can be assumed that the country is unprepared to deal with the needs of recently arrived immigrants, and even less so with those who are illegal and undocumented.

In terms of the MEC project, we have focused on the most recent arrivals into our country from Morocco and parts of South America (Ecuador, Colombia and Peru), as well as the indigenous ethnic minority, the gypsies. All these minorities have certain experiences in common: bad living conditions; a high percentage either unemployed or working in the black economy; a lack of awareness, especially among immigrants, of how to access health and social services, and so on.

All these groups have a high percentage of young people in their populations; it is notable that there is virtually no information or data available about those aged 55+ either within the health system or the social services. This kind of information, so vital for our research, will have to be sought during the next phase of our study.

The legislative framework under which the immigrant population has to live demonstrates how illegal immigrants have no right to specialised social services or to health care, except for acute emergency treatment. Nevertheless, we have observed that these services are granted, independently of an immigrant’s legal status, which we would argue is reason enough to amend the law so that the use of these facilities becomes a right rather than by dint of the goodwill of administrators or medical personnel. Immigrants tend to use the services of NGOs or charitable or religious institutions, partly for cultural reasons, partly out of ignorance of what is available and partly out of fear of being reported and expelled in the case of undocumented immigrants.

The most common health problems among immigrants and gypsies arise mainly from the conditions in which they are forced to live. The authorities must examine this problem in more depth because it lies at the root of most of the subsequent problems suffered by ethnic minorities.

From our observations, a series of questions relating to health and social services inevitably arises. To what extent are the health and social services and their professional personnel ready to receive these groups? What is being done to remedy this situation? And how are these agencies preparing to receive such groups in the future? We suspect that the answers will be fairly negative, but further research is needed to produce relevant data so that the problems can be understood in detail and specific proposals, applicable to all groups, be made.

It is essential to look at the situation of immigrants and minorities in the context of the alarming growth in racist and xenophobic trends which is afflicting all European societies and has not left Spain untouched.
Multiculturalism is more an intellectual than a practical concept in Spanish society. We need to ask ourselves, as did one member of Barcelona’s African community, what aspects of our lifestyle are we ready to give up in order to achieve and benefit from a multicultural society?
Introduction

This report briefly describes the current situation of ethnic minorities in Finland in general and the social and health care of older minority ethnic people in particular. Both the country profile and this report are based on the available statistics and research into minority elderly care in Finland. It was not until the 1990s that the number of immigrants to Finland increased sharply, although remaining the lowest in Western Europe. As a consequence, research on immigrant minorities in Finland is only now reaching the level it has already attained in other countries. In particular, there are few studies into special groups such as older people.

The situation of minority ethnic elders is described in as much detail as possible, given the available data. But much information available in other Western European countries has no equivalent in Finland. For example, there are no statistics on the health of ethnic minority communities in general, let alone that of minority ethnic older people. This lack of knowledge demonstrates the obvious need for the MEC project in Finland, for the country’s future, as elsewhere in Europe, will be a multicultural one. Even if the questions posed by multiculturalism have arisen later than in other Western European nations, now is the time to prepare for a society in which a rapidly ageing population is no longer all white and Finnish speaking.

To set the ethnic minority population in context, Table 1 overleaf presents statistics on the total population by gender.

The population of Finland is ageing rapidly. At present, 26% of the population is aged 55+ and the number of the elderly will double during the next three decades. By the year 2010, the number of those 75+ will increase by some 55,000 (14.2%) and the ageing of the population will escalate further during the following decades (Vaarama et al., 2001). Projections by age of the total population are presented in Table 2.

The statistics presented in this report concentrate mainly on three ethnic minorities in Finland: the Russian-speaking, Vietnamese-speaking and Sami minorities. These three minorities were chosen as the focus of the MEC project for three main reasons: first, both immigrant and traditional minorities are represented; second, within immigrants, both refugees and the repatriated are included; and, third, both visible and invisible minorities are included.
### TABLE 1  
**Age structure of the Finnish population by gender** as of 31 December 2000

<table>
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<tr>
<th>Ages</th>
<th>Females</th>
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<th>Males</th>
<th>%</th>
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<td>0–14</td>
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</tr>
<tr>
<td>15–24</td>
<td>322,307</td>
<td>12.2</td>
<td>336,701</td>
<td>13.3</td>
<td>659,008</td>
<td>12.7</td>
</tr>
<tr>
<td>25–34</td>
<td>319,411</td>
<td>12.0</td>
<td>333,681</td>
<td>13.2</td>
<td>653,092</td>
<td>12.6</td>
</tr>
<tr>
<td>35–44</td>
<td>374,020</td>
<td>14.1</td>
<td>386,891</td>
<td>15.3</td>
<td>760,911</td>
<td>14.7</td>
</tr>
<tr>
<td>45–54</td>
<td>409,850</td>
<td>15.5</td>
<td>417,724</td>
<td>16.5</td>
<td>827,574</td>
<td>16.0</td>
</tr>
<tr>
<td>55–64</td>
<td>289,854</td>
<td>10.9</td>
<td>277,145</td>
<td>11.0</td>
<td>566,999</td>
<td>10.9</td>
</tr>
<tr>
<td>65–74</td>
<td>244,159</td>
<td>9.2</td>
<td>192,630</td>
<td>7.6</td>
<td>436,789</td>
<td>8.4</td>
</tr>
<tr>
<td>75–84</td>
<td>174,299</td>
<td>6.6</td>
<td>87,715</td>
<td>3.5</td>
<td>262,014</td>
<td>5.1</td>
</tr>
<tr>
<td>85+</td>
<td>59,570</td>
<td>2.2</td>
<td>18,825</td>
<td>0.7</td>
<td>78,395</td>
<td>1.5</td>
</tr>
<tr>
<td>Total</td>
<td>2,651,774</td>
<td>100</td>
<td>2,529,341</td>
<td>100</td>
<td>5,181,115</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Statistics Finland, 2001a

### TABLE 2  
**Population projections by age of the total population (2000–30)**

<table>
<thead>
<tr>
<th>Ages</th>
<th>2000</th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–14</td>
<td>936,333</td>
<td>851,482</td>
<td>832,925</td>
<td>805,322</td>
</tr>
<tr>
<td>15–24</td>
<td>659,008</td>
<td>651,631</td>
<td>584,108</td>
<td>566,527</td>
</tr>
<tr>
<td>25–34</td>
<td>653,092</td>
<td>662,775</td>
<td>655,569</td>
<td>650,827</td>
</tr>
<tr>
<td>35–44</td>
<td>760,911</td>
<td>654,812</td>
<td>663,965</td>
<td>656,848</td>
</tr>
<tr>
<td>45–54</td>
<td>827,574</td>
<td>746,511</td>
<td>646,188</td>
<td>655,733</td>
</tr>
<tr>
<td>55–64</td>
<td>566,999</td>
<td>785,669</td>
<td>716,820</td>
<td>626,344</td>
</tr>
<tr>
<td>65–74</td>
<td>436,789</td>
<td>505,065</td>
<td>713,197</td>
<td>665,190</td>
</tr>
<tr>
<td>75–84</td>
<td>262,014</td>
<td>308,769</td>
<td>380,091</td>
<td>554,914</td>
</tr>
<tr>
<td>85+</td>
<td>78,395</td>
<td>101,235</td>
<td>124,533</td>
<td>169,022</td>
</tr>
<tr>
<td>Total</td>
<td>5,181,115</td>
<td>5,267,949</td>
<td>5,317,396</td>
<td>5,290,563</td>
</tr>
</tbody>
</table>

Source: Statistics Finland, 2001b

### TABLE 3  
**Age structure of foreign (non-citizen) population by gender**

<table>
<thead>
<tr>
<th>Ages</th>
<th>Females</th>
<th>%</th>
<th>Males</th>
<th>%</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–14</td>
<td>8457</td>
<td>18.6</td>
<td>8759</td>
<td>19.2</td>
<td>17,216</td>
<td>18.9</td>
</tr>
<tr>
<td>15–24</td>
<td>6483</td>
<td>14.2</td>
<td>6419</td>
<td>14.1</td>
<td>12,902</td>
<td>14.2</td>
</tr>
<tr>
<td>25–34</td>
<td>10,946</td>
<td>24.0</td>
<td>11,228</td>
<td>24.7</td>
<td>22,174</td>
<td>24.3</td>
</tr>
<tr>
<td>35–44</td>
<td>8950</td>
<td>19.7</td>
<td>9303</td>
<td>20.4</td>
<td>18,253</td>
<td>20.0</td>
</tr>
<tr>
<td>45–54</td>
<td>4983</td>
<td>10.9</td>
<td>5122</td>
<td>11.2</td>
<td>10,105</td>
<td>11.1</td>
</tr>
<tr>
<td>55–64</td>
<td>2277</td>
<td>5.0</td>
<td>2404</td>
<td>5.3</td>
<td>4681</td>
<td>5.1</td>
</tr>
<tr>
<td>65–74</td>
<td>1908</td>
<td>4.2</td>
<td>1531</td>
<td>3.4</td>
<td>3439</td>
<td>3.8</td>
</tr>
<tr>
<td>75–84</td>
<td>1141</td>
<td>2.5</td>
<td>662</td>
<td>1.5</td>
<td>1803</td>
<td>2.0</td>
</tr>
<tr>
<td>85+</td>
<td>393</td>
<td>0.9</td>
<td>108</td>
<td>0.2</td>
<td>501</td>
<td>0.6</td>
</tr>
<tr>
<td>Total</td>
<td>45,538</td>
<td>100</td>
<td>45,536</td>
<td>100</td>
<td>91,074</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Statistics Finland, 2001c
Ethnic minorities in Finland

Demographic context of ethnic minorities

The age structure of the immigrant population is presented in Table 3. It should be noted that the broad category of immigrant includes all those entering the country, including those of Finnish origin returning, and not just those of foreign origin. Since large-scale immigration is still a relatively new phenomenon in Finland, the average age of immigrants is considerably lower than that of the population as a whole. In particular, the age structure of the refugee population differs from the general age structure, since refugees are usually young people and families with small children. In some refugee groups, there are virtually no older people. Of the immigrants in Finland, 75% are of working age, but only 6% of foreigners are aged 65+ compared to 15% of the Finnish population in this age group (see Table 1). The highest numbers of elderly are among immigrants from Sweden, the USA and Canada and are mostly repatriates returning to Finland on retirement.

It is illegal in Finland to register people according to ethnic group. Hence, separate figures for minorities are arrived at in three main ways: by country of birth, language and citizenship. All have advantages and disadvantages for assessing the size of the minority population and all three are used by researchers in the field of immigration. ‘Citizenship’ does not reveal those people of immigrant origin who have been granted Finnish citizenship. ‘Country of birth’ does not enable us to distinguish between Russians, Estonians and others born in the former Soviet Union from Finnish citizens also born there, nor does this criterion take account of the second generation – children born in Finland to immigrant parents. Language is perhaps the best way, at least for the purposes of the MEC project, of distinguishing between ethnic Finns and minorities, as well as between different minorities. Language, too, as a criterion can be problematic, as each individual’s language, as registered in the Population Information System, is based on his/her (or usually the parents’) own declaration, and bilingual people or mixed couples have to choose which language to register. For the MEC project, however, this is not believed to cause any major difficulties.

The Russian-speaking group is the largest in Finland (see Table 4 overleaf) and, because of the nature of immigration from Russia to Finland, this group is, on average, older than other immigrant groups. The Somalis are the largest refugee group, and the Vietnamese, who originally came as refugees, are the sixth largest group of foreign origin.

Finland also has three traditional cultural and linguistic minorities (see Table 5) who have lived there for centuries and can be regarded as integrated in many aspects with the majority population. However, cultural differences distinguish them in several ways and, even though they have long been part of Finnish society, they can still experience difficulties, for example when dealing with the Finnish welfare system.
### TABLE 4  
**Minorities of immigrant origin according to language**

<table>
<thead>
<tr>
<th>Language</th>
<th>Number</th>
<th>% of total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Russian</td>
<td>28,205</td>
<td>0.50</td>
</tr>
<tr>
<td>Estonian</td>
<td>10,176</td>
<td>0.20</td>
</tr>
<tr>
<td>English</td>
<td>6,919</td>
<td>0.10</td>
</tr>
<tr>
<td>Somali</td>
<td>6,454</td>
<td>0.10</td>
</tr>
<tr>
<td>Arabic</td>
<td>4,892</td>
<td>0.09</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>3,588</td>
<td>0.07</td>
</tr>
<tr>
<td>German</td>
<td>3,298</td>
<td>0.06</td>
</tr>
<tr>
<td>Albanian</td>
<td>3,293</td>
<td>0.06</td>
</tr>
<tr>
<td>Kurdish</td>
<td>3,115</td>
<td>0.06</td>
</tr>
<tr>
<td>Chinese</td>
<td>2,907</td>
<td>0.06</td>
</tr>
</tbody>
</table>

Source: Statistics Finland, 2001d

### TABLE 5  
**Traditional minorities**

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>% of total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swedish-speaking Finns</td>
<td>c. 295,000</td>
<td>5.7</td>
</tr>
<tr>
<td>Roma</td>
<td>min. 10,000</td>
<td>0.2</td>
</tr>
<tr>
<td>Sami</td>
<td>7,502</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Sources: Ministry of Social Affairs and Health, 2001b; Sami Parliament, 2001
By far the largest of the three (5.7% of the population) are the Swedish-speaking Finns who are geographically concentrated in the western and southern parts of Finland, as well as on the islands of Aland. Since Swedish is an official language in Finland under the Constitution, the position of the Swedish-speaking minority is quite secure. They are entitled to services in their mother tongue and all civil servants are required to pass an examination in Swedish (Ministry of Social Affairs and Health, 2001a).

The Roma, the next of these groups, are much more disadvantaged and often face discrimination and racism. Only since the 1960s has legislation been passed to improve the position of the Roma in Finland. They are still worse off economically and socially than the majority population (Ministry of Social Affairs and Health, 2001b).

The Sami people, the third traditional minority, live in northern Scandinavia and are indigenous to the area. Their exact number is unknown, but is estimated to be over 75,000. Most Sami live in Norway (over 40,000), with around 15–25,000 in Sweden and 2000 in Russia. In Finland, they number about 7000 (Ministry of Social Affairs and Health, 2001c).

Patterns of migration

During the 1990, the number of immigrants to Finland quadrupled: in 1989, there were 21,174 immigrants compared to approximately 85,000 a decade later. However, the foreign population of Finland is small in number, both in comparison with the European average of 5% and with other Nordic countries (Taalve, 1999). As of December 2000, foreigners made up 1.8% of the total population of Finland (Population Register Centre, 2001).

Most immigrants to Finland are repatriates or return migrants (i.e. those who return voluntarily to the country they once emigrated from). In the 1970s and 1980s, most came from Sweden; in the 1990, the majority came from Estonia and the former Soviet Union. Most of the latter have entered Finland because people of Finnish origin, living in what was formerly the USSR, were granted repatriate status in 1990. Applicants have to prove that either they, at least one of their parents or two of their grandparents are/were of Finnish nationality. Despite being known as ‘repatriates’, most have never lived in Finland and their adaptation to Finnish society has not been easy due to language problems and differences in cultural background. Approximately 70% of the people who have moved to Finland from the former Soviet Union have repatriate status (Kyntäjä, 1999; Taavela, 1999); the remaining 30% have been granted residence permits on the basis of work or marriage to a Finnish national.

Not all applicants for repatriation can be permitted to enter immediately, since it is necessary for the municipal authorities to find accommodation for them. In practice, in Russia and Estonia, many thousands are on the waiting list to move (19,000 in February 2002). Only those who have jobs waiting for them in Finland are allowed to bypass the queuing system (see: http://www.mol.fi/migration/inker.pdf).
Most Russian-speaking people in Finland live in the capital or in other large cities. Almost half of the foreign population lives in the South, in or near the capital, and the Southwest, around the city of Turku. Foreigners are concentrated in urban areas, as are refugees, many of whom were originally housed in rural municipalities but have tended to move to the big cities. In eastern Finland, the Russians form a majority of the foreign population (Nieminen, 2001). Since the collapse of the Soviet Union, there has been a great deal of cross-border traffic between Finland and Russia, and, in eastern Finland, the number of Finnish–Russian marriages has increased considerably.

Vietnamese refugees started coming to Finland in 1979. The so-called ‘boat people’ attracted worldwide media attention when they risked their lives escaping from Vietnam after the war. The refugee flow from Vietnam still continues, although the reasons for leaving have varied over the years (Tran, 1991). In 1987, the government began placing newly arrived refugees in different parts of the country and today the Vietnamese community is dispersed across Finland, although the majority of Vietnamese still live in the South (Liebkind, 1994). In the 1990, the number of people for whom Vietnamese was their first language increased from 1947 to 3588. However, it is hard to estimate how many Vietnamese have moved to Finland from abroad and how many were born there (Nieminen, 2001).

Sami people, a traditional minority, still live mostly in the North, in Lapland, with only a few in the cities of the South. About 4000 (c. 60%) of the Sami live in the municipalities of Enontekiö, Inari, Sodankylä and Utsjoki (known as the Sami home district) and constitute one-third of the population of this area. The municipality of Utsjoki has a Sami majority (Sami Parliament, 2001). Sami culture differs considerably between the regions, for example, there are three different Sami languages in Finland alone.

Age distribution

The age structure of these three minorities is shown in Table 6 overleaf. While 15% of the total population of Finland is 65+, only 3.7% of Russians have attained this age. Russians are also less represented among the 55–64 age group. Vietnamese children under 14 constitute some 30% of the Vietnamese population, a proportion that is considerably higher than for the total population (18%). Conversely, those 55+ represent 26% of the total population, but only 4.5% of the Vietnamese are in this age group.

Among immigrants overall, the distribution of women is almost identical to that of men. Within different nationalities, however, there are enormous differences in gender distribution. Russians are one of the most unevenly distributed groups, since 62% of the Russian-speaking population in Finland are women. The underlying reason is that many Finnish men have married Russian women, but marriages between Finnish women and Russian men are rare (Nieminen, 2001).
Socioeconomic position of minorities in Finland

Housing and living conditions

In Finland, renting a flat is considered to be expensive and it is usual to commit oneself to a large bank loan in order to purchase a house or flat. Cheaper rents are usually available only in municipally-owned housing, which is seen as low status. People living in rented accommodation are usually either young or financially badly off. This pattern may be changing gradually, but property ownership is still a common criterion for assessing the socioeconomic situation of the Finnish population.

Some 68% of the total population are owner-occupiers and only 27% live in rented flats. Among Russian-speaking people, however, only 24% own their accommodation, as do 17% of Vietnamese-speaking people. The Sami, on the other hand, have higher levels of owner-occupancy (73%) than the Finnish. Usually levels of owner-occupancy increase with age, but the reverse is true of the Vietnamese. Only 7% of those aged 55+ are owner-occupiers (Statistics Finland, 2001e).

Household composition

Among the Finnish population, older people seldom live with their children or family members other than their spouse. Of the Finnish population aged 55+, 31% live in single-person households, a rate similar to that of the Russian population (26%). However, only 14% of older Vietnamese live alone (Statistics Finland, 2001e). Vietnamese family structure differs from the Finnish model and it is common for several generations to live together. Although many Vietnamese feel that living with their extended family is not possible in Finland (not only are flats small, but grandparents are usually not in Finland), it still seems to be more common among this community than among other ethnic groups.

The Sami concept of family is also wider than that of the nuclear family and includes aunts, uncles and cousins. The village community that, as a whole, herds reindeer is still important (Magga, 1998). Some 25% of Sami aged 55+ live in single-person households, although this figure should be treated with caution because only 1734 Sami are included in these statistics (Statistics Finland, 2001e).

Income

As of December 1999, average annual income per capita of the total Finnish population was €14,359; for those aged 55+, it was €15,857. However, the average income of those from ethnic minorities was considerably lower. The average annual income for non-Finnish individuals was about €7508; in other words, minority individuals earned on average only 52% of the annual Finnish income. The main explanation for this is the high level of unemployment among the non-Finnish population (Statistics Finland, 2001e).

In 1999, the average annual income of Russian immigrants was €6090 and slightly higher for those aged 55+, at €6829. Vietnamese incomes were only €5703 per person, with an increase for those 55+ to €6213.
### TABLE 6  
Age structure of Russians, Vietnamese and Sami in the Sami home district (%)  

<table>
<thead>
<tr>
<th>Ages</th>
<th>Russians</th>
<th>Vietnamese</th>
<th>Sami</th>
<th>% of total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–14</td>
<td>19.1</td>
<td>30.0</td>
<td>22.1</td>
<td>18.1</td>
</tr>
<tr>
<td>15–24</td>
<td>16.6</td>
<td>21.0</td>
<td>15.0</td>
<td>12.7</td>
</tr>
<tr>
<td>25–34</td>
<td>18.4</td>
<td>21.0</td>
<td>10.0</td>
<td>12.6</td>
</tr>
<tr>
<td>35–44</td>
<td>22.4</td>
<td>15.7</td>
<td>15.4</td>
<td>14.7</td>
</tr>
<tr>
<td>45–54</td>
<td>14.5</td>
<td>7.8</td>
<td>13.8</td>
<td>16.0</td>
</tr>
<tr>
<td>55–64</td>
<td>5.2</td>
<td>2.3</td>
<td>10.2</td>
<td>10.9</td>
</tr>
<tr>
<td>65–74</td>
<td>2.6</td>
<td>1.6</td>
<td>8.0</td>
<td>8.4</td>
</tr>
<tr>
<td>75–84</td>
<td>0.9</td>
<td>0.5</td>
<td>4.3</td>
<td>5.1</td>
</tr>
<tr>
<td>85+</td>
<td>0.3</td>
<td>0.1</td>
<td>1.3</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Source: Statistics Finland, 2001e

### TABLE 7  
Educational level of selected minorities (%)  

<table>
<thead>
<tr>
<th></th>
<th>Russians</th>
<th>Vietnamese</th>
<th>Sami (N=1690)</th>
<th>% of total population (N=5,171,302)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic level/unknown</td>
<td>58</td>
<td>82</td>
<td>56</td>
<td>52</td>
</tr>
<tr>
<td>Vocational/ matriculation examination</td>
<td>20</td>
<td>16</td>
<td>33</td>
<td>29</td>
</tr>
<tr>
<td>University/ polytechnic</td>
<td>22</td>
<td>2</td>
<td>11</td>
<td>19</td>
</tr>
</tbody>
</table>

Source: Statistics Finland, 2001e
Sami average income in 1999 was €10,328; again, slightly higher for the older age group at €10,944. The most striking feature of these figures is the gap between the population as a whole and all the minorities. The figures include all taxable income – wages, pensions, social security and unemployment payments, as well as income from capital (Statistics Finland, 2001e).

Employment and integration in the labour market

Integration in the Finnish labour market has been difficult for immigrants, partly because their numbers grew most strongly while Finland was experiencing its worst economic recession of the 20th century (Ekholm, 1994). Also racism and the diminishing demand for unskilled labour affect the employment opportunities of immigrants in particular. Refugees are extremely disadvantaged in the Finnish labour market, with an unemployment rate among certain groups as high as 76% (Nieminen, 2001). In the year 2000, the unemployment rate for all foreigners in Finland was 34% while, for the whole population, the rate was 13% (Ministry of Labour, 2001; Nieminen, 2001). Of the Russians, as many as 46% were unemployed and the unemployment rate of the Vietnamese was as high as 49.5%. Yet, among refugees in Finland, the Vietnamese are still better off than other groups.

The Sami have traditionally supported themselves by fishing, hunting or herding reindeer, depending on their environment. Nowadays they are increasingly being forced to give up their traditional livelihoods and move into more modern occupations. Currently, only 10–20% make their living from reindeer (Magga, 1998). Sami problems on the labour market are very different from those of immigrants. Accurate statistics on their employment rates are difficult to locate but, of the 1734 Sami for whom figures were available, only 10% were unemployed in 2000.

Education

Statistics on education are not very reliable because information on the education of foreigners is often lacking or qualifications are difficult to compare with Finnish ones. Of Vietnamese in Finland, 82% have only basic education or their educational level is unknown (the comparable figure for the whole population is 52%). Only 11% of Sami have university degrees (19% for the whole population). One reason for this could be the scattered nature of communities in Lapland: secondary school attendance, which is required for university level studies, often means moving away from home at an early age. Older Sami experienced severe difficulties and discrimination at school. They were often not allowed to speak their own language and could be punished for using it outside the classroom. All teaching was in Finnish and language difficulties made learning far more difficult for Sami children. This negative experience of education may still affect older Sami people’s willingness to use their own language in institutional settings and their attitudes towards authority. The Sami have not been encouraged to demand services in their own languages (Magga, 1997).

The figures in Table 7 include children, thus giving a higher proportion of those whose educational level is unknown than would otherwise be the case.
Finnish immigration policy

Immigrant affairs are dealt with by several branches of the administration. The Ministry of Labour coordinates integration policy through its regional economic and development centres and local employment offices in cooperation with the municipal authorities. The Ministry of the Interior and the Ministry of Foreign Affairs control entry to Finland and issue permits. In addition, other ministries (Social Affairs and Health, Education, Justice, Environment) plan and monitor immigrant policies relevant to their particular fields.

Immigration policy is mainly regulated by two acts: The Finnish Aliens Act (with the Aliens Decree) and the Act on the Integration of Immigrants and Reception of Asylum Seekers. The Aliens Act covers entry to Finland, visas, residence permits, work documents, travel documents and the different statuses under which residence permits may be granted. It has been amended several times and is often criticised for its complexity and lack of clarity. A new Aliens Act is currently being drafted by civil servants.

The Integration Act, on the other hand, is relatively new. It came into force in May 1999 and its implementation has been monitored by the Ministry of Labour, which reported on it to parliament in May 2002. The Integration Act introduced two central components of Finland’s integration policy. First, each municipal authority is obliged to draw up an integration programme, setting out objectives, means, resources and cooperative measures to facilitate the integration of immigrants within the municipality. In making and implementing this programme, immigrants, NGOs, employee and employer organisations and other local parties are to have a voice.

The second new component introduced by the Integration Act is the individual integration plan. Immigrants who register as unemployed jobseekers or who apply for social assistance are entitled to a personal integration plan, to be drawn up in cooperation with the local authority and the employment office. The right to an integration plan lasts for three years from the time of an individual’s first registration with the Population Information System.

Because immigration to Finland began so recently, the country has been able to benefit from other countries’ experiences in formulating its immigration policy. However, this involves the risk of overlooking typically Finnish circumstances. Multiculturalism has been the guiding principle of Finnish policy since 1990, mainly because of the Swedish influence. Practical support for multiculturalism can be seen in the provision of financial resources for teaching in immigrants’ own languages and for religion and culture. It is also recommended that more immigrants be employed in public administration (Ylänkö, 2001).
In a government policy document (see: http://www.intermin.fi/eng/refuge.html), Finnish integration policy is formulated as follows:

Integration means that immigrants participate in the economic, political and social life of society as equal members, having both the duties and rights of the members of society. At the same time, they should be able to maintain and develop their own culture and religion in harmony with Finnish law.

Toukomaa and Puustinen (2001) argue that the same kind of ideology that underlies integration policy operates in social and health care. Because the system is based on the principle of equality, no special services are offered to anyone. Although, at first sight, this seems fair, it creates problems for minorities. Immigrants are expected to adapt to the Finnish system, even if it means altering their beliefs and outlook on life. Toukomaa and Puustinen believe that efficiency of service delivery would improve if every patient or client were treated as an individual, in line with his/her own culture and values.

Policy and services for older people in Finland

Ethical principles and legal framework

Following a UN recommendation, a national strategy and policy on ageing and the aged was drawn up in 1996, including an action plan up to 2001. The intention was to provide policy guidelines and recommendations to be implemented at regional and local levels by all the relevant agencies, organisations and individuals.

The general principles of the policy on ageing are:

- normality
- respect for the aged
- safety
- social integration
- self-determination

- individuality
- freedom of choice
- pluralism
- equality
- justice

Policy on ageing and the aged is pursued at both national and local levels. Nationally, it involves general welfare policy (housing, labour, educational, environmental and family policy), pensions policy and social welfare and health services. Government policy provides the statutory framework for the local policies that are pursued in the municipalities. Even if the goals of local and national policy are identical, local policy is always based on existing resources, values and needs in each municipality (Vaarama and Kauto, 1998).

The Constitution of Finland lays down safeguards for fundamental civil and human rights. The public authorities must ensure that these rights are implemented, a duty that also forms the basis for the provision and development of care and services for older people.
### TABLE 8  Profile of older people's services in 1988–2000

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Clients (% of all aged 65+)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home help services</td>
<td>19.3</td>
<td>11.8</td>
<td>11.0</td>
<td>10.7</td>
<td>−44.6</td>
</tr>
<tr>
<td>Auxiliary services</td>
<td>15.1</td>
<td>13.4</td>
<td>13.5</td>
<td>13.5</td>
<td>−10.6</td>
</tr>
<tr>
<td>Support for informal care</td>
<td>1.8</td>
<td>1.5</td>
<td>1.7</td>
<td>1.8</td>
<td>0</td>
</tr>
<tr>
<td>People living in service housing</td>
<td>0.9</td>
<td>1.9</td>
<td>2.6</td>
<td>2.7</td>
<td>200.0</td>
</tr>
<tr>
<td>Residential home</td>
<td>4.4</td>
<td>3.5</td>
<td>3.4</td>
<td>2.7</td>
<td>−38.6</td>
</tr>
<tr>
<td>Long-term care at health centres</td>
<td>1.6</td>
<td>1.9</td>
<td>1.7</td>
<td>1.7</td>
<td>6.3</td>
</tr>
<tr>
<td>Long-term specialised care</td>
<td>2.2</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
<td>−95.5</td>
</tr>
<tr>
<td>Long-term institutional care (total)</td>
<td>7.3</td>
<td>5.4</td>
<td>5.1</td>
<td>5.0</td>
<td>−31.5</td>
</tr>
<tr>
<td><strong>Clients (% of all aged 75+)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Home help services</td>
<td>46.2</td>
<td>28.8</td>
<td>25.4</td>
<td>24.4</td>
<td>−47.2</td>
</tr>
<tr>
<td>Auxiliary services</td>
<td>36.1</td>
<td>32.6</td>
<td>31.2</td>
<td>30.8</td>
<td>−14.7</td>
</tr>
<tr>
<td>Support for informal care</td>
<td>4.2</td>
<td>3.8</td>
<td>4.0</td>
<td>4.2</td>
<td>0</td>
</tr>
<tr>
<td>People living in service housing</td>
<td>2.1</td>
<td>4.6</td>
<td>6.0</td>
<td>6.2</td>
<td>195.2</td>
</tr>
<tr>
<td>Residential home</td>
<td>10.5</td>
<td>7.0</td>
<td>7.8</td>
<td>6.1</td>
<td>−41.9</td>
</tr>
<tr>
<td>Long-term care at health centres</td>
<td>4.1</td>
<td>4.0</td>
<td>4.0</td>
<td>3.9</td>
<td>−4.9</td>
</tr>
<tr>
<td>Long-term specialised care</td>
<td>3.0</td>
<td>0.3</td>
<td>0.2</td>
<td>0.2</td>
<td>−93.3</td>
</tr>
<tr>
<td>Long-term institutional care (total)</td>
<td>17.0</td>
<td>12.0</td>
<td>12.0</td>
<td>11.4</td>
<td>−32.9</td>
</tr>
</tbody>
</table>

* People receiving home help services, excluding home help for people living in service housing;
* People in service housing and intensified service housing;
▲ Calculated figure: clients aged 65+ proportionate to the population aged 75+

Changes in statistical practice taken into account.
The following stipulations are crucial:

- Everyone is equal before the law. No one shall, without an acceptable reason, be treated differently from other persons on the grounds of sex, age, ethnic origin, language, religion, conviction, opinion, health, disability or other reason that concerns his/her person.

- Everyone has the right to life, personal liberty, integrity and security. The personal integrity of the individual shall not be violated, nor shall anyone be deprived of liberty arbitrarily or without a reason prescribed by an Act.

- Everyone's private life, dignity and the sanctity of the home are guaranteed.

- Those who cannot obtain the necessary means for a life of dignity have the right to receive essential subsistence and care.

- The public authorities shall guarantee for everyone, as provided in more detail by other Acts, adequate social, health and medical services and shall promote the health of the population.

The rights to proper treatment for social welfare clients and medical patients are formulated in the Act on the Status and Rights of Social Welfare Clients (812/2000) and the Act on the Status and Rights of Patients (795/1992). These laws stipulate that the individual has a right to good social and health services. Each person must be treated so that his/her dignity is not violated and so that his/her convictions and privacy are respected. Both these laws incorporate an obligation to respect a client's self-determination. The law on social welfare also stresses the importance of making a service and care plan, which should always be drawn up on a mutual basis with the client.

Service delivery

Today's services for the elderly offer a wide range of activities. In most municipalities, elderly people are provided with:

- multifaceted and community-based services (home care, auxiliary services, day centre activities)
- rehabilitation
- periodic or respite care in homes for the elderly or at health centres
- different types of service housing\(^1\) (small-scale and group accommodation, housing with high and intensified levels of service provision)
- multifaceted institutional care for special groups such as people with dementia or those in need of psychiatric treatment.

Table 8 shows the most common services available to older people in Finland and the development of the coverage of the services from 1988–2000. It should be emphasised that the selection of services is exactly the same for minority ethnic older people as it is for the majority population. This means that the special needs of minorities may well be overlooked because the aim of integration policy has been to adjust immigrants to the system of service provision and not the system to the immigrants.

---

1 Service housing means living in a specially equipped or ordinary apartment where daily home services are provided. Service housing may be arranged in an institution, in a service house, ordinary rented accommodation or in an apartment owned by the client. Intensified service housing has staff on night duty as well.
The figures distinctly show the considerable cuts made to home help services during this 12-year period. The general tendency away from traditional institutional care in residential homes towards service housing is also clearly visible.

Social security benefits and allowances are mainly funded by tax revenues and social insurance premiums. The latter are mainly paid by employers but, during recent years, the proportion paid by employees has risen considerably. Most minority ethnic elders have to rely on publicly-funded services as their economic situation does not allow them to pay for private health care.

Role of minority organisations in service delivery

Most ethnic minority organisations in Finland are small voluntary groups with no or very few employees. Only seldom do they offer services and, when they do, these are fairly minimal (for example, a social club for the elderly that meets every other month). None of the organisations concentrates specifically on elders. They usually work on a more general basis, advocating minority rights and encouraging cultural traditions.

Problems in social and health care

Minority ethnic elders face the same problems regarding their care as do all older people. But, in addition to problems such as the much discussed quality of care in institutions and the lack of sufficient home help services, minority ethnic elders have to deal with problems specific to them in social and health care. These problems are described in this chapter.

Lack of knowledge of services and financial entitlements

Although not much research on the use of social and health care services by ethnic minority elders is available, it is generally believed that immigrants are unaware of all the services to which they are entitled. In particular, the availability and content of home help services are unknown. In addition to knowing little about what services for help in the home are available, some older immigrants view such help negatively. Unlike Finnish people, many immigrants prefer to receive help from their children or family and feel that to ask for help from the state is humiliating (Kuusi, 2000). Similarly, Sami people are used to managing independently for as long as possible and will tend to turn to relatives for help rather than the health care system (Magga, 1998). Rehabilitation is another example of a service that is unfamiliar to the immigrant population (Hyttinen and Tikkanen, 1997). Since older immigrants often need both social and health care services, Pitkänen and Tomperi (1997) emphasise the importance of cooperation between these two sectors. Because older immigrants are unfamiliar with the Finnish welfare system, they are often unable to ask for appropriate help.

Likewise, the Sami find welfare bureaucracy distant, overcomplicated, controlling and rigid and the divisions between different sectors, such as social and health, difficult to accept (Laatu, 1997).
The Sami find it hard to obtain information about services or possible financial help from the system, as well as about their own rights as patients. The main contributory factor is the language problem (Magga, 1998).

Language difficulties

Several studies have stressed the problems that Sami people face when information on services is unavailable in their language. Although most Sami speak Finnish fairly well, they find it difficult to understand formal bureaucratic language. Moreover, apart from difficulties with language, there are differences in values, goals and ways of thinking between Finnish and Sami cultures. The Sami hold authority in great respect, which inhibits them from asking for advice or putting forward their own opinions. At present, institutional care for the Sami means, at its worst, that a person can be forced to give up his/her language and culture and lose contact with his/her community. The staff in institutions do not necessarily speak Sami and no attention is paid to minority cultures (Magga, 1998). In the case of older immigrants, language difficulties not only inhibit the use of social and health services, but also affect life in a range of areas. Because of their lack of language skills and their limited social contacts, older people of immigrant origin are in danger of becoming isolated from Finnish society (see: http://www.intermin.fi/eng/refuge.html; see also Kuusi, 2000).

Although the users of social and health care are legally entitled to be understood and listened to, in practice they are often forced to speak Finnish because officials do not speak the client’s language and interpreters are not available due to a lack of resources. The Act on the Status and Rights of Patients (discussed previously) does not impose an absolute obligation on municipalities to provide interpreters, but states that an interpreter is to be provided where possible, if necessary for an individual’s care. State subsidies are too low to cover the costs of the bilingual services that are needed in the Sami district, for example (Lukkarinen, 2001).

Economic problems

One of the most severe problems for older immigrants is caused by the Act on National Pensions. Anyone 65+ who moves to Finland is not covered by the national pension scheme. In practice, this means that older people from Russia are dependent on social assistance, which they have to apply for every month (see: http://www.mol.fi/migration/inker.pdf). This is a humiliating experience as social assistance is means tested and applicants are required to report all their income and expenditure regularly. In addition, social assistance is granted only for periods of time spent in Finland, which makes it difficult for older people (mostly repatriates) who would like to visit family members in their countries of origin. Time spent abroad is noted by the social services office, where passports are checked regularly for foreign entry stamps (Kuusi, 2000). A bill has been drafted to create a new benefit, similar to the national pension, for older immigrants. The new act will probably come into force in October 2003.
Ignorance of cultural differences

Even though the practice of medicine in Russia is similar to that in Finland, several differences exist. Because the time slots for GP appointments in Finland are so short, Russian-born people have the impression that one can only bring one extremely urgent issue before a Finnish doctor. Distrust of the Finnish or western health care system can also discourage users. In the Soviet Union, most doctors were specialists; hence, many Russians doubt whether GPs (most of the doctors in health centres) can master the whole field of medicine sufficiently. This impression is emphasised when doctors consult a pharmacopeia in the presence of the patient. Distrust and dissatisfaction with the lack of diversity in treatments have led to some Russians returning temporarily to their country of origin for health care. In Finland, it is extremely rare for a doctor to visit a patient at home and many immigrants see this as a great shortcoming of Finnish health care (Toukomaa and Puustinen, 2001).

In the choice of cure, cultural differences also become apparent. In Russia, many doctors use elements of natural cures, but this is not the case in Finland. Russian immigrants often feel that they do not need synthetic drugs or surgical intervention, but that their ailments could be treated more ‘naturally’ (Toukomaa and Puustinen, 2001). This is even more the case with the Sami people, who have traditionally turned to their own healers in cases of illness; even now, healers are more sought after by the Sami than by the majority population. The Sami are, however, generally unwilling to discuss any resort to healers with health care professionals because of the negative attitudes to such practices that they have previously encountered. This has frequently led to a situation in which a patient and his/her family may conceal essential information from doctors and nurses (Snellman, 1995). All of these cultural differences affect minorities’ willingness to use Finnish social and health services. The situation is made worse by the negative attitudes held by some Finnish social and health care professionals (Taavela, 1999).

Conclusion

Since the number of immigrants in Finland is still quite low, little attention has been paid to the special needs of this heterogeneous group, nor has attention been sufficiently focused on the needs of traditional minorities in relation to social and health care. The issue of minorities in the welfare system has been put forward in several reports, but the application of better practice on a wider scale has not yet occurred. Ethnic minority elders are a particularly vulnerable group of people who do not actively demand better services for themselves and whose voices may therefore easily go unheard. However, skilful professionals should take the special needs of these groups into account in their everyday work.
In Finland the system of service provision is the same for everyone; its ideological basis is evidenced in its great emphasis on equality. What is not always understood, however, is that equality cannot be realised in every instance by the use of identical methods, but that an applied approach would sometimes be more effective. Positive examples do exist: in the town of Lappeenranta, a detailed procedure for accessing services has been designed for older immigrants who may elsewhere find themselves deprived of services due to language difficulties. This kind of good practice needs to be disseminated and developed in other parts of the country so that essential services reach all minority ethnic elders.

The application of immigration policy and its guiding principle, integration, are, in practice, mostly directed towards people of working age. This leads to further isolation for older people who already have fewer social contacts and are often less adept at learning the local language. In the area of social and health care, there are certain clear problems for ethnic minority elders. Language difficulties and insufficient knowledge of services are the most common factors inhibiting service use. Cultural differences may be so powerful that repatriates prefer to travel to their countries of origin for treatment instead of using services in Finland. Cultural differences can be further exacerbated in situations where social and health care professionals have negative or prejudiced attitudes towards minorities and therefore do not make any special effort to make the situation easier and less intimidating for the client/patient.

Although little research has been conducted in the field of care for minority ethnic elders in Finland, this report should demonstrate how essential this is and how unavoidable are the issues that the MEC project raises. The information compiled by this research should prove invaluable in directing the attention of social and health care professionals in Finland towards minorities in general and minority ethnic elders in particular.
General context of ethnic minority elders

The history of Hungary has been marked by numerous changes to the size and status of the country, varying levels of hostility and good relations with other nationalities in the ethnically mixed region of the Danube-Carpathian Basin, traumatic episodes of war and population upheavals. Issues affecting minorities go back well before the 20th century and are closely linked to the fact that, since the establishment of Hungary’s present borders in 1920, far more Hungarians live as minorities in neighbouring countries (3.3 million) than there are minorities living in Hungary itself. There are Hungarian minorities living in each of the states on its borders – Austria, Slovakia, the Ukraine, Rumania, Yugoslavia, Croatia and Slovenia.

Within Hungary, minorities make up about 10% of the country’s population, but estimates on their size and composition vary considerably, since people are not classified according to national or ethnic background. Since 1993, the Act on Minorities has made a declaration of national identity (out of 13 recognised nationalities) or multiple identity possible, and there has been new vigour in the process of minority self-government, particularly at the local level. But, from the research point of view, the lack of compulsory registration presents difficulties, especially as regards underrepresentation of particular groups, and there is a consequent lack of firm data on which to draw comparisons and plan services.

Census-taking over the past century, for example, has had to rely upon voluntary mother tongue or ethnic identification, and citizens’ hesitation in assuming such identification has understandable historical roots. Up to and including the present, the country’s laws and official practices do not offer sufficient protection against discrimination on the basis of national/ethnic origin; moreover, there is deep-seated antipathy to surrendering personal data to state authorities. This holds true even in cases where certain forms of ethnic monitoring may serve to enhance their rights as minorities (Krizsán, 2001: 157).
### TABLE 1  Age distribution of the Hungarian population (1949–2000) (%)

<table>
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<tbody>
<tr>
<td>0–14</td>
<td>24.9</td>
<td>25.4</td>
<td>21.1</td>
<td>21.9</td>
<td>20.5</td>
<td>17.1</td>
</tr>
<tr>
<td>15–39</td>
<td>38.8</td>
<td>36.8</td>
<td>37.0</td>
<td>35.8</td>
<td>35.5</td>
<td>35.3</td>
</tr>
<tr>
<td>40–59</td>
<td>24.7</td>
<td>24.1</td>
<td>24.8</td>
<td>25.3</td>
<td>25.0</td>
<td>27.9</td>
</tr>
<tr>
<td>60+</td>
<td>11.7</td>
<td>13.8</td>
<td>17.0</td>
<td>17.1</td>
<td>18.9</td>
<td>19.7</td>
</tr>
</tbody>
</table>

Sources: Demographic Data, 1900–80; CSA Demographic Yearbook, 1990, 1992, 2001
It is valuable for Hungary to be part of the MEC project, since in each of the project’s major areas of activity, Hungary has experience to offer and something to gain. Hungary, as a Central European country which is on track to join the European Union (EU) in the near future, can provide an important comparison with existing members of the EU on issues of elderly care in general and minority elderly care in particular. At the same time, there has, until now, been no systematic collection of information on national and ethnic minority elders in Hungary, so the MEC project has clear benefits for the country itself.

Minority issues have become more significant in practically every European country and the MEC project aims to raise awareness – based on empirical evidence – of current strengths and deficits in the care of minority elders. Minorities in Hungary differ significantly in terms of history and sociopolitical status from those in Western Europe and so its experience can raise awareness of minorities that have a long history of living alongside a majority community. Similarly, within Hungary itself, the project can do much to stimulate debate and action in the hitherto rather neglected issue of minority elderly care.

It is hoped that the project will lead to concrete social policy proposals and programmes for the region as a whole and for each participating country. Again, Hungary will have something to offer Europe, especially as regards policies concerning ‘older’, more assimilated minorities. In turn, it will gain ideas for service provision suited to conditions in the 21st century.

**Demographic patterns**

**Age and gender structure**

A salient feature of modern Hungary has been the ‘greying of the population’. The proportion of children has been decreasing, while the elderly population has been gradually increasing, both as a percentage and in absolute numbers. Table 1 shows this trend from 1949–2000.

Within the 60+ age group, there has been a gradual increase in the proportion and actual numbers of the ‘very old’ (i.e. those aged 80+). In 1900, those aged 80+ accounted for 0.5% of the total population whereas, in 1990, they numbered 260,000 or 2.5% of the total population.

A further change over the century has been the increasing proportion of female to male elders. The ratios for the number of women to every 1000 men in the Hungarian population aged 60+ were 1000:1058 in 1900; 1000:1489 in 1980; and 1000:1597 in 2000. The older subgroup of the elderly (those aged 70+) showed this gender gap even more clearly, such that, in 2000, for every 1000 men of this age, there were 1851 women.

Gender differences also emerge strongly when the family status of those aged 60+ is examined. In 2000, of the 760,000 men aged 60+, 75% were married, 16% widowed, 5.5% divorced and 3.5% single. However, of the 1,214,070 women aged 60+, only 35.8% were married, 52.8% widowed, 7.8% divorced and 3.6% single. In the 80+ cohort, the 46% of widowed men contrast strongly with the 87% of women of this age who are widowed.
The ethnic minority population

Several national communities have lived in Hungary since the foundation of the state. The modern ethnic and linguistic composition of the country was established following the twin processes of depopulation and migration during the Ottoman occupation, with mass spontaneous migration and the organised resettlement of people in the 17th and 18th centuries. It was then that the minorities now living in Hungary moved into their present territory, with the exception of the Slovene population on the western border. Towards the end of the 19th century, non-Hungarian nationals living within its borders constituted more than 50% of the total population. Following the revision of the borders after the First World War, this proportion changed significantly. Some 33% of ethnic Hungarians living in the Carpathian Basin (3.3 million people) now live outside the present borders, while the number of minorities living within these borders has declined. Today, minorities make up some 10% of the population. It should be noted at this point that, as a rule, refugees and asylum seekers have not been an aspect of minority issues in Hungary and, thus, will not be dealt with here.

A common feature of most of Hungary’s national and ethnic minorities is that, having lived within the framework of the Hungarian state for centuries, they profess a dual identity; their consciousness of being Hungarian is as strong as their national or ethnic ties. Most left their original homelands and communities before the formation of a standardised written language and, as a consequence, the languages and dialects they use to this day are, in general, archaic linguistic variations.

This lengthy historical coexistence is an important criterion in the definition formulated in the legislation dealing with minorities, namely the 1993 Act LXXVII on the Rights of National and Ethnic Minorities (Chapter 1, Section 1, Subsection [2]). This states that ‘All groups of people who have lived in the territory of the Republic of Hungary for at least one century, who represent a numerical minority in the country’s population, whose members are Hungarian citizens, who are distinguished from the rest of the population by their own languages, cultures, and traditions, who demonstrate a sense of belonging together that is aimed at preserving all of these and at expressing and protecting the interests of their historical communities’ are national and ethnic minorities recognised as constituent components of the state. The Act defines the Bulgarian, Romany, Greek, Croatian, Polish, German, Armenian, Rumanian, Ruthenian, Serb, Slovak, Slovene and Ukrainian ethnic groups as national or ethnic minorities native to Hungary.

Of importance for this study, in the sense that it highlights the difficulties inherent in the underrepresentation of minorities in research and statistics, is the following statement from the Act: ‘It is the individual’s exclusive and inalienable right to take on and declare their affiliation to a national or ethnic group or a minority. Nobody is obliged to proclaim that they belong to a minority group.’

According to the 1990 census, in a population of 10,374,823, a total of 232,751 persons declared a minority affiliation and 137,724 stated that their native language was one of the national or ethnic minority languages.
Estimates by researchers and minority organisations indicate that the true number of national and ethnic minorities is much greater than the census indicates. Individual ethnic groups are reckoned to number anything from a few thousand persons up to almost 500,000.

The difference between the estimated and declared figures is partly due to historical, social and psychological factors related to minority questions in Central Eastern Europe. The figures reflect the emotional and cultural dilemma for many minority individuals of having a dual identity. Many feel themselves to be equally Hungarian and of a minority nationality, but the opportunity to record this was not available in the 1990 census.

To a certain extent, it is possible to track minority affiliation using three questions posed in the 1990 census regarding nationality, mother tongue and spoken language. Minority responses to these three questions allow us to draw some conclusions about ethnic affiliation. We should note that an admission of affiliation to a particular nationality does not directly presuppose an acquaintance with its native language. Mother tongue is generally regarded as meaning the language acquired during childhood and the language generally spoken in the family, yet some sections of the population speaking a minority native language profess Hungarian nationality. Besides these two criteria, additional information can be gleaned by taking into account what other languages, besides the native language, are spoken if the minority language is not commonly taught and internationally used. However, statistics on the latter will include not only minorities who do not ‘declare’ themselves, but also those people of Hungarian nationality who were resettled in, or who fled to, Hungary and who still speak the language of the state in which they used to live. Table 2 overleaf shows the number of national and ethnic minorities, based on data from the 1990 population census, research and other surveys.

Settlement patterns

A characteristic feature of the situation in Hungary is that the ethnic/national groups are scattered geographically throughout the country in some 1500 localities, where generally they are in a minority. A feature of the settlement pattern of the largest minority group, the Roma, is that they are concentrated in the underdeveloped and economically depressed areas of the country. Thus, 56% of Roma live in eastern Hungary, compared to 40% of the country’s total population, and 24.3% live in the northeastern provinces, compared to 12.6% of the total population.

Projections

There are practically no studies in Hungary on projections of minority group populations. The reasons for this are obvious: more than half a century of underrepresentation in censuses and a lack of research on virtually all minority groups except Roma. The only empirically-based forecast concerns this latter group. As a consequence of higher than average birth and mortality rates, the Roma population is relatively young. Conservative forecasts predict that Roma will form 6.5% of the total population by 2015 (Kemény et al., 1996).
### TABLE 2  Estimated size of minority groups (census 1990)

<table>
<thead>
<tr>
<th>Minority Group</th>
<th>Number with minority identity</th>
<th>No. speaking language as mother tongue</th>
<th>Non-mother tongue speakers of minority language</th>
<th>Unofficial population estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Romany</td>
<td>142,683</td>
<td>48,072</td>
<td>22,933</td>
<td>400,000–600,000</td>
</tr>
<tr>
<td>German</td>
<td>30,824</td>
<td>37,511</td>
<td>416,182</td>
<td>200,000–220,000</td>
</tr>
<tr>
<td>Slovak</td>
<td>10,459</td>
<td>12,745</td>
<td>56,107</td>
<td>100,000–110,000</td>
</tr>
<tr>
<td>Croatian</td>
<td>13,570</td>
<td>17,577</td>
<td>18,297</td>
<td>80,000–90,000</td>
</tr>
<tr>
<td>Rumanian</td>
<td>10,740</td>
<td>8730</td>
<td>40,625</td>
<td>25,000</td>
</tr>
<tr>
<td>Serb</td>
<td>2905</td>
<td>2953</td>
<td>13,646</td>
<td>5000</td>
</tr>
<tr>
<td>Slovene/Wend</td>
<td>1930</td>
<td>2627</td>
<td>1566</td>
<td>5000</td>
</tr>
<tr>
<td>Armenian</td>
<td>—</td>
<td>37</td>
<td>48</td>
<td>3500–10,000</td>
</tr>
<tr>
<td>Greek</td>
<td>—</td>
<td>1640</td>
<td>1260</td>
<td>4000–4500</td>
</tr>
<tr>
<td>Bulgarian</td>
<td>—</td>
<td>1370</td>
<td>1665</td>
<td>5000</td>
</tr>
<tr>
<td>Polish</td>
<td>—</td>
<td>3788</td>
<td>5948</td>
<td>10,000</td>
</tr>
<tr>
<td>Ukrainian, Ruthenian</td>
<td>—</td>
<td>674</td>
<td>1192</td>
<td>—</td>
</tr>
<tr>
<td>Ruthenian</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>6000</td>
</tr>
<tr>
<td>Ukrainian</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>2000</td>
</tr>
<tr>
<td>Other*</td>
<td>19,640</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>232,751</td>
<td>137,724</td>
<td>579,469</td>
<td>—</td>
</tr>
</tbody>
</table>

* The two languages were given in the same question in the census;
• Number of persons in the census declaring a minority affiliation not listed in the questionnaire.

### TABLE 3  Economic activity of older Hungarians (1992 and 1998) (%)

<table>
<thead>
<tr>
<th>Economic status</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>55–59</td>
<td>60+</td>
<td>55–59</td>
</tr>
<tr>
<td>Employed</td>
<td>45.0</td>
<td>3.8</td>
</tr>
<tr>
<td>Entrepreneur</td>
<td>4.1</td>
<td>0.8</td>
</tr>
<tr>
<td>Temporarily unemployed</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Unemployed</td>
<td>4.1</td>
<td>0.2</td>
</tr>
<tr>
<td>Pensioner, with some employment</td>
<td>1.8</td>
<td>4.2</td>
</tr>
<tr>
<td>Non-working pensioner</td>
<td>45.0</td>
<td>90.9</td>
</tr>
<tr>
<td>Other inactive</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

Source: Medgyesi et al., 1999
Socioeconomic profile

Employment and income

It is difficult to provide data on employment and income that pertain specifically to minority groups because of the lack of research in this area and the problems associated with classification of minority group status, as discussed above. In the 1960s and 1970s, one in every four or five households was headed by someone who was either on a pension or unemployed; by the 1980s, it was one in three. Since the political changes of 1989, the number of such households has sharply increased; by 1995, the heads of 54% of households were economically inactive and, of these, 6% were unemployed and 44% were pensioners (Ferge, 1999: 38). It should be noted that, until 1996, the pensionable age for women was 55 and for men 60; citizens were then entitled to receive the state pension. From 1996, the pensionable age was raised to 62 for both women and men. A study by Medgyesi et al. (1999) tracks the changes in the economic status of older citizens following the revision of the standard pensionable age, and the data are presented in Tables 3 and 4.

The rapid growth in the number of ‘non-working pensioners’ (45 to 51.6% of men and 67.2 to 80.1% of women in the 55–59 age group) between 1992 and 1998 can be ascribed directly to changes resulting from Hungary’s political and economic transformation. Older people who lost their jobs found it far more difficult than younger people to obtain other work. Those who had the choice tended to opt for early retirement as opposed to the uncertainties of the labour market. Clearly, raising the age of retirement has done nothing to arrest this tendency.

Compared to that of the Hungarian population as a whole, the standard of living of elderly people is low, and significantly so for those who live alone. The average annual income of elderly people in 1998 was 10.5% lower than the estimated average – HUF 348,552 (€ 1394) compared to HUF 389,426 (€ 1558) (Medgyesi et al., 1999: 20). Thus, while the financial situation for Hungary’s elderly people is fairly difficult, it is not markedly worse than for the population as a whole. But, as Ferge (1999: 20) points out, sociologists need to look beyond the statistics because pensioners and elderly people also have to deal with the fact of their devalued status within society and their lack of confidence in a better future or any hope for improvement. The growing impoverishment of the elderly can also be traced to socioeconomic trends such as the sharp decrease in legally obtainable work for pensioners, which affects those aged 60–69 most directly.

Income is, therefore, mostly confined to state benefits. Of the elderly, 60% obtain 90% of their income from state welfare pensions – the old age pension, widows’ pension, disability pension – and means-tested assistance. For the elderly population as a whole, it is calculated that around 80% of their income is from state benefits and about 10.8% from salaries. Income from investments and fixed capital is comparatively small; 8.6% of their total income. The real value of the old age pension has declined steadily over the past few years, by about 16–17% since 1986. However, this decline is by no means as drastic as it might have been given the performance of the economy generally.
Housing

The quality of housing has improved steadily over the past few decades and the full range of amenities, including central heating, flushing toilets, running water and telephones, was available in 54.7% of all dwellings in 1998. The availability of these amenities does not differ greatly between pensioners and other citizens; the main item lacking is access to a telephone (Medgyesi et al., 1999).

More data exist on the Roma in relation to their housing conditions. A particular trend in rural areas is that Roma move into properties of extremely low value in small villages (under 1000 inhabitants), often after the villages have been abandoned by their original (non-Roma) owners. In such settlements, there is an accumulation of disadvantage resulting from the lack of inherited cultural traditions, the lack of education or qualifications among the new inhabitants and geographical isolation. There are clear differences between the Roma and other sections of the Hungarian population in the standard of housing. Whereas 15.7% of the Hungarian population live in dwellings without modern amenities, about 60% of Roma live in such dwellings. Lack of access to a flushing toilet and running water distinguishes the housing conditions of Roma from those of the population as a whole (Havlicsek, 1999).

Health

According to the 1990 census, at least 31.5% of those who were aged 70+ had ‘mild health problems’; 40% had some form of chronic illness; and 25.9% had one or more life threatening diseases (Central Statistical Authority, CSA). Diseases of the circulatory system and cancers are the most common life threatening conditions. More than 70% of the country’s mortality is caused by circulatory disease, cancer and liver disease. According to the figures for 1999, men’s life expectancy is 66.3 years and women’s 75.1 years – both somewhat below EU averages (Institute for Medical Research, 2001: 2–9). Very little information exists on social and health care variables and on conditions that affect minority elders in particular. However, as a result of a number of developments over the past decade affecting Hungary’s minorities, there is an opportunity for this to begin to change. In 1990, the Office for National and Ethnic Minorities was established and the right to ‘minority self-government’ was introduced at both local and national levels.
Service providers

Health and social care providers

Mainstream (statutory)

Until the late 1980s, service provision for Hungarian elders was, like all areas of social care, synonymous with state, and hence centrally planned, poverty relief. By far the most important forms of care were the health services provided by the state system and state financial aid (pensions, means-tested assistance and help ‘in kind’). Compared to the countries of Western Europe, other forms of social provision, such as nursing homes, day care centres and hospices, were few and far between. However, the guaranteed provision of housing should also be regarded as a form of social service, since, in effect, it means that all Hungarian elders, regardless of their previous employment history or financial situation, can at least count on having a home.

A number of innovations were introduced towards the end of the 1980s. In some areas, transitional care arrangements were set up to provide a vital link between residential and non-residential services. However, these positive developments were brought to an abrupt halt as a consequence of the social and political changes that took place from 1989–90.

In 1986, regional care centres were established with the task, among others, of coordinating the different services. In assessing the work of such centres, reference has consistently been made to the particular burden imposed by home care needs. Factors that are regarded as important include:

- the growing numbers of ‘younger’ senior citizens
- the lack of different types of residential services
- problems with the quality and availability of means to promote home living
- lack of preventive and rehabilitation services
- the almost complete lack of home-based nursing for seriously or chronically ill elders.

In the wake of the powerful decentralising process that took shape after 1990, direct social service provision came under the auspices of local authorities. Under it, the state delegated the task of dealing with social problems to the lowest tier of government. Its independence is enshrined in the 1993 Local Government Act (Act 52) which guarantees that the functioning of local authorities be separated from the workings of central government.

Non-government (civil society)

Civil society and non-governmental organisations (NGOs) expanded massively in the 1990s. By 1997, there were over 50,000 registered associations and foundations. Such organisations generally provide a variety of services; they also attempt to create connections between the different parts of the social service network so as to improve the quality of life of those who receive support. In this way, civic organisations have begun to introduce services that were previously unknown in Hungary, but that are widespread in the EU.
Generally, they provide most support for people at both ends of the age spectrum: children/young people and the elderly. As these are the groups that are most likely to be disadvantaged and exposed to a variety of risk factors, this is not surprising. Many people also look towards non-profit-making organisations to help meet their social, cultural and other needs. In brief, the NGO sector has a clear role in developing innovation in service provision and in improving networking between service providers (Széman and Utasi, 1996).

### Types of service

Under the 1993 Social Services Act, the statutory services available to elders include:

- **Financial aid.** This is of two kinds: statutory; that is, the old age pension, widows’ pension and disability pension; and, depending on the situation, a non-contributory top-up payment which is means tested.
- **Aid ‘in kind’.** This is means-tested assistance for meeting basic living expenses.
- **Personal aid.** This consists of residential care (old people’s homes, nursing homes) and home-based services (nursing care, meals-on-wheels). It also includes the establishment of seniors’ clubs which offer recreational and day care services.

The special attention paid by NGOs to the situation of pensioners is important because they form a large and growing proportion of the population and are steadily becoming impoverished. As a result, there is a substantial need for various forms of social assistance, health care and specialist technical support, both among younger people on disability pensions and among old age pensioners. Earlier surveys found that 15% of elders felt the need for technical and specialist aid (Széman, 1996).

### Patterns of service usage

A decade after the changes to service provision that followed the political changes, it is clear that such provision still does not respond adequately to the expressed needs of elderly people or those uncovered by research.

In 1999, out of every 100 citizens aged 60+,

- 2 received home care services
- 5 received hot meals at home
- 2 visited senior citizens’ clubs
- 1.8 were in general residential care
- 0.5 were in residential facilities for people with disabilities, and
- 0.1 were in some form of temporary or emergency residence (KSH, 2000: 24).

About 50% of Hungarian settlements or municipalities have no home care services and 30% make no provision for a meals service (SZCSM, 2001). Improvement in the quality of services, for example, significant levels of home care, development of voluntary services, and so on, is as relevant today as it was before 1990. At the same time, the slow development of a social service infrastructure should be blamed not only on funding difficulties, but also on the major professional challenges encountered on the ground.
There has, for example, been a reluctance on the part of many victims of forced repatriation and the holocaust to identify themselves as such. Moreover, the use of mother tongues (other than Hungarian) has not featured in the provision of health and social services, especially to elders. There is no specific data on patterns of service use by minority elders for the reasons discussed earlier.

Barriers to service access

Specific research is lacking in this area. As regards means-tested assistance, practices are inconsistent between the various local authorities and, in respect of the Roma, there has also been discrimination. As for residential care, attitudes are extremely negative towards placing elderly family members in institutions, especially in rural areas.

Legal context

The programmes of successive democratically elected Hungarian governments since 1990 all suggest that the country now pays particular attention to the assertion of national and ethnic minority rights, that it values its cultural variety, which dates back centuries, and that it considers the presence of minorities and the preservation of their languages, traditions and cultures to be important elements of national social and cultural life. Over the last decade, the consistent aim of domestic minority policy, based on consensus, has been to establish a hospitable environment for national and ethnic minorities in which they can preserve and pass on their cultural identities and live freely, with their rights enshrined in law.

The Office for National and Ethnic Minorities (ONEM), established in 1990, is responsible for coordinating the implementation of the government’s objectives. ONEM is an independent state administrative body with national authority, operating under the auspices of the Ministry of Justice. It continually assesses the situation of national and ethnic minorities and the assertion of their rights. It prepares, analyses and drafts papers on minority policy which the government can use as a basis for resolutions on minority affairs. It is also charged with facilitating the exchange of views and information between the government and minority organisations.

ONEM is involved in the following:

- drafting government programmes enabling implementation of the Act on Minorities
- providing the necessary coordination in light of any modifications to the Act
- monitoring the implementation of tasks and duties undertaken by state administrative bodies in relation to minorities, and
- participating in the coordination of such activities.

Before 1993, minorities’ public roles were undertaken by various organisations of civil society. However, the Act on the Rights of National and Ethnic Minorities lays down the right of minorities to establish their own local and national ‘self-governments’ within the overall framework of government.
Minority self-governments are elected bodies that represent the interests of the given minority at both local and national levels. Local minority self-governments, unlike organisations operating in an associative form, represent not only their membership, but also the entire minority community of a settlement or municipality. Minority self-governments were established to guarantee cultural autonomy. As such, they have rights enshrined in law allowing them to make decisions in their own spheres of authority on the foundation, taking over and maintenance of institutions, particularly in the areas of local education, local printed and electronic media and the fostering of traditions and culture.

Voting for minority self-governments takes place at the same time as the municipal elections. During the elections, every voter in a given settlement may cast his/her vote for candidates of the particular minority. Proof of the growing success and strengthening of the minority self-government system is shown in the following: during the elections of 1994 and 1995, 822 minority self-governments were formed but, following the 1998 elections, 1367 local and nine Budapest-based minority self-governments were formed. The greatest growth was in the number of Roma minority self-governments, but the number of German, Slovak and Croatian minority self-governments also increased significantly. As a result of the elections, the Roma formed 768 self-governments; German communities elected 272; Slovaks 76; Croatians 75; Serbs 35; Poles 33; Rumanians 33; Armenians 25; Greeks 19; Bulgarians 15; Ruthenians 10; Slovenes 10; and Ukrainians five.

Among the various forms of minority self-government, it is worth looking more closely at those that are simultaneously settlement or municipal governments and also minority self-governments. The status of ‘minority settlement self-government’ confers the same rights as regional autonomy and opens the way to realising, in the most effective way, the interests of minorities. While there were 46 minority settlement self-governments under the former parliamentary term, 63 such bodies were established out of the 1367 local minority self-governments following the October 1998 elections. The German and Croatian minorities availed themselves most fully of this opportunity.

Minority self-governments may decide on the monuments and memorial sites to be protected and the dates of local and national holidays. They have the right to establish and run cultural and educational institutions such as schools, museums and theatres. They are entitled to determine independently their own organisational and operational regulations. Local minority self-governments have a right to veto proposals made by the municipal government on cultural, educational or linguistic matters related to the given minority. They also hold a veto over the appointment of directors of minority institutions.

National minority self-governments represent their particular minority at national level. National self-governments are formed on the basis of electoral assemblies, following the formation of local minority self-governments. All 13 minorities in Hungary established their own national self-governmental structures in 1999. The national minority self-governments, as partners
in legislation and state administration, present their views on planned regulations and legislation concerning those they represent. The law grants them the right to monitor minority education as well as participate in developing curriculum materials used in minority education.

Quality of life issues

Some comparisons between the three minority groups selected for the MEC project may serve to highlight quality of life issues affecting the elderly. The Roma form the largest minority group in Hungary and, as a result of relatively extensive social research, also the minority about which most data exist. Roma started to settle in the Hungarian kingdom from the 15th century when it covered most of the Carpathian Basin. The generally calm but distrustful relationship between Roma and the majority community since then has been punctuated by episodes of harassment, forced assimilation and open repression. With the exception of the Jews (who are not classified as a minority group), Roma are in a unique position among Hungary’s minorities in their exposure to racism and racist prejudice. At the present time and in spite of constitutional prohibition, Roma constantly experience discrimination in many areas of public life ranging from education and the world of work to the practices of central and local government bureaucracy. Hostile statements on the Roma are openly made in public speeches and private conversation.

The family status of Roma citizens reveals notable differences when compared with the non-Roma sections of the population. The proportion of married couples, divorcees and widowed people is below the national average, while the proportion of de facto marriages or cohabitation is significantly higher. There are clear normative and cultural reasons for the high frequency of such partnerships and, according to census data, as many as 40% of Roma in the 14–29 age group are in de facto marriages. Of all the minority groups, the Roma tend to be the most endogamous, with 84–89% of marriages taking place within the same group. In sharp contrast to the national trend, there are more men than women within the Roma population.

There has been a gradual improvement in the rates of basic education among the Roma. While, in 1971, only 26% of those aged between 20 and 29 years had completed eight years of schooling, by 1993 this had increased to 77%. This means, however, that Roma elders have low levels of education and high levels of illiteracy. Until the 1940s, Roma were concentrated in the peasant and craft sectors of the labour market and were indeed recognised experts in non-industrial crafts such as woodwork, metalwork and music. Between 1949–89, the socialist period in Hungary, the Roma were generally excluded from land distribution programmes, since land was given to those who had already worked in agriculture. Instead they were encouraged to work in the rapidly expanding industrial and construction sectors, leading to their urbanisation – a process hitherto unfamiliar to them. Nevertheless, in 1971, for example, there was practically no difference between the levels of employment among Roma and non-Roma men; 87% of men in the total population were employed compared with 85% of Roma men.
In the years since the downfall of the socialist system, many Roma have lost the basis for their low but secure living standards. By the end of 1993, whereas 64% of men in the total population aged 15–59 were employed, the same was true of only 29% of Roma men. Among women, the differences were even more striking; 66% of women in the overall population aged 15–59 were employed, but only 15% of Roma women in this age group. Significant numbers of Roma are thus classified as ‘economically inactive’ (which may include working in the informal/black economy) or ‘unemployed’. In some rural settlements, more than 90% of Roma are unemployed and, countrywide, in more than 50% of Roma households, there is not a single person earning an income in the formal economy (Kemény et al., 1996). This has resulted in Roma families becoming significantly dependent on social aid and welfare.

A host of factors combine to influence negatively the state of health of large numbers of Roma: poor housing, lack of hygiene facilities, overcrowding, hard physical labour and the impact of prejudice and deprivation on mental health. The proportion of suicides, occupational injury and alcohol addiction is above the average for the country. Patterns of communication between health service providers and patients are marked by false interpretations on the part of both parties and a deepening sense of mistrust. The lack of take-up among elderly Roma citizens of the services provided by local authorities is, among other things, the consequence of mistrust, inadequate communication and prejudice on the part of non-Roma service providers (Orsós, 1999). An increase in the numbers of Roma service providers has been suggested as one of the necessary steps to deal with this, in addition to culture-sensitive, anti-discriminatory training for non-Roma. On the whole, there is a huge gap in data about Roma elders, most particularly on how the wider community’s prejudice affects the health, social needs and service requirements of elderly Roma.

Germans form the second largest minority group in Hungary, their numbers unofficially estimated at up to 220,000 people, the vast majority of whom profess dual nationality. The experiences of this group are useful to examine in this study because, since 1995, the German community, with the support of the German government, has been organising culture-sensitive services for elders, among others. There are, for example, now a number of old people’s homes that, while not specifically German institutions, nevertheless operate in municipalities with a large German minority. These and other initiatives from the German community could provide good examples of the potential for minority-sensitive services for the elderly in Hungary as a whole.

Germans were settled in Hungary from the 18th century onwards under repopulation measures taken following population upheavals during the period of Turkish domination. By the early part of the 19th century, they could be found in higher proportions than other nationalities in sectors such as industry, mining, commerce and skilled crafts. Partly as a consequence of the reaction against Habsburg (Austrian) domination, well-off German burgers in cities and towns across Hungary rapidly assimilated into Hungarian culture from the mid-1800s, leaving behind German language and culture to flourish mainly in the many rural settlements. This situation came to an abrupt end, however, after the Second World War, when, as a form of ‘collective punishment’, about 50% of the German minority were repatriated to Germany and Austria.
Since then, the disintegration of small village communities, urbanisation, industrialisation and the consequences of education policy have resulted in the primacy of Hungarian at all levels of communication.

For the past decade, however, Germans have been among the first to take advantage of the new political and cultural climate regarding minorities. A total of 272 German minority self-governments were elected in municipalities throughout the country in 1998, and the German national body has 53 members. It is likely that, in future censuses, the number of citizens declaring German mother tongue affiliation (37,511 in 1990) and German ethnic identification (30,824 in 1990) will increase. On the basis of the 1990 figures, the German community is a rapidly ageing one, with the proportion of children having decreased from 24% to 7% since 1940 and those aged 60+ having increased from 14% to 44%. Of all the minority groups, the Germans have the highest proportion of widows and married couples and the lowest percentage of divorcees. This also helps to explain why 60% of Germans professing mother tongue affiliation are women.

Of the German minority, 88% live in their own homes or in homes owned by relatives – a higher level than the national average. Living conditions are similar to, or slightly above, the national average, with more Germans having access to flushing toilets and running water. The German minority comes second among all minorities for its schooling levels – 28% of those aged 18+ have finished high school and 11% of those aged 25+ have tertiary-level qualifications. Of those gainfully employed, a high proportion works in the health, social and cultural services sectors, and there is also evidence of a higher than average number in the professions. Most salient, however, is the fact that of those who professed German mother tongue affiliation in the 1990 census, 44% were aged 60+ and many of these would not be in active employment. There are currently no statistics on the health status of the German community, but research is being carried out (Széman, 1996; Váradi, 2000).

Croatians have settled in Hungary in small numbers at various times as far back as the 11th century, but (like the Germans) particularly under the repopulation measures of the 18th century. About seven or eight cultural groupings can be found among the Croatians presently living in Hungary and each maintains its own dialect, folk traditions and cultural legacy. Census figures since 1900 show a steady decline in the number of people classifying themselves as mother tongue Croatian; 68,161 in 1900; 37,885 in 1940; and 17,577 in 1990. Even fewer classify themselves as Croatian by ethnicity – 13,570 in 1990 (KSH, 1995). Of this number, those aged 60+ had, by 1990, increased to more than 30%. There is a high percentage of widows among the Croatian community, especially middle-aged widows (8.1% are aged 40–59). Compared to the national average, a larger proportion of those aged 60+ live with their families.

Most Croatians live in southwest Hungary – 83% in the four counties of Baranya, Zala, Vas and Győr–Moson–Sopron. In a small number of settlements, they constitute between 40–70% of the inhabitants. Most Croatians live in homes they own themselves (36%) or in the homes of relatives (57%). As regards their access to modern amenities, they conform to national trends.
### TABLE 5  Pensions spending (1990–97)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of people receiving pensions</th>
<th>Total pensions spending (HUF blns)</th>
<th>Total pensions spending in real terms (HUF blns)</th>
<th>Share of GDP (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>2,556,000</td>
<td>202.1</td>
<td>202.0</td>
<td>9.7</td>
</tr>
<tr>
<td>1995</td>
<td>3,027,000</td>
<td>582.2</td>
<td>186.0</td>
<td>10.4</td>
</tr>
<tr>
<td>1996</td>
<td>3,082,000</td>
<td>669.8</td>
<td>173.0</td>
<td>9.7</td>
</tr>
<tr>
<td>1997</td>
<td>3,123,000</td>
<td>804.8</td>
<td>176.0</td>
<td>9.4</td>
</tr>
</tbody>
</table>

*1990 = 100

Note: Inflation accounts for the decline in real income despite growth in absolute terms

Source: CSA Yearbook, 1997
Education levels are below those of the population as a whole: 17–18% have completed high school (compared to the national figure of 29%) and 5–6% of those aged 25+ have tertiary-level qualifications (compared to 10.1% for the country as a whole; KSH, 1995). Among Croatians of school age, however, there is a high rate of age-appropriate schooling – higher indeed than the national average – which indicates that it is older Croatians whose schooling levels are particularly low.

A larger percentage of Croatians work in agriculture than the national average and fewer work in industry and construction. According to the 1990 census figures, about 42% are in active employment, roughly on a par with national figures. Nothing specific is known about the health conditions of the Croatian minority but, from the information available, it would seem that the health problems of Croatian elders do not differ greatly from those of elders in Hungary in general.

**Funding of services**

The number of pensioners has increased by 22% in the seven years from 1992–98 and funds to meet this increase have hardly kept pace. While the absolute amount spent on pensions has grown by a factor of four, this has meant a 20% reduction in real terms in outlay (Ferge, 1999: 36–7). Table 5 presents the statistics on pensions spending from 1990–97.

As noted previously, all statutory services other than pensions have been delegated to local government level. In principle, local authorities can draw on a number of funding sources:

- per capita grants from central government, based on number and composition of inhabitants
- rebates on pay-as-you-earn taxation
- municipal taxes
- other sources such as from the sale of fixed property
- funds obtained through specific project applications.

In practice, however, most local authorities only have regular access to income from the first two sources listed. It has been a particularly difficult period for at least 1000 local authorities – about one-third of the total – which have an ageing population. What is more, it was only in 1993 that the legal framework for compulsory social service provision by local governments was established under the 1993 Social Services Act. This meant that, between 1990 and 1993, in the absence of guidelines, most local governments tended to use social service funds for other additional purposes or simply tried to keep social service provision at a basic level. Only a few local authorities had the prescience to improve their standards of social care.

Funding of the NGO sector is in a state of constant flux. The growth of this sector was marked by a number of contradictions in its relationship to the state. In the first half of the 1990s, the regulations governing NGOs were constantly being tightened up, while the proportion of state funding was around 20–22% below that found elsewhere in Western Europe.
A primary source of funds for such organisations has thus tended to be foreign aid. The real significance of foreign aid lies in its model-building potential and its capacity to promote innovative activities. The support given to the Hungarian civil society sector from abroad has helped to alleviate the deteriorating situation of certain social groups.

Conclusion

Among the demographic processes relevant to Hungarian society, the most well known is that, for a number of decades, there has been a steady increase in the growth of the elderly population in both relative and absolute terms. While the most obvious trend in the ‘greying of the population’ is the relative preponderance of elders within the population as a whole, it would be a mistake to overlook the actual numbers in the elderly population and its growth in absolute terms. After all, calculations and planning concerning the need for such services depend directly upon the size of the population to be served. They also need to take into account its various characteristics. Among these characteristics is ethnic minority affiliation, which we believe it is necessary to take into account when considering the special needs of elders who, in one form or another, belong to Hungary’s national or ethnic minorities.

It would be like repaying an old debt if the country henceforth did something concrete for its minority elders. A first step would be to recognise that there are differences among senior citizens and, through empirical investigation, to describe their special needs more precisely. Services could then be planned and organised to meet their needs more accurately. Until now, however, little has been done in this regard. There are many gaps in data, and sociological research has not focused on this area. The needs of citizens of minority groups are likely to differ in important respects from those of the majority of the country’s elderly. While this may be partly a matter of qualitative assessment, the statistics to hand – deficient as they are in accuracy – also point to some of the following factors.

Low percentage of elderly among the Roma

Even to those who are familiar with the fact that the mortality rate for Roma is higher than the national average, it is nevertheless a shock to encounter the real figures. According to the 1990 census, those aged 60+ declaring Roma as their mother tongue or ethnic identity represented only 4.3% and 5.1% of the Roma population respectively. The CSA data for 1993 are hardly less shocking; 8.6% aged 60+ compared to the national average of 18.9% in the 1990 census. Again, in 1990, of those who classify themselves as mother tongue Germans, the percentage of those aged 60+ has increased to 44% and for ethnic Germans to 28%. For Croatians, the figure is between 32 and 34%. There are thus clear differences between the percentages of elders among the various population groups in Hungary and it is important to obtain a better understanding of the reasons for this.
Family status

From the point of view of minority groups, it is perhaps more interesting to consider data that reflect family status. Of the groups, Roma tend to be the most endogamous, with an 84–89% marriage rate within the same ethnic group. In contrast, almost half (49%) of German minority women have partners from outside their group. After Roma, Croatians have the highest percentage of endogamous marriages. The rate of marriage among Roma is lower than for the other groups, but the percentage of cohabitation or ‘common-law’ marriages is very high. The proportion of widows is half the national average. The Germans are first among the minorities in terms of marriage rates and they also have a very low rate of divorce. The family status of Croatians is marked by a large percentage of married people, younger married couples and, of all the minority groups, the highest proportion of widows, especially middle-aged widows. Common-law or de facto marriages are extremely rare, forming only 2% of all partnerships.

Housing conditions

According to the statistics, differences can be seen in the housing conditions of the various groups. While the Roma live in conditions often well below standards for the country as a whole, the Croatians are roughly in line with the national average and the Germans somewhat above national standards.

However, much as statistics can assist in drawing comparisons like those above, they do not convey a sense of what an elder who identifies as Roma, German or Croatian actually feels. They provide little indication of the concerns and thoughts of such people who know, for example, that they have little opportunity to use their mother tongue to express their deepest thoughts. Nevertheless, the statistics are useful in that they draw our attention to deeper trends and indicate the type of research that still needs to be carried out.
General context of ethnic minorities in Bosnia and Herzegovina

Since medieval times, Bosnia, subsequently known as Bosnia and Herzegovina (BH), has been one of the largest and most complex multiethnic societies in Europe. In the words of an old Yugoslav proverb, Bosnia’s history consists of: ‘Five nations, four languages, three religions, two alphabets, but only one desire – independence’ (Eller, 1999: 243).

There are historical records for two major ethnic groups of non-Slav origin that settled in Bosnia in medieval times and retained their cultural distinctiveness: the Jews and the Gypsies. Some would add a third ethnic group, termed by the Slavs Vlachs or Vlassi (Aromanians), a clear reference to their Latin-derived language and not to be confused with Serbs, Gypsies or any other ethnic group. Since the beginning of Austro-Hungarian rule (1878), many other ethnic minorities have become part of the ethnic mix of historic Bosnia, including Hungarians, Czechs, Turks, Greeks and some 25 other groups, but their history is poorly documented.

According to the last federal census (1991), BH had 4,377,033 inhabitants and the ethnic population structure was: Bosnian Muslims (now officially called Bosniaks) 1.9 million (43.5%); Serbs 1.4 million (31.2%); Croats 760,852 (17.4%); Yugoslavs 242,682 (5.6%); others 100,671 (2.3%), including the ethnically undeclared and those of unknown affiliation as well (Federal Office of Statistics, 2001).

There are several fundamental issues, however, which a researcher has to take into account in studying ‘ethnic minorities’ in present-day BH. First, BH was one of the six republics of the Socialist Federal Republic of Yugoslavia (SFRY) created after the Second World War. In April 1992, BH proclaimed its independence. This ushered in a period of bitter warfare (1992–96). The signing of the Dayton Agreement in December 1995 marked the end of the war and established a basis for peace and reconciliation as far as military conflicts between the three major constituent peoples (Serbs, Bosniaks and Croats) were concerned. As at 2002, the Republic of BH consists of two entities: the Federation of BH, with ethnic majority populations of Bosniaks and Croats, which controls 51% of the total territory; and the Republika Srpska (RS), dominated by Serbs, which controls 49% of the pre-war territory of the Republic of BH.
Each of these entities has its own Constitution. The difference between these Constitutions is remarkable, as if they were written for two different nation states. Thus, any discussion of BH needs to specify which part, or ‘entity’, is referred to – the Federation or the RS.

Second, as in the former SFRY, none of the successor states do more than list their recognised national groups. These lists are fairly arbitrary and almost always leave some groups outside the framework of minority protection. Worse than in Croatia or Slovenia, neither of the two Constitutions of BH provides any specific list of ‘recognised minorities’ beyond listing the three constituent national groups (Bosniaks, Serbs, Croats), but lumps them all together as ‘others’.

Third, BH is the only European country which has not held, and probably will not hold, a new population census for another ten years (Simic, 2001). The official explanation is that the country has no economic resources to pay for this, but many other reasons may lie behind the situation. Consequently, there is no accurate information available on the current demographic structure of the population, let alone essential household statistics and estimates of mortality and morbidity for specific ethnic groups, whether majority or minority groups.

Last, but not least, to understand the general context of minority elderly care in present-day BH, special attention must be paid to the emergence of the ‘new’ minorities created by the war (1992–95). Specifically, what ‘ethnic cleansing’ meant in this war boils down to the one million ‘newly created ethnic minorities’ who once lived in territories now seized by another majority national group (i.e. those other than their ‘own’ constituent peoples). Now Serbs living in the Federation are a ‘minority’, as are Bosniaks and Croats living in RS. The final outcome of the mutual ethnic cleansing between Bosniaks, Serbs and Croats was the dramatic redrawing of the entire ethnic map of pre-war BH. According to UNHCR sources, some 1.2 million refugees fled abroad as a result of the conflict, mainly to countries of the former Yugoslavia and Western Europe (UNHCR, 1999). In addition, 1.3 million people were internally displaced. Altogether, nearly 60% of the total population was affected by the conflict. Moreover, of the estimated refugees who returned to BH from abroad between 1996 and September 2001, only 28% of them have been able to return to their pre-war homes (UNHCR, 2001c).
Demographic patterns

Age structure

According to updated official statistics released to the MEC project, the age structure of the pre-war population of BH was as shown in Table 1 overleaf.

UNHCR local estimates indicate that elders currently constitute about 11% of the population, as opposed to 6.5% in 1991. This would suggest that the elderly population has increased by some 4.5% as a percentage of the total population, mostly because of the different rates of emigration among younger age groups during and after the war. Even so, the population of BH is still not part of the cluster of populations in Europe with the highest percentage of elders (Lang, 2001).

Ethnic minorities

Ethnic groups, other than the constituent peoples of the former Yugoslavia, were relatively small in size even in the pre-war population of BH, and their size became even smaller during and after the war. According to the 1991 census, Roma (as the largest minority) numbered just under 9000 (0.2%) in the pre-war population; Albanians nearly 5000 (0.1%); and Ukrainians just below 4000 (0.1%) (the next two largest minority groups). Hungarians, Czechs, Italians, Poles, Germans, Jews and a dozen other minority groups, all fewer than 1000 members in absolute size, made altogether only 0.5% of the total population of 4.4 million (Federal Office of Statistics, 2001: 51, Table 4.6).

As far as the post-war situation is concerned, one of the recent Helsinki Committee for Human Rights in Bosnia and Herzegovina reports (1999) maintains that, out of the 25 or so minorities present in BH before the war, only a few have remained since: ‘Local witnesses appearing before the Committee claimed that only Roma (ca. 6000) and Jews remained out of minority groups in Bosnia and Herzegovina’ (1999: 1). The decrease in the size of a great many minorities is certainly true, however, the above-quoted estimate of the Helsinki Committee must be biased. According to recent estimates made for MEC, many ethnic minority groups other than Roma and Jews still live in BH, including Albanians, Slovenians, Hungarians and Czechs, among others. Their numbers must, however, be lower compared to the pre-war situation and they probably comprise mainly elderly people who had to stay simply because they had neither the chance nor the ability to leave. In Sarajevo alone, for instance, the Association of Hungarians (an NGO) still counts nearly 400 members in 2002. The Czech organisation Ceska Beseda is about the same size.
<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Number of females</th>
<th>%</th>
<th>Number of males</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–14</td>
<td>500,936</td>
<td>22.8</td>
<td>526,455</td>
<td>24.8</td>
</tr>
<tr>
<td>15–24</td>
<td>345,983</td>
<td>15.8</td>
<td>374,016</td>
<td>17.8</td>
</tr>
<tr>
<td>25–34</td>
<td>352,946</td>
<td>16.1</td>
<td>380,684</td>
<td>17.4</td>
</tr>
<tr>
<td>35–44</td>
<td>299,524</td>
<td>13.6</td>
<td>311,457</td>
<td>14.3</td>
</tr>
<tr>
<td>45–54</td>
<td>234,174</td>
<td>10.7</td>
<td>224,373</td>
<td>10.3</td>
</tr>
<tr>
<td>55–64</td>
<td>229,815</td>
<td>10.5</td>
<td>209,843</td>
<td>8.6</td>
</tr>
<tr>
<td>65–74</td>
<td>116,679</td>
<td>5.3</td>
<td>70,995</td>
<td>3.3</td>
</tr>
<tr>
<td>75–84</td>
<td>59,434</td>
<td>2.7</td>
<td>37,257</td>
<td>1.3</td>
</tr>
<tr>
<td>85+</td>
<td>53,747</td>
<td>2.5</td>
<td>48,715</td>
<td>2.2</td>
</tr>
<tr>
<td>Total</td>
<td>2,193,238</td>
<td></td>
<td>2,183,795</td>
<td></td>
</tr>
</tbody>
</table>

Settlement patterns

In medieval times, a typical settlement pattern in Bosnian society was a scattered one (i.e. dispersed into smaller-sized villages that were ethnically homogeneous – ‘Serb villages’ or ‘Muslim villages’). Also characteristic were the medium-sized towns, traditionally ethnically mixed, which were, however, divided into ‘ethnic quarters’ (for example, the ‘Muslim’ and ‘Serb’ quarters of Sarajevo, or ‘Muslim’ and ‘Croat’ sides of the Neretva river in Mostar). One group would often predominate. Historic ethnic minorities, such as Roma, Jews and Hungarians, always gravitated towards urban settings, since these were important trade and cultural centres. The major urban settlements have always been: Sarajevo (the historic capital of Bosnia), Tuzla and Bihac (dominated by Bosniaks), Banja Luka and Doboj (dominated by Serbs), Mostar and Livno (dominated by Croats). These traditional Bosnian urban settlements were perhaps the first prototypes of a multiethnic society (Malcolm, 1996).

Regarding current settlement patterns, no reliable statistical information exists on this matter. However, it is generally known that BH was, until the outbreak of the recent war, one of the fastest urbanising societies in the Balkan region (see, for example, Euphin-East Network, 1999/2000). In 1980, some 36% of the population was urban. By 1991, this figure had risen to 62%, only to drop back to 42% in 1997. That the balance has shifted back to the predominantly rural society of some 20 years ago is probably due to the military destruction of a great many major cities such as Sarajevo and Mostar, on the one hand, and, related to that, to the emigration and displacement of mainly urban people, on the other hand.

At present, both MEC research and other sources suggest that the settlement patterns and housing conditions are as chaotic for indigenous ethnic minority groups as for the ‘newly created’ minorities on the ethnogeographic map of BH. This is particularly true of the Roma population, as evidenced by numerous human rights reports (Roma Rights, 2000).

Share of elderly (65+) in the total population (estimated and predicted)

As pointed out earlier, BH is probably the only European country that did not carry out a census of its population as expected for the year 2001. Consequently, this creates difficulties in making any accurate estimates and predictions for the changing patterns of its demographic composition during and after the war. Official statistics would suggest that the share of 0–14 year olds in the total population is currently 23%, 15–59 year olds constitute 65% of the population, and the share of elders aged 60+ amounts to 11% (Fact Sheet of the BH Embassy to US, 2002). However, this must be rather an impressionistic estimate, since no exact figures are available on either this or other demographic features of the BH population; that is, other than statistics drawn from the last federal census of 1991.

According to the last three federal censuses, the share of the elders (aged 65+) in the 1971 census was 4.7%; in the 1981 census, 6.1%; and, in the 1991 census, 6.5%, which makes, on average, a quotient of some 0.28% annual growth rate of elders in the pre-war population of BH.
### Table 2: Actual and predicted proportion of elders (aged 65+) in the total population

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Estimated</th>
<th>Predicted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>3,746,111</td>
<td>4,124,256</td>
<td>4,377,033</td>
</tr>
<tr>
<td>Male</td>
<td>1,834,600</td>
<td>2,050,913</td>
<td>2,183,795</td>
</tr>
<tr>
<td>Female</td>
<td>1,911,511</td>
<td>2,073,343</td>
<td>2,193,238</td>
</tr>
<tr>
<td>Male 65+</td>
<td>76,892</td>
<td>105,966</td>
<td>110,252</td>
</tr>
<tr>
<td>Female 65+</td>
<td>99,451</td>
<td>144,400</td>
<td>176,113</td>
</tr>
<tr>
<td>Total 65+</td>
<td>176,343</td>
<td>250,366</td>
<td>284,365</td>
</tr>
<tr>
<td>Male 65+ (%)</td>
<td>4.2</td>
<td>5.2</td>
<td>5.0</td>
</tr>
<tr>
<td>Female 65+ (%)</td>
<td>5.2</td>
<td>7.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Total share 65+ (%)</td>
<td>4.7</td>
<td>6.1</td>
<td>6.5</td>
</tr>
</tbody>
</table>

Sources: 1971–1991 census figures from Federal Office of Statistics, 2001: 49, Table 4.3; Statistical estimates for 2001 and forecasts for years 2010–30 are based on average growth rates between 1981–91, with coefficients of growth: 0.06 for the total population; 0.02 for males aged 65+; 0.22 for females aged 65+; 0.14 for all aged 65+

### Table 3: Life expectancy at birth in BH by gender, estimated and projected

<table>
<thead>
<tr>
<th></th>
<th>Estimated</th>
<th>Change 1985–91</th>
<th>Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>71.4</td>
<td>71.9</td>
<td>71.9</td>
</tr>
<tr>
<td>Female</td>
<td>74.0</td>
<td>74.4</td>
<td>74.5</td>
</tr>
<tr>
<td>Male</td>
<td>68.6</td>
<td>69.1</td>
<td>69.3</td>
</tr>
<tr>
<td>Difference women/men</td>
<td>5.4</td>
<td>5.3</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Having only these statistics at hand, we made an estimate for the year 2001 and a hypothetical forecast of the population growth for the next three decades assuming that the statistical trends in the future would resume the population growth rates of the last decade before the war (1981–91), including the share of the elders. The results of these calculations are shown in Table 2.

Given the abovementioned constraints, our calculation would suggest that the population of BH in the next few decades would probably remain in the cluster of ‘younger populations’ on the demographic map of Europe, which includes Albania, FYR Macedonia, Yugoslavia (Serbia–Montenegro) and Moldova, among others (Dankó, 1998).

**Life expectancy at birth (actual and predicted)**

According to official statistics, life expectancy at birth in the pre-war population of BH was 69.2 years for males and 74.6 years for females (Federal Office of Statistics, 2001: 50, Table 4.4). Eurostat estimates for the year 1990 give approximately the same figures (i.e. 69.7 years for males and 75.2 years for females; Statistics in Focus, 2001). Based on Euphin-East Network estimates, life expectancy at birth in the population of BH has shown the pattern of change between 1985 and 1991 illustrated in Table 3, and we calculated projections for the next three decades.

The life expectancy at birth for both males and females in the present population of BH, like in most Central East European (CEE) countries, is well below the average of EU member countries, where life expectancy is 74.6 years for men and 80.9 years for women, according to the latest estimates (Lang, 2001). Our projections would suggest that, in the next few decades, the life expectancy of both men and women in BH would continue to rise, similar to trends in other CEE countries, with a widening gap between men and women (see Reamy and Oreskovic, 1999).

**Socioeconomic conditions**

**Employment, unemployment and pay**

The share of the working age population in BH gradually increased in the decades before the war: 58.9% of the total population according to the 1971 census; 64.9% in 1981; and, in 1991, 65.3%. The unemployment rate was relatively low (11.9% in 1991) when compared to current average unemployment rates of 35–45%, which is a huge figure if compared with the 8.3% average unemployment rate in European countries (Eurostat, 2002).

In the Federation of BH only (population 2.3 million), in May 2002, a total of 390,455 persons were employed, of whom 27,916 persons were in waiting (temporary jobless). If compared with employment rates from before the war, this figure represents only 61.9% of the level in 1991 (Federal Office of Statistics, 2002).

At the same time, the average unemployment rate was 41.9%. Currently well over 280,000 persons are seeking jobs, according to the same source.
Most of them are non-qualified workers (37.9%), followed by qualified workers with complete secondary schooling (35.3%). Curiously, semi-qualified workers with elementary school attainment and persons with university or higher educations are the two least numerous groups among the job seekers (3.1 and 2.2% respectively).

The average monthly net wage in 1999 was KM 374.54 (domestic currency: KM 1 = € 0.5). In 2001, this rose to KM 443.26 (or € 222) and, in May 2002, it was estimated at KM 475.50 (or € 238) per month. In March–May 2002, the average net wage rose by 8.9% in relation to the same period in the previous year.

In 1999, the average number of paid out pensions was 265,123, with an average monthly value of KM 173.88 (€ 87). By 2001, the number of paid out pensions had increased to 280,465 (5.8% increase) and the average pension went down to KM 170.12 (or € 85). In May 2002, the level of paid out pensions was as follows:

<table>
<thead>
<tr>
<th>Pension Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average paid out pension</td>
<td>KM 187.95 (€ 94)</td>
</tr>
<tr>
<td>The lowest paid out pension</td>
<td>KM 170.00 (€ 85)</td>
</tr>
<tr>
<td>The highest paid out pension</td>
<td>KM 633.22 (€ 317)</td>
</tr>
<tr>
<td>Guaranteed amount of pension</td>
<td>KM 155.08 (€ 78)</td>
</tr>
</tbody>
</table>

As far as the cost of living is concerned in the Federation of BH, the value of the so-called ‘consumer basket of necessary products’ in December 1999 was KM 428 (€ 214) and, in 2001, it averaged at KM 438 (or € 219), an increase of some 2.3%. In June 2002, the estimated value of the ‘consumer basket’ was KM 456 (or € 230), which made another 5% increase in relation to the last year’s average. If we compare the current value of the ‘basket’ (€ 230), as calculated by experts, with the most recently estimated average wages (€ 238), the difference comes to just about € 8 for ‘family saving’. This is to suggest that an average four-member family that lives on one single average salary could save virtually nothing from the monthly household income. The situation of pensioners turns out to be even worse. Given the average paid out pension per month (some € 94) and the calculated value of the ‘consumer basket’ (€ 115 for a two-member family), we arrive at a figure of € 21 missing from the family’s monthly budget to pay for the most necessary goods and services.

Employment and ethnicity

It seems obvious to state that no data are available on the employment of different national/ethnic groups. The only preliminary information we have consists of that gathered so far through critical analysis, consultation with focus groups for this project and expert assessments (see Baráth, 2002a).

According to the available evidence, members of the Roma community have by far the highest rates of unemployment, partly due to their generally low levels of education. However, discrimination must also be considered a factor, not only discrimination against the Roma, but also against many minorities in the country – both ‘old’ and ‘newly created’ – who actually do not belong to the group of ‘constituent peoples’ dominating in a given entity, region or municipality. The large-scale discrimination against the Roma throughout the country is prominent and diverse, ranging from education and employment to housing and property needs, and it is well documented in various sources (see Human Rights Co-ordination Centre, 2001).
Household structure

Extended households with eight or more members were not rare in the traditional Bosnian society (18% according to the 1948 census). Their share of the total number of households was dramatically decreased in Tito’s Yugoslavia (to 2.4% in the 1991 census) due to rapid urbanisation and industrialisation. On the other hand, the share of single-member households has not changed much in the same period (8.6% in the 1948 census compared with 10.8% in the 1991 census). In 1948, four-member families made just about 14% of the enumerated households and, by 1991, their share had doubled (28.8%). This is to suggest that a ‘modal’-size household in the pre-war society of BH comprised four members (two parents plus two children). No data are available whatsoever regarding the transformation of household structures during and after the 1992–95 war. One may only suspect that many pre-war households have changed both in size and composition due to displacement and other reasons (such as divorce in multiethnic families). As far as the household structure of minority elders is concerned, we may have two guesses based on recently conducted interviews and focus group consultations in the preparatory phase of this particular project. First, while a ‘typical’ Bosnian family currently may consist of two parents and their two children, evidence would suggest that most Roma minority elders still live in extended households counting more than four members and, in some cases, even 10 or more members (Suljic, 2002). Second, and on the opposite side, representatives of other indigenous minority communities, such as Hungarians and Czechs, maintain that the vast majority of their elders currently live in single-member or two-member households due to the emigration of younger family members during and/or shortly after the war (Hrzek, 2002; Huber, 2002).

Housing

In November 2000, the UNHCR asked the International Management Group (IMG) to prepare a report on housing stock and essential infrastructure, with special emphasis on the housing needs of refugees and displaced persons. The results of this special assessment suggested a need for new housing for some 26,536 displaced persons to allow them to return to their pre-war localities. In 2001, however, only 4135 people have been rehoused due to the housing reconstruction projects, leaving a total of 22,401 persons still homeless (UNHCR/IMG, 2001).

This is to illustrate that the main problem in BH, much as in Croatia, is the return of refugees and displaced persons to their pre-war houses and property. This is equally true for both old and newly created minorities. As far as the old (indigenous) minorities are concerned, the housing problems of the Roma people are the most shocking. One of the worst regions in this respect is Bijeljina. One of many Roma Rights reports for BH states that:

Roma refugees have little chance of maintaining an acceptable standard of living in Bijeljina. According to the Centre for Protection of Minorities Rights, none of the approximately six hundred Roma in Bijeljina is employed and only three children attend school.
TABLE 4  Mortality rates in EU member and three CEE countries (1980 and 2000)

<table>
<thead>
<tr>
<th></th>
<th>Crude death rate per 1000 population</th>
<th>Infant mortality rate per 1000 live births</th>
<th>Life expectancy at birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU members</td>
<td>10.5</td>
<td>9.7</td>
<td>12.4</td>
</tr>
<tr>
<td>BH</td>
<td>6.4</td>
<td>8.0</td>
<td>31.5</td>
</tr>
<tr>
<td>Croatia</td>
<td>10.9</td>
<td>n/a</td>
<td>20.6</td>
</tr>
<tr>
<td>Hungary</td>
<td>13.6</td>
<td>13.5</td>
<td>23.2</td>
</tr>
</tbody>
</table>

Source: Statistics in Focus, 2001: 6, Table 4

TABLE 5  Selected statistics on war casualties in BH by ethnic group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Total number</th>
<th>Killed and missing</th>
<th>Displaced</th>
<th>Refugees</th>
<th>Total affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bosniaks</td>
<td>1,898,963 (43.4)</td>
<td>138,800 (7.2)</td>
<td>602,000 (31.1)</td>
<td>641,000 (33.0)</td>
<td>1,380,800 (72.7)</td>
</tr>
<tr>
<td>Serbs</td>
<td>1,365,093 (31.2)</td>
<td>89,300 (6.5)</td>
<td>350,000 (25.4)</td>
<td>330,000 (23.5)</td>
<td>769,300 (56.4)</td>
</tr>
<tr>
<td>Croats</td>
<td>759,906 (17.4)</td>
<td>19,600 (2.6)</td>
<td>135,600 (17.6)</td>
<td>222,500 (28.9)</td>
<td>377,100 (49.6)</td>
</tr>
<tr>
<td>Other groups</td>
<td>353,071 (8.0)</td>
<td>10,300 (2.9)</td>
<td>83,000 (23.1)</td>
<td>57,500 (16.0)</td>
<td>150,800 (42.7)</td>
</tr>
<tr>
<td>Total</td>
<td>4,377,033 (100.0)</td>
<td>248,000 (5.8)</td>
<td>1,170,000 (26.7)</td>
<td>1,250,000 (28.6)</td>
<td>2,678,000 (61.2)</td>
</tr>
</tbody>
</table>

Percentages in brackets are with respect to the population of given ethnic entity.
In addition, since March 1999, there have been three cases in which unknown perpetrators have thrown bombs into the yards of Romani houses in Bijeljina and numerous cases of verbal abuse of Roma. The tense atmosphere has resulted in Romani returnees moving either to neighbouring municipalities under Bosniak (i.e. Bosnian Muslim) rule, or returning to Germany, where many of them spent the war. (Roma Rights, 2000)

Health conditions

Vital statistics

The demographic data collected by Eurostat for 2000 includes some statistics on BH (Statistics in Focus, 2001). Table 4 provides a series of comparative statistics on mortality and life expectancy in the EU and for three CEE countries selected for the MEC project: BH, Croatia and Hungary.

Demographic and health consequences of the war (1992–95)

As far as BH is concerned, one has to take into account the enormous amount of human casualties and suffering among all nationalities and ethnic minorities which, by any and all means, make BH different from both EU member and EU candidate countries for the time being. A small segment of war casualties is shown in Table 5.

To understand the effects of the 1992–95 war on the general health of the population of BH, the following statistics should be added to the evidence shown in Table 5. The war adversely affected birth and mortality rates, as well as the neonatal mortality rate, maternal mortality and morbidity rates and other health indicators (Ljubic and Hrabac, 1998). During the war, the number of births in the Federation decreased by around 50% compared with pre-war figures. Reports on mortality rates during the war indicate a level some three to five times higher than before the war. The number of people suffering from tuberculosis, for instance, increased by about 50%, with many young and old people contracting the disease. Hepatitis A and gastroenteritis were the main problems during the war, especially in overcrowded collective centres. There were epidemics of diseases transmitted by rats, for example, haemorrhage fever in 1995. Fortunately, even during the worst times, there were no epidemics that could significantly increase mortality from communicable diseases. The number of postsurgical anaerobic infections (gas gangrene, tetanus, and so on) was also relatively low during the war. As well as communicable diseases, there were massive physical injuries both to military personnel and the civilian population. In addition to the usual rates of morbidity, there are now approximately 20,000 permanently physically disabled people in the Federation of BH alone, including a large number of amputees (around 5000 are registered) and those who have suffered injury to the spinal cord, brain and peripheral nervous system (Smajkic et al., 1997).
Health situation of elders

Health statistics on those 65+ are available only up to the last census year, 1991. Just before the war, the five leading causes of death among those 65+ were the following: diseases of the circulatory system, including heart attacks and strokes (59.6% of all deaths); cancers (14.2%); endocrine, metabolic and nutritional diseases (3.9%); diseases of the respiratory system (3.4%); and diseases of the digestive system (2.5%). Gender differences were evident. More elderly women than men died from diseases of the circulatory system (63.3 compared with 55.6% respectively) and endocrine diseases (4.8 compared with 2.8%), whereas the opposite was true for cancers, as the second leading cause of death among elders (18.6% of men compared with 10.2% of women). No updated statistics are available as to whether any significant changes occurred during and after the war. Similarly, we have no information whatsoever about the epidemiological situation of elders in specific minority groups, such as differential mortality and morbidity rates specific to one or another ethnic minority group. One can only guess that the life expectancy of the Roma minority, for instance, is far below the national average and that the health situation of Roma elders must be the worst for the full range of morbidity and mortality statistics due to the combination of general poverty, unhealthy life conditions and poor access to good quality health and social services.

Choice of minority groups for the MEC project

Four criteria were adopted for the selection of three minority groups for this project, as recommended: 1) the relative size of the group; 2) its language and cultural distinctiveness; 3) the dominant place of residency (urban/rural); and 4) growth trends in the near future. The following three groups were selected for closer study: Roma, Hungarians and Czechs. The major characteristics of these groups are outlined in Table 6 overleaf.

In the full country profile for this project (Baráth, 2002c), we listed several reasons for the inclusion of these three minority groups for more in-depth study, including: their cultural distinctiveness, both among themselves and in relation to the constituent peoples of former Yugoslavia; their current willingness to preserve a distinct cultural identity; and open or hidden discrimination by mainstream society in terms of public, health and social services, to name a few distinctive features.
Health and social care providers

Mainstream providers

Doctors, pharmacists, nurses, midwives, social workers and many other mainstream health and social care personnel obtained their qualifications at the various universities and higher educational centres of the former Yugoslavia (Sarajevo, Tuzla, Banja Luka, Belgrade, Zagreb, Split, Ljubljana, and so on). A number of MDs did their postgraduate training abroad. Consequently, the perspectives and educational background of health and social care providers in BH are very similar to that of their colleagues in other successor states of the former Yugoslavia. In particular, they were trained to combine social casework with health care services (Skrbic et al., 1984). As far as social work education is concerned, it should be noted that the first college-level qualification in social work in the former Yugoslavia was established in Sarajevo back in early 1970s. Table 7 overleaf shows the mainstream (statutory) health and social services manpower resources in BH before and after the war.

The figures are self-explanatory. Before the war, qualified personnel in health and social care were fairly evenly distributed between primary (basic) and specialist (clinical) care. However, the war led to a dramatic decrease in the numbers of health professionals working in basic health care. The numbers of GPs, midwives, community nurses, and so on dropped, while the employment rates for health professionals in hospitals and clinical centres rose dramatically, partly due to the necessary ‘militarisation of health and social services’ during the war (Bagaric, 2000).

Voluntary sector providers

One can roughly estimate that currently over 600 international and local NGOs and humanitarian organisations are active throughout BH, but only a few are minority organisations. The best known are: Unija Roma (Roma Union of BH); Magyar Polgárok Egyesülete – Madjarsko Undruzenje Gradjana (Association of Hungarian Citizens); Ceska Beseda – Udruzenje Ceha (Association of Czechs); and Klub Slovenaca (Slovenian Club). Most of them function outside of legal recognition and regulation and face scarcity of resources. Since the war, a public debate has begun about how to define more clearly the status of NGOs and their employees. Only a few NGOs have a clearly specified purpose, such as raising money to help sick children or single mothers; raising the issue of safety in the mining industry; caring for the elderly and sick (Hadzihalilovic, 1999).

Mainstream service typology

As a field report for the International Crisis Group (1999) points out, the health and social care system in BH is a ‘labyrinth of pre-war, wartime and post-war institutions, often exercising overlapping administrative authority’. According to the health authorities of both the Federation and RS, health and social services in BH will probably continue its pre-war pattern of development.
### TABLE 6  Selected statistics and information on chosen minorities for the MEC project

<table>
<thead>
<tr>
<th></th>
<th>Size and share (%) in census</th>
<th>Expected in 2001</th>
<th>aged 55+ in 2001</th>
<th>Expected urban/rural share</th>
<th>Expected Cantons/regions of main density</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>3,746,111</td>
<td>4,124,256</td>
<td>4,377,033</td>
<td>4,645,303</td>
<td>1,059,285</td>
</tr>
<tr>
<td>Roma</td>
<td>1456</td>
<td>(0.04)</td>
<td>7251</td>
<td>(0.18)</td>
<td>8864</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hungarians</td>
<td>1262</td>
<td>(0.07)</td>
<td>945</td>
<td>(0.05)</td>
<td>893</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Czechs</td>
<td>871</td>
<td>(0.05)</td>
<td>690</td>
<td>(0.03)</td>
<td>590</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: 1971–91 census data, Federal Office of Statistics, 2001: 49, Table 4.3; 2001 figures are provisional data based on own statistical forecast; last two columns are estimates based on 1991 census, supplemented by current field interviews conducted with minority community leaders (April–May 2002)

### TABLE 7  Health and social care manpower resources in BH before and after the war (1980–98)

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of physicians per 100,000 inhabitants</th>
<th>No. of GPs</th>
<th>% of physicians working in hospitals</th>
<th>% of nurses working in hospitals</th>
<th>No. of auxiliary nursing personnel</th>
<th>No. of midwives</th>
<th>No. of pharmacists</th>
<th>No. of dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>4230</td>
<td>42.29</td>
<td>41.10</td>
<td>41.30</td>
<td>1415</td>
<td>1281</td>
<td>408</td>
<td>799</td>
</tr>
<tr>
<td>1985</td>
<td>5829</td>
<td>55.94</td>
<td>38.60</td>
<td>40.00</td>
<td>919</td>
<td>1503</td>
<td>625</td>
<td>1250</td>
</tr>
<tr>
<td>1991</td>
<td>7027</td>
<td>62.01</td>
<td>37.70</td>
<td>40.80</td>
<td>588</td>
<td>1566</td>
<td>811</td>
<td>1346</td>
</tr>
<tr>
<td>1998</td>
<td>1740</td>
<td>29.46</td>
<td>64.40</td>
<td>67.90</td>
<td>42</td>
<td>369</td>
<td>55</td>
<td>203</td>
</tr>
</tbody>
</table>

Below is a brief overview of the health care system, based on a recent UNHCR field report (2001b).

*Primary health care* is provided at local health centres and their outpatient facilities and is managed at the municipal level. The following types of primary health care institutions exist:

- **Ambulanta (AMB)** – *Basic Ambulatory Primary Health Care*. AMBs are found in nearly every village. Usually a nurse carries out the day-to-day work, with a GP visiting at least once a week. In larger villages, a GP is available every day. Equipment is minimal and an AMB cannot refer patients directly to a hospital.

- **Dom zdravlja (DZ)** – *House of Health: Advanced Ambulatory Care*. DZs are located in the main villages of each municipality, usually alongside a Hitna pomoc (HP) or accident and emergency facility. They are often linked to a pharmacy. The staff of a DZ includes a GP, epidemiologist, occupational physician, gynaecologist and paediatrician. They also have a basic laboratory and a small x-ray machine. DZs carry out triage, additional treatment, prescription of drugs and transfers to secondary- and tertiary-level health centres.

- **Hitna pomoc (HP)** – *Accident and Emergency Centre*. HPs combine first aid and accident and emergency treatment and operate 24 hours a day, seven days a week. They are usually located in a DZ. HPs can be visited by patients directly or can be contacted by telephone. Very few HPs have properly equipped ambulances or emergency vehicles, and most of these are international donations.

- **Farmacija** – *Pharmacy*. There are state-run pharmacies throughout BH, as well as private pharmacies. Some pharmacies have been set up with stocks of drugs donated by international humanitarian organisations. State pharmacies are sometimes located within DZs, although many are run separately.

*Secondary health care* is typically provided in Bolnica or general hospitals in the capitals of each canton (in the Federation) and in each region (in RS). General hospitals practise the usual range of physiological and surgical medicine, such as dialysis, transfusions, surgical operations, anaesthesia, radiology and radiography, gynaecology and obstetrics, as well as dealing with infectious diseases (a speciality in BH). There are also basic laboratory facilities. According to UNHCR’s quality assessment, the majority of general hospitals meet minimum requirements, but in most cases the condition of equipment is questionable.

*Tertiary health care* in BH is mainly provided by Klinicki Centar (clinical centres). These serve as teaching centres for university medical schools. Clinical centres are generally located in capitals and major cities. In the past, BH had a number of such centres with highly trained teams of medical professionals and specialists, educated at leading medical schools both in the former Yugoslavia (Belgrade, Zagreb, Ljubljana) and abroad (Vienna, Prague, among others). Clinical centres should meet international standards and have a wide range of specialists and essential equipment. They are the pinnacle of health care in BH and the institutions to which, in principle, all patients are to be referred when general hospitals are unable to provide the necessary expertise in diagnosis or treatment.
### TABLE 8  Numbers of beds in cantonal hospitals and clinical centres, Federation of BH (1991, 1996 and projected)

<table>
<thead>
<tr>
<th>Hospital name</th>
<th>Location</th>
<th>1991</th>
<th>1996</th>
<th>Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Centre</td>
<td>Sarajevo</td>
<td>3306</td>
<td>1947</td>
<td>1740</td>
</tr>
<tr>
<td>Clinical Centre</td>
<td>Tuzla</td>
<td>1950</td>
<td>1793</td>
<td>2279</td>
</tr>
<tr>
<td>Clinical Centre</td>
<td>Mostar</td>
<td>1100</td>
<td>1200</td>
<td>1200</td>
</tr>
<tr>
<td>State Hospital</td>
<td>Sarajevo</td>
<td>420</td>
<td>250</td>
<td>300</td>
</tr>
<tr>
<td>Cantonal Hospital</td>
<td>Zenica</td>
<td>1815</td>
<td>1109</td>
<td>1109</td>
</tr>
<tr>
<td>Cantonal Hospital</td>
<td>Livno</td>
<td>280</td>
<td>199</td>
<td>248</td>
</tr>
<tr>
<td>Cantonal Hospital</td>
<td>Bihac</td>
<td>800</td>
<td>1000</td>
<td>800</td>
</tr>
<tr>
<td>Cantonal Hospital</td>
<td>Travnik</td>
<td>410</td>
<td>410</td>
<td>410</td>
</tr>
<tr>
<td>Cantonal Hospital</td>
<td>Jajce</td>
<td>200</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>Cantonal Hospital</td>
<td>Orasje</td>
<td>0</td>
<td>46</td>
<td>70</td>
</tr>
<tr>
<td>Cantonal Hospital</td>
<td>Gorazde</td>
<td>15</td>
<td>17</td>
<td>120</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>10,296</td>
<td>8113</td>
<td>8476</td>
</tr>
</tbody>
</table>

Source: Ljubic and Hrabac, 1998: Table 2

### TABLE 9  Hospital and primary care resources in BH before and after the war (1983–99)

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of hospitals</th>
<th>No. of hospitals per 100,000 residents</th>
<th>Acute care hospital beds per 100,000 inhabitants</th>
<th>Psychiatric care beds per 100,000 inhabitants</th>
<th>Acute care in hospital admission per 100,000 inhabitants</th>
<th>Av. stay in acute care hospitals (in days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1983</td>
<td>1921</td>
<td>95</td>
<td>2.27</td>
<td>376.69</td>
<td>50.38</td>
<td>1.89</td>
</tr>
<tr>
<td>1985</td>
<td>2086</td>
<td>95</td>
<td>2.22</td>
<td>362.42</td>
<td>45.61</td>
<td>1.85</td>
</tr>
<tr>
<td>1991</td>
<td>1463</td>
<td>86</td>
<td>1.90</td>
<td>329.34</td>
<td>49.11</td>
<td>1.53</td>
</tr>
<tr>
<td>1994</td>
<td>423</td>
<td>36</td>
<td>n/a</td>
<td>399.20</td>
<td>24.00</td>
<td>0.85</td>
</tr>
<tr>
<td>1995</td>
<td>638</td>
<td>25</td>
<td>n/a</td>
<td>387.10</td>
<td>23.50</td>
<td>n/a</td>
</tr>
<tr>
<td>1998</td>
<td>1488</td>
<td>37</td>
<td>1.01</td>
<td>327.53</td>
<td>28.94</td>
<td>0.85</td>
</tr>
<tr>
<td>1999</td>
<td>1193</td>
<td>39</td>
<td>1.90</td>
<td>n/a</td>
<td>39.19</td>
<td>n/a</td>
</tr>
</tbody>
</table>

It should not be forgotten that some of the major targets of military aggression in BH, as in Croatia, were the general hospitals (along with schools, libraries and places of worship). Table 8 shows the changes in hospital and clinical centre capacity in the Federation, both pre-war and post-war, as well as planned reconstruction.

Interface between health and social care services

As in other successor states of the former Yugoslavia, social care in BH was always interlinked with health care, and the boundaries between the two were always in confusion. The potential for confusion between these two major services is now even greater given the introduction of fee-paid, private services. However, in those areas where health and social care facilities remain relatively intact and continue to function, albeit at a greatly reduced level, the following types of social service provision are still available:

- **Primary care level.** Combined health and social service care is provided in AMBs and DZs by GP teams (mostly nurses), in community care services (such as care in the home, if available) and by local or regional social work centres.

- **Secondary care level.** There is a combination of health and social care provided in general hospitals (for example, through psychiatric departments), in homes for children and young people, in homes for elders, and so on. At this level, specially trained staff, such as teams of community nurses, provide most of the services.

- **Tertiary care level.** Special institutes in the DZs cater for persons with chronic disabilities. At this same level, rehabilitation centres employ a wide range of medical specialists and other personnel, including physiotherapists and specialists in remedial education.

Service usage pattern

In the past, most users of health and social services were oriented to primary health care. According to research carried out in the early 1970s, the traditional doctor–patient relationship dominated the pattern of service use and was more important than other predictors of service use such as the perceived seriousness of an illness (Baráth, 1971). This pattern of usage arose from the fact that the GP system of provision was well adapted to BH’s geography, with its many small villages scattered across mountain areas. It was reinforced by a strong traditional focus on public health in medical education in the former Yugoslavia, called the A. Stampar School of Public Health and Social Medicine (Grmek, 1966). However, in the past few decades, no comprehensive survey has been carried out of service utilisation in BH, let alone surveys of the health needs of elders and how far they seek help from professional, non-statutory or alternative providers. The only current usable statistics for BH are those on primary care units, hospital facilities and bed capacities before and after the war (see Table 9).

As is evident, the war did enormous damage to health care facilities in the country as a whole. In Sarajevo’s clinical centre alone, 3306 beds in 1991 had been reduced by 1996 to 1947 beds (a loss of 59%).
Health authorities maintain that health and social service planning should assume that existing and improved primary health care facilities should handle 70–80% of all medical cases but, in reality, only 10–20% are dealt with at this level (UNHCR, 2001b). Although we have no exact data on the use of different types of health care facilities, even such a rough estimate suggests that hospital resources are being overused. Moreover, as public health officials for the Federation have pointed out, the way the entire system functions has led to an irrational use of resources. For example, health centres (D2s), supposed to be institutions for primary health care, have become a hybrid of emergency care departments and specialised clinics, of which some now operate at the secondary level of provision. Basic therapeutic procedures, when carried out at university hospital centres, are considered – and charged for – as tertiary-level care, yet the same or more complex procedures carried out at a general hospital are judged as secondary-level care (Ljubic and Hrabac, 1998).

As in many other successor states of the former Yugoslavia, the health care system in the Federation is currently being restructured in order to rationalise scarce resources and set priorities (Federal Ministry of Health, 1998). One strategic plan is to reform primary health care by introducing ‘family-centred care’. According to this, ‘The field of practice of a family health doctor … will probably include epidemiological and managerial skills, as well as curative and preventive services, health promotion, advice and counselling’ (Hrabac, 1997).

Barriers to service access

Barriers to service access in BH include a whole range of factors and their interplay:

*Environmental conditions*

Most regions of BH are mountainous, with many small and steep valleys. According to a recent survey of the users of primary care services, roughly 70% of all patients (even in large cities like Tuzla or Banja Luka) have to walk to an AMB rather than go by car due to a lack of financial resources (Goodwin et al., 1999).

*Wartime losses*

Losses both in service infrastructure and qualified manpower resources were enormous on each side. Before the war, there were, on average, 4.5 patient beds per 1000 inhabitants in the 12 larger cities and a total of 30,147 health professionals, of whom 7027 were physicians. During the war, almost all BH’s regions came under heavy military attack and/or siege (for example, Sarajevo, Mostar), resulting in massive population movements, including the migration of thousands of qualified health personnel. In Croat-dominated territories, for instance, about two-thirds of physicians and other health workers left their home institutions during the war. In 10 cantons of the Federation alone, 1944 physicians, of whom 1169 were specialists, had to leave. Nearly 500 dentists left, around 270 pharmacists and over 4000 medical technicians; a total of 6772 health professionals. Damage to or destruction of medical facilities led to further losses. In mainly Croat areas, only four out of 35 institutions survived intact; five were razed to the ground (Bagaric, 2000).
New and unmet health and social needs

The war caused dramatic changes in the epidemiology of the civilian population and led to the emergence of new unmet needs. As noted earlier, apart from the normal incidence of morbidity, there are approximately 20,000 permanently disabled, a large number of amputees and people suffering spinal cord and brain injuries. The Federal Experts Team for Mental Health estimate that approximately 15% of the total population suffer from psychological disturbances requiring treatment, and large numbers suffer post-traumatic stress disorder. The main consequences of such untreated traumas are the increased rates of chronic mental health disorder, suicide, drug addiction, and so on. In short, the enormous losses sustained by the pre-war health care system together with new and pressing health and social needs have raised substantial barriers to access to professional help. Such unmet needs are likely to exacerbate the country’s already poor public health situation for years – perhaps decades – unless radical reforms are carried out, as planned, by the health authorities.

Essential drug lists (EDLs) and drug availability

The World Health Organisation’s (WHO) EDL consists of about 250–300 drugs that should be available free of charge in all countries as basic treatments. In BH, the WHO’s EDL serves as the basis for each entity’s own approved drug list and as the basis for some cantonal or regional lists. The Federation’s EDL lists about 160 drugs and the RS’s lists 105. The Croat-dominated section of Canton 7 (Herzegovina–Neretva) lists 76 drugs. As UNHCR observers point out, the problem is not only that these lists are of varying lengths and far below WHO standards, but that they are not even effective as far as they go. Often listed drugs can still only be obtained by paying the full price (UNHCR, 2001b). The structure of provision and supply of medicines in BH discriminates especially against the poor and the elderly; it also opens up possibilities for corruption among mainstream providers.

Barriers to health insurance

In theory, the majority of the population in BH is supposed to be covered either by public or private health insurance. In practice, however, many experience great difficulty in accessing their medical insurance, principally because insurance coverage is limited geographically to the location where health insurance contributions are paid (health care registration). Insurance is not transferable to another canton or entity. When individuals move from one region to another, their health insurance does not go with them. Without effective insurance coverage, people have to pay the full cost of medical fees. For example, for a birth, the fees range from KM228–650 in the Federation and from KM300–500 in RS. As a UNHCR report points out:

Given the prevailing economic situation in BH, in which generally low salaries are only irregularly paid, and in which pensions and other state provided financial supports are often not paid, this requirement constitutes a considerable addition to an already heavy financial burden. (UNHCR, 2001b)
Ethnic minority discrimination

The Constitution of BH (Article 3) sets out the principle of equal rights and equality of conditions for all citizens, however the reality is quite different. According to a Helsinki Committee report:

The present national political authorities take care only of their ‘own national corps’ so that no one cares about the so called ‘classic national minorities’, Roma in this case. It can be said that the national political authorities behave in such a manner as [to imply that] the minorities do not exist at all. (Helsinki Committee for Human Rights, 1999)

MEC data on minority elders from the three ‘classic minority groups’ selected for this study showed that only the Roma reported severe discrimination regarding access to health and social services on both economic and ethnic grounds. Hungarian and Czech minority elders emphasised general economic discrimination against all elders. In the words of the facilitator for one Roma focus group organised for this project:

All the participants refer to their very poor financial situation as a consequence of massive unemployment [among the Roma]. The only prospect one can have for getting access to effective health care is through money, which Roma do not have. To the question, whether they feel second-class citizens, in other words, whether they feel discriminated against on ethnic grounds, they say they have always been discriminated against, regardless of what they did, regardless of the differences among them over schooling or anything else. All that because of the colour of their skin. (Šuljic, 2002)

Legal context

Under the Constitution of BH, health and social care are the responsibility of each entity. However, in spite of many similarities inherited from the pre-war system, a number of significant differences exist between the Federation of BH and RS and, consequently, a number of difficulties in ensuring access to adequate health care for the entire population of Bosnia and Herzegovina. As UNHCR’s experts describe the current situation:

Health care systems in BH are basically regulated by entity laws on health care and health insurance. ... While most people in BH are covered by these laws, there are also special laws relating to the provision of health care to particular categories of persons, such as war-veterans and invalids, families of soldiers killed in combat, displaced persons and refugees. (UNHCR, 2001b)

As far as health insurance is concerned, the law in BH defines two types of insurance schemes: compulsory and extended (private). In each entity, legislation on health insurance makes contributions compulsory for all residents with a regular income. ‘Extended’ health insurance schemes in each entity mean that a person already insured on a compulsory basis voluntarily pays higher contributions in order to secure premium services. It is unnecessary to emphasise that such a health insurance scheme severely discriminates against the million or so refugees and displaced persons in BH who still have no permanent habitation or regular employment (Baráth, 2002b).
Refugees and asylum seekers

Between the end of the war in 1996 and February 2002, UNHCR had organised or assisted the repatriation of a total of 228,544 war refugees from 36 countries, ranging from Australia to the US. Most (80%) returned from Germany as the main host country. In the Federation alone, the UNHCR (2002) estimates that there were some 210,000 displaced persons and 8150 refugees from the former Yugoslavia as at 31 December 2001. Estimates for RS amount to 206,500 displaced persons, 950 refugees from the SFRY and 23,500 refugees from Croatia. It has been estimated that around 1.43 million refugees and displaced persons from the former Yugoslavia are currently in need of a lasting settlement in southeastern Europe (UNHCR, 2001a).

The Constitution of BH assigns control over immigration, refugee and asylum policy and regulation to the state (Article II.1). However, partly because of the complexities of the legal system and conflicting legislation, the situation is extremely confused and open to abuse. To quote again from UNHCR field reports: ‘BH is faced with an increasing number of irregular migrants, many of whom are channelled by traffickers and smugglers who rely on BH as an “easy” route to Western Europe’ (UNHCR, 2001a).

The Immigration and Asylum Act (BH Official Gazette 23/99) states that a person granted asylum has rights as defined in the 1951 Refugee Convention. These include the right to ‘free basic medical care, in the case of need, both upon arrival and throughout the asylum procedure’. The Act, which was drafted with the assistance of UNHCR, OHR and the Council of Europe, came into force on 31 December 1999. It replaces any former legislation relating to foreigners or refugees originating from outside BH, such as the Act on Displaced Persons and Refugees (Official Gazette, 7/1994, 13/1994, 26/1996, 8/1994, 13/1994).

Quality of life issues

On this, we can do no better than to quote the following statement made by Janez Kovac (a pseudonym), from Sarajevo, in one of the Institute for War and Peace Reporting’s Balkan Crisis Reports (2002):

A decade after the outbreak of war, Bosnia is at peace but remains mired in petty political struggles and almost hopeless poverty. ... Constitutional changes, furious pre-election political games and a first ever ‘Oscar’ award form part of Bosnia’s confused landscape as it marks the tenth anniversary of the beginning of the war in this republic. ... For many people, ideological rhetoric and promises to protect the national interests are a thing of the past. Although opinions and perceptions still differ sharply about the origins of the war and who is to blame, what matters most now are jobs and salaries. ... The moderates who took over the Federation and state administration in 2000 have initiated several programmes to combat poverty, reform welfare and trim the social and military budget, which currently consumes half the total expenditure, leaving few funds for employment, education and health. However, the unemployment rate hovers at the 40% level, though this official figure disguises a large number of workers who do not register as employed to evade taxes.
Funding of services

The total cost of the health system in BH in 1991 was approximately 6.5% of GDP (or about US$245) per capita. This was above the average for other socialist countries in the region. During the war, the GDP contribution to the health sector in the Federation decreased to some 1.25% annually. Some estimates for 1997 suggested that the health insurance fund covered only 45.8% of the necessary expenditure. Consequently, the remainder of the health budget has had to be funded from three additional sources: around 10.2% in direct payments from citizens; 29% from federal, cantonal and municipal budgets; and 15% from other sources, including charities and humanitarian organisations (Federal Ministry of Health, 1998). Taxing service users with extra payments does not only discriminate particularly against elders who live on low pensions (€80–90 per month on average), but leads to corruption among mainstream providers, as we discovered during recent MEC focus groups held with minority elders.

Conclusion

According to the available evidence, there are three major problems with the health and social care of minority elders in BH today. First, despite all the emphasis on ‘priority setting’ in BH’s health system, the issue of ‘elderly care’ is not even mentioned, as if this section of the general population does not exist. Lesser still is any awareness of the special needs of ethnic minority elders. Second, the post-war restructuring of health and social care in BH seems to be heavily biased towards high-level, super- and hyper-specialised, profit-making clinical services at the expense of primary care. The effectiveness of the recent reforms and priority-setting agenda remains to be seen, as do levels of accountability. Third, the new health insurance scheme envisaged for BH (a compulsory basic level, plus the payment of extra premiums for better services) turns out to be a system for taxing the elderly twice over. This is true for minority elders, whether they are from a classic ethnic minority, such as Roma, or from those new minorities created as a consequence of the partition of historic Bosnia into two political entities following the war.
Introduction

Croatia, like Hungary and Bosnia and Herzegovina (BH) represents a special case study in the broader context of MEC’s comparative research project for a number of reasons. First, in a historically multiethnic society such as Croatia, the terms ‘minority’ and ‘majority’ are context-dependent. Their meaning here is specific to the country’s history and somewhat different from their customary usage in most other European countries. Second, Croatia is one of the Central East European (CEE) countries recently heavily hit by war, with all the consequences of this for thousands of minority elders. Hence, one of the major lessons to be learnt from the experience of Croatia is how such elders managed to survive in the very midst of ‘ethnic’ warfare and what their health, social welfare and quality of life are like since the war. Last, but not least, Croatia is one of the few countries whose health professionals are ideologically rooted in a strong commitment to, and experienced in, public health with an emphasis on primary and community care. Thus, there is an opportunity to learn whether, to what extent and how the concept of ‘social medicine’, the ruling paradigm of the country’s social and health care system since the early 20th century, applies now in meeting the special needs of minority elders (Grmek, 1966).
Major historic migrations

Croatia’s current situation and politics cannot be understood today without reaching far into its medieval past – still an important issue – hence a brief outline is provided. Until the penetration of the Ottoman Empire into Central Europe in the 14th century, the medieval Balkans were mainly free of large-scale population migrations (Fine, 1983). After the first lost battle with the Turks at Kosovo (1389) and the fall of the Serbian medieval state (1459), a ‘chain’ of mass movements started in these territories, their latest dramatic episodes taking place during the recent wars in the former Yugoslavia (1992–95), which included ethnic cleansing (Zubrinic, 1995).

Serbs, as the ethnic group most exposed to Turkish penetration, first migrated en masse towards Central Europe (Croatia and Hungary). In the late 17th century, there followed one of the greatest migrations of Serbs from Serbia proper to the Pannonian Plains, known as ‘The Great Wandering’ (Seoba Srba). This subsequently fuelled the national myth of Serbian ‘homelessness’ and served as an instrument for the political manipulation of Serbs in the diaspora throughout the 19th and 20th centuries.

Croatia was one of the most attractive countries for immigration during the late 19th century, under the Austro-Hungarian monarchy, both because of the richness of its natural resources and the early emergence of its civil society. According to the 1910 census, Croatia was a truly mixed, multiethnic society, similar to other parts of historic Hungary. As a constituent part of the newly formed Royal Yugoslavia (in 1918), Croatia became a shared land composed of: 41.8% Croats; 24.7% Serbs; 13.6% Hungarians; 10.7% Germans; and 9.2% other ethnic groups (Erdélyi, 1928).

Croatia, as part of a Yugoslavia whose boundaries were reshaped under Tito, has remained open to large-scale population movements – both immigration and emigration. Although no official statistics exist due to the political ideology of the time, large numbers of Slav and non-Slav ethnic groups settled in Croatia in the 1960s and 1970s. These were mostly young adult migrant workers or university students and included Albanians, Bosniaks (Bosnian Muslims), Greeks and Hungarians from Vojvodina. Today these groups still shape the ethnic map of Croatia; a large proportion of this population is now aged 55+.

Finally, the greatest and most recent population movement accompanied the war in Croatia and BH. This was mainly due to the use of ethnic cleansing as a strategy for handling political conflicts between the three ‘majority’ Slav groups in these territories: Croats, Serbs and Bosniaks. As a consequence of the war, Croatia lost some 300,000 citizens, its ethnic Serbs (Pravoslavs by religion) and gained an almost equal number of immigrants from BH, of whom some are Bosniaks and others are Herzegovians or Bosnian Croats. At the time of writing, large-scale movements into, within and out of present-day Croatia continue. According to recent UNHCR estimates (December 2001), the number of refugees and displaced persons in Croatia in need of international protection still amounts to over 42,000.
Demographic status of Croatia

According to the latest census (March 2001), the total population of Croatia is currently 4.4 million and its demographic structure is as follows:

- **Ethnic composition.** Croats form 89.6% and 24 indigenous ethnic minorities represent 7.5% of the population. Immigrants from over 23 different European countries contribute 0.5% of the population and immigrants from non-European countries 2%, including Africans, South Americans, Australians and Chinese. The main historic minorities are: Serbs (4.5%), Bosniaks (0.5%), Italians (0.4%), Hungarians (0.4%), Albanians (0.3%), Slovenians (0.3%) and Czechs (0.2%). Most sections of Croatia's minority population have family roots in, and a shared culture with, their counterparts in neighbouring countries such as Italy, Austria, Slovenia, Hungary, BH, Serbia and Montenegro.

- **Language.** The official language is Croatian (a variant of South Slavic languages closest to Serbian) and Latin script is officially used. Croatian as a mother tongue is spoken by 96.1% of the population. The rest of the population (3.9%) speak 24 different native tongues, although most of them speak Croatian as well. The main minority languages are: Serbian or its combination with Croatian (Serbo-Croat or Croato-Serbian) (spoken by 1.2% of the population), Italian (0.5%), Albanian (0.3%), Hungarian (0.3%), Slovenian (0.3%), Bosnian (0.2%) and Czech (0.2%).

- **Religion.** The vast majority of the population (87.8%) are Roman Catholic and the rest (12.2%) are divided among 13 different religions: 4.4% Serbian Orthodox (Pravoslav), 1.3% Muslims, 2.2% non-believers and 3% agnostics.

- **Age distribution.** 0–6 year olds form 7.6% of the population; 7–14 year olds, 9.4%; 15–19 year olds, 6.7%; 20–64 year olds represent 60.2%; and the elderly (throughout, this term refers to those aged 65+) make 15.6%. In international comparison, Croatia has one of the 'oldest' populations in the region of CEE. Most elderly people live in urban areas or suburbs of major cities, including Zagreb, Osijek, Rijeka and Split.

- **Educational attainment of population aged 15+.** The educational attainment of Croatia's population approximates the average of other CEE countries: 2.9% of the adult population have no formal schooling; 37.5% have completed basic schooling; 47.1% have completed some kind of secondary schooling; 4.1% have completed some kind of non-university college; 7.3% have completed faculty or university training; and the share of professionals with master's and/or doctoral degrees is 0.5% of the total population. However, one notices significant gender differences. The share of women aged 15+ with no formal schooling is about four times higher than the rate for equivalent men (4.4% compared with 1.2% respectively), whereas the share of men and women among faculty and university graduates is nearly equal (7.6% compared with 7% respectively).

- **Economic activity and employment status.** The proportion of the population registered as economically active is 44%. Of these, however, 20.4% were unemployed at the time of the census. The share of the economically inactive persons was 55.8% of the population; of these, 39.1% were retired people, 12.3% housewives, 2.4% were unable to work and 44.4% were inactive for other reasons (for example, preschool children, pupils and/or students, physically unable to work) (Central Bureau of Statistics, 2002).
### Table 1: Ethnic mix of Croatia (1991 and 2001)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Size in 1991 census</th>
<th>Share (%)</th>
<th>Size in 2001 census</th>
<th>Share (%)</th>
<th>Change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total population</strong></td>
<td>4,784,265</td>
<td>100.00</td>
<td>4,437,460</td>
<td>100.00</td>
<td>–7.25</td>
</tr>
<tr>
<td><strong>Ethnic nationality declared</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Croats</td>
<td>3,736,356</td>
<td>78.10</td>
<td>3,977,171</td>
<td>89.63</td>
<td>11.53</td>
</tr>
<tr>
<td>Serbs</td>
<td>581,663</td>
<td>12.16</td>
<td>201,631</td>
<td>4.54</td>
<td>–7.62</td>
</tr>
<tr>
<td>Bosniaks</td>
<td>43,469</td>
<td>0.91</td>
<td>20,755</td>
<td>0.47</td>
<td>–0.44</td>
</tr>
<tr>
<td>Slovenians</td>
<td>22,376</td>
<td>0.47</td>
<td>13,173</td>
<td>0.30</td>
<td>–0.17</td>
</tr>
<tr>
<td>Hungarians</td>
<td>22,355</td>
<td>0.47</td>
<td>16,595</td>
<td>0.37</td>
<td>–0.10</td>
</tr>
<tr>
<td>Italians</td>
<td>21,303</td>
<td>0.45</td>
<td>19,636</td>
<td>0.44</td>
<td>–0.01</td>
</tr>
<tr>
<td>Czechs</td>
<td>13,086</td>
<td>0.27</td>
<td>10,510</td>
<td>0.24</td>
<td>–0.03</td>
</tr>
<tr>
<td>Albanians</td>
<td>12,032</td>
<td>0.25</td>
<td>15,082</td>
<td>0.34</td>
<td>0.09</td>
</tr>
<tr>
<td>Montenegrins</td>
<td>9724</td>
<td>0.20</td>
<td>4926</td>
<td>0.11</td>
<td>–0.09</td>
</tr>
<tr>
<td>Roma</td>
<td>6695</td>
<td>0.14</td>
<td>9463</td>
<td>0.21</td>
<td>0.07</td>
</tr>
<tr>
<td>Macedonians</td>
<td>6280</td>
<td>0.13</td>
<td>4270</td>
<td>0.10</td>
<td>–0.03</td>
</tr>
<tr>
<td>Slovaks</td>
<td>5606</td>
<td>0.12</td>
<td>4712</td>
<td>0.11</td>
<td>–0.01</td>
</tr>
<tr>
<td>Ruthenians</td>
<td>3253</td>
<td>0.07</td>
<td>2337</td>
<td>0.05</td>
<td>–0.02</td>
</tr>
<tr>
<td>Germans</td>
<td>2635</td>
<td>0.06</td>
<td>2902</td>
<td>0.07</td>
<td>0.01</td>
</tr>
<tr>
<td>Ukrainians</td>
<td>2494</td>
<td>0.05</td>
<td>1977</td>
<td>0.04</td>
<td>–0.01</td>
</tr>
<tr>
<td>Others</td>
<td>7102</td>
<td>0.16</td>
<td>25,215</td>
<td>0.57</td>
<td>–0.08</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>4,496,429</td>
<td>93.98</td>
<td>4,330,355</td>
<td>97.58</td>
<td>3.60</td>
</tr>
<tr>
<td><strong>Ethnic nationality undeclared</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yugoslavs</td>
<td>106,041</td>
<td>2.22</td>
<td>0</td>
<td>0.00</td>
<td>–2.22</td>
</tr>
<tr>
<td>Others</td>
<td>118,869</td>
<td>2.48</td>
<td>89,130</td>
<td>2.01</td>
<td>–0.47</td>
</tr>
<tr>
<td>Unknown</td>
<td>62,926</td>
<td>1.32</td>
<td>17,975</td>
<td>0.41</td>
<td>–0.91</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>287,836</td>
<td>6.02</td>
<td>107,105</td>
<td>2.41</td>
<td>–3.60</td>
</tr>
</tbody>
</table>

Ethnic mix before and after the war

The ethnic map of Croatia changed drastically during and after the war, as indicated above. Table 1 summarises these changes. A few dramatic consequences of the 1992–95 war are evident. First, Croatia’s total population shrank by 7.3%, primarily due to the emigration of large numbers of people with an ethnic affiliation other than Croat. Second, although the relative ‘gain’ of the national majority appears significant (with an 11% increase in declared Croats in the total population), the end results for most minorities are negative (i.e. showing a substantial loss in the size of their pre-war membership). This is generally true for the ethnic communities of Serbs, Bosniaks and Hungarians. Third, the once sizeable political grouping of Yugoslavs simply vanished from the ethnic national map of present-day Croatia.

Urban/rural distribution of minorities

Data on the regional distribution of different ethnic groups in Croatia from the recent census are currently unavailable. However, they could be approximated on the basis of 1991 census data, which are displayed in Table 2 overleaf.

By and large, the urban/rural population split in Croatia was fairly equal before the war. However, the geographic dispersal of particular minorities has always shown marked differences in this respect, a situation that may not have changed much during or since the war, except for those rural regions badly hit by it such as eastern Croatia. The dispersal of historically indigenous minorities such as Serbs, Italians, Hungarians, Czechs and Germans is either balanced between urban and rural areas or is mainly rural, whereas the bulk of the new ethnic communities and groups typically reside in urban areas.

Demographic and health characteristics of elders

In spite of the long tradition of social care for the elderly (Belicza, 1997) and the traditional emphasis on primary care in Croatia (Kovacic and Sosic, 1998), up-to-date professional knowledge about the demographic characteristics and health status of specific groups of the elderly is limited. Research data on specific demographic characteristics and differential mortality and morbidity rates, as well statistics on the differential use of health and social services by minority groups and minority elderly, are lacking. The only exceptions are some demographic and quality of life data recently issued for the Hungarian elderly, thanks to a few pilot studies undertaken during and after the war (Baráth, 2000; Bognár, 1995).
### TABLE 2  Distribution of ethnic groups by residency (1991 census)

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Urban (n)</th>
<th>Rural (n)</th>
<th>Total (N=100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>2,597,205</td>
<td>2,187,060</td>
<td>4,784,265</td>
</tr>
<tr>
<td>Of these:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Croats</td>
<td>2,006,769</td>
<td>1,729,587</td>
<td>3,736,356</td>
</tr>
<tr>
<td>Serbs</td>
<td>281,570</td>
<td>300,093</td>
<td>581,663</td>
</tr>
<tr>
<td>Bosniaks</td>
<td>34,686</td>
<td>8783</td>
<td>43,469</td>
</tr>
<tr>
<td>Slovenians</td>
<td>16,908</td>
<td>5468</td>
<td>22,376</td>
</tr>
<tr>
<td>Hungarians</td>
<td>8005</td>
<td>14,350</td>
<td>22,355</td>
</tr>
<tr>
<td>Italians</td>
<td>12,884</td>
<td>8419</td>
<td>21,303</td>
</tr>
<tr>
<td>Czechs</td>
<td>4658</td>
<td>8428</td>
<td>13,086</td>
</tr>
<tr>
<td>Albanians</td>
<td>9456</td>
<td>2576</td>
<td>12,032</td>
</tr>
<tr>
<td>Montenegrins</td>
<td>8680</td>
<td>1044</td>
<td>9724</td>
</tr>
<tr>
<td>Roma</td>
<td>3367</td>
<td>3328</td>
<td>6695</td>
</tr>
<tr>
<td>Macedonians</td>
<td>5446</td>
<td>834</td>
<td>6280</td>
</tr>
<tr>
<td>Slovaks</td>
<td>2725</td>
<td>2881</td>
<td>5606</td>
</tr>
<tr>
<td>Ruthenians</td>
<td>1566</td>
<td>1687</td>
<td>3253</td>
</tr>
<tr>
<td>Germans</td>
<td>1509</td>
<td>1126</td>
<td>2635</td>
</tr>
<tr>
<td>Ukrainians</td>
<td>1412</td>
<td>1082</td>
<td>2494</td>
</tr>
<tr>
<td>Other ethnic groups</td>
<td>5278</td>
<td>1821</td>
<td>7099</td>
</tr>
<tr>
<td>Undefined groups</td>
<td>192,286</td>
<td>95,553</td>
<td>287,836</td>
</tr>
</tbody>
</table>


### TABLE 3  Proportion of elderly in Croatia by gender (%)

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1971</td>
<td>8.5</td>
<td>11.7</td>
<td>10.2</td>
</tr>
<tr>
<td>1981</td>
<td>9.1</td>
<td>13.5</td>
<td>11.4</td>
</tr>
<tr>
<td>1991</td>
<td>8.6</td>
<td>14.5</td>
<td>11.6</td>
</tr>
<tr>
<td>1992</td>
<td>8.8</td>
<td>14.8</td>
<td>11.9</td>
</tr>
<tr>
<td>1993</td>
<td>8.8</td>
<td>14.8</td>
<td>11.9</td>
</tr>
<tr>
<td>1994</td>
<td>9.2</td>
<td>15.2</td>
<td>12.3</td>
</tr>
<tr>
<td>1995</td>
<td>9.1</td>
<td>15.2</td>
<td>12.3</td>
</tr>
<tr>
<td>1996</td>
<td>9.2</td>
<td>15.3</td>
<td>12.3</td>
</tr>
<tr>
<td>1997</td>
<td>9.2</td>
<td>15.3</td>
<td>12.3</td>
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<tr>
<td>1998</td>
<td>9.2</td>
<td>15.3</td>
<td>12.4</td>
</tr>
<tr>
<td>1999</td>
<td>12.4</td>
<td>18.6</td>
<td>15.6</td>
</tr>
<tr>
<td>2001</td>
<td>12.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Share of elderly in the total population

The figures in Table 3 would suggest that, in spite of the dramatic decrease in population in the past 10 years or so, the proportion of elderly in the population continues to grow, and more so among women than men. That 15.6% of the population is aged 65+ means not only that Croatia has one of the oldest populations in Europe (behind Belgium, with 15.8%), but also that this sudden increase in age occurred in only a few years after the war. This is due, as pointed out earlier, to substantial emigration rates among younger people during and after the war combined with a gradual decrease in birth rates since the mid-1960s. Life expectancy at birth for all Croatians currently is 70.7 years for men and 77.5 years for women, which approximates the average life expectancy of men and women in EU member countries (74.6 for men and 80.9 for women), according to recent estimates (Lang, 2001). If this trend of an ageing Croatian population continues, statistical projections would suggest that, by 2030, two in every 10 citizens will be 65+, with a widening gender gap, according to my estimates, as shown in Table 4.

Life expectancy at age 65 and recent changes

Regarding life expectancy at age 65, one may observe remarkable patterns of change during and after the war, as compared to baseline estimates from 1985 (see Table 5). The curious element of these changes lies in the fact that, at the very beginning of warfare in Croatia, life expectancy at age 65 went up by nearly one full year for elderly men and women compared to the baseline rates from 1985. It stayed stable at the same (high) level throughout the war years and suddenly went down shortly after the war, below the baseline estimates from 1985.

Causes of death among the elderly

Curiously, statistics compiled by the World Health Organisation (WHO, 1999) covering the leading causes of death among those 65+ in Croatia suggest that rates of circulatory and cerebrovascular disease among the elderly went down at the outbreak of war (1990–91). The rates remained at a lowered level throughout the war and suddenly increased in the years afterwards, surpassing even the 1985 baseline rates. Both circulatory and cerebrovascular disease are well known for their strong psychosomatic element, and thus their aetiology can indicate the impact of stressful life events on large masses of people, especially the elderly.

The incidence of neoplasms (cancer) remained stable throughout the war years, with a slight increase in the last few years. Ischaemic heart disease (including acute heart attacks), as the fourth main cause of death among the elderly, increased dramatically at the outbreak of the war and remained at high levels during and after it. Finally, the rate of suicides and other self-inflicted injuries among the elderly went up just before the outbreak of military conflict (1990), dropping slightly during it and then rising again.
### TABLE 4  Actual and predicted proportion of elderly in the total population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>4,601,469</td>
<td>4,784,265</td>
<td>4,437,460</td>
<td>4,364,841</td>
<td>4,366,054</td>
<td>4,366,033</td>
</tr>
<tr>
<td>Male</td>
<td>2,226,890</td>
<td>2,318,623</td>
<td>2,135,900</td>
<td>2,095,731</td>
<td>2,096,486</td>
<td>2,096,472</td>
</tr>
<tr>
<td>Female</td>
<td>2,374,579</td>
<td>2,465,642</td>
<td>2,301,560</td>
<td>2,269,110</td>
<td>2,269,568</td>
<td>2,269,561</td>
</tr>
<tr>
<td>Male 65+</td>
<td>203,223</td>
<td>199,239</td>
<td>265,108</td>
<td>306,332</td>
<td>312,742</td>
<td>313,739</td>
</tr>
<tr>
<td>Female 65+</td>
<td>321,041</td>
<td>356,801</td>
<td>428,432</td>
<td>495,299</td>
<td>505,735</td>
<td>507,364</td>
</tr>
<tr>
<td>Total 65+</td>
<td>524,264</td>
<td>556,040</td>
<td>693,540</td>
<td>801,631</td>
<td>818,477</td>
<td>821,103</td>
</tr>
<tr>
<td>Male 65+ (%)</td>
<td>9.1</td>
<td>8.6</td>
<td>12.4</td>
<td>14.6</td>
<td>14.9</td>
<td>15.0</td>
</tr>
<tr>
<td>Female 65+ (%)</td>
<td>13.5</td>
<td>14.5</td>
<td>18.6</td>
<td>21.8</td>
<td>22.3</td>
<td>22.4</td>
</tr>
<tr>
<td>Total share 65+ (%)</td>
<td>11.4</td>
<td>11.6</td>
<td>15.6</td>
<td>18.4</td>
<td>18.8</td>
<td>18.8</td>
</tr>
</tbody>
</table>


### TABLE 5  Estimated life expectancy at age 65 (1985–99)

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Male</td>
<td>12.4</td>
<td>12.9</td>
<td>13.0</td>
<td>13.2</td>
<td>12.9</td>
<td>12.8</td>
<td>13.1</td>
<td>12.1</td>
<td>11.8</td>
<td>11.4</td>
<td>11.3</td>
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<tr>
<td>Female</td>
<td>15.6</td>
<td>16.1</td>
<td>16.3</td>
<td>16.4</td>
<td>16.3</td>
<td>16.4</td>
<td>16.6</td>
<td>15.8</td>
<td>15.6</td>
<td>15.2</td>
<td>15.5</td>
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<tr>
<td>Total</td>
<td>14.2</td>
<td>14.8</td>
<td>15.0</td>
<td>15.1</td>
<td>14.9</td>
<td>15.0</td>
<td>15.2</td>
<td>14.3</td>
<td>14.0</td>
<td>13.6</td>
<td>13.7</td>
</tr>
</tbody>
</table>

Source: Euphin-East Network, 2002
Social support needs of the elderly

A recent longitudinal study carried out with a group of 99 elders from Zagreb (37 men and 62 women) sheds some light on the quality of ageing for this particular segment of the elderly in Croatia (Despot-Lucanin et al., 1997). The number of elders living alone substantially increased over the 15-year follow-up period. The main lesson to be drawn was that the more social support was available for elders through close interpersonal contacts, the healthier they felt, the better were their functional abilities and the fewer their psychosomatic symptoms in contrast with their peers who were more short lived. In spite of its limited scope, this study draws attention to the importance and viability of social support theory as a framework both for research and for the promotion of health and social care for the elderly (see Baráth et al., 1987; Vaux, 1988).

Use of health and social institutions by the elderly

One of the earliest studies on the use of health and social services in the former Yugoslavia illustrated that the prime predictor of visits to the doctor by elderly patients seemed not to be the perceived severity of their illness, but rather the quality of their relationship with their doctor (Baráth, 1973). Another more recent study shows that the number of elderly patients referred by GPs for additional specialist examinations and hospital treatment decreases with age. This is contrary to the increased morbidity among this age group (Tomek-Roksandic, 1988). The author interprets this somewhat unexpected finding by arguing that the elderly, in most cases, entrust their health care to family physicians that they know well rather than to largely unknown, highly qualified clinical specialists. As for social institutions for the elderly in Croatia, the most typical and widely used institutions are the old people’s homes located in or near larger cities, where there are also hospitals for chronic patients and short-stay, psychogeriatric facilities. Data gathered by Tomek-Roksandic on a typical urban population (Zagreb) suggests that only 3.6% of the elderly request entry into these institutions and that most would resist their own doctor’s recommendation to do so. According to a survey of family doctors, those elders who do find accommodation in old people’s homes remain in them for health and not social reasons.

The motivation behind such selective use of health and social institutions by the elderly is complex and needs to be looked at carefully. This was corroborated by a recent preliminary study on the attitudes of the elderly towards their major problems conducted with elderly participants (average age 71) at the University for the Elderly in Zagreb (Tomek-Roksandic and Budak, 1997). Of the respondents, 25% claimed that loneliness was their major problem. Almost equal percentages (21%) reported poor health and inactivity. Lack of communication (15%) and depression (11%) followed. Curiously enough, only 8% of the participants considered economic status the major problem of the elderly. Over 70% of participants stated that they minded being addressed as ‘old people’, considering it inappropriate. Recently, health and social work professionals have begun to make ‘third age’ the official designation for referring to elders.
<table>
<thead>
<tr>
<th>Minority</th>
<th>Size and share (%) in 1991 census</th>
<th>Size and share (%) in 2001 census</th>
<th>Aged 55+ estimated % of group</th>
<th>Urban/rural (% of group in 1991)</th>
<th>Regions of main density in 2001 (% of group)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bosniaks</td>
<td>43,469 (0.9)</td>
<td>20,755 (0.5)</td>
<td>n/a</td>
<td>Mainly urban (79.8)</td>
<td>Istria/Primorje/Zagreb (59.3)</td>
</tr>
<tr>
<td>Hungarians</td>
<td>22,355 (0.5)</td>
<td>16,595 (0.4)</td>
<td>50.0</td>
<td>Mainly rural (64.2)</td>
<td>Baranja/Osijek/Vukovar (71.3)</td>
</tr>
<tr>
<td>Czechs</td>
<td>13,086 (0.3)</td>
<td>10,510 (0.2)</td>
<td>50.0</td>
<td>Mainly rural (64.4)</td>
<td>Bjelovar/Daruvar (75.5)</td>
</tr>
</tbody>
</table>

Elderly populations in special need

Shortly after the war, a group of Croatian and international experts carried out a survey of two major United Nations Protected Areas (UNPA) which had been under occupation by Yugoslav military and paramilitary forces for over five years (Lang et al., 1997). They interviewed 10,594 people in 524 settlements, of whom 70% were Serb, 28% Croatian, 1.1% Bosniaks and 1% of undefined nationality. The research uncovered a dramatic situation. More than 75% of the remaining population (those who had not fled) were civilians aged 60+. They were scattered across 524 villages and hamlets, 73 of which had only one inhabitant. One-third of the people had no income and only 17% were eligible for pensions or welfare payments. Only one-quarter had access to public transport for the supply of goods and food and only half had electricity in their homes. Two-thirds felt ill and 6% needed emergency assistance.

In short, large numbers of migrant and ethnic minority elders need to be given special attention because, according to the authors of this research, they may well comprise by far the largest of the ‘abandoned populations’ of present-day Croatia. This assumption has also been corroborated in recent reports by WHO observers. According to one such report:

> Immigrant and ethnic minorities can have specific patterns of diseases and health needs because of cultural, socio-economic and behavioural factors and exposure to different environments in their country of origin. Obtaining access to health care that can meet such specific needs and is culturally and linguistically acceptable can also be difficult. Moreover, many immigrants have a higher risk of living in relative poverty and being marginalized in their countries of residence, which can result in reduced health status compared with non-immigrants. Illegal immigrants in particular can find it difficult to obtain health care and following up any care given can be problematic. (WHO, 1999: 4)

Choice of target groups for the MEC project

Four criteria were adopted for the selection of the three minority groups for this project: 1) the relative size of the group; 2) its language and cultural distinctiveness; 3) the dominant place of residency (urban/rural); and 4) growth trends in the near future. Initially, the following three groups were selected for closer study: Bosniaks, Hungarians and Italians. Later on, for methodological reasons, the Czechs replaced the Italians as the third target group. The major characteristics of these groups are outlined in Table 6.

Currently, precise demographic and health statistics do not exist either for these or any other minority group in Croatia. However, considerable differences are believed to exist between these groups, which are also distanced, socially and culturally, both from the current (mainly Croatian) and the pre-war, mixed (Croatian–Serbian) mainstream society. In the full country profile study for the MEC project, we provide an in-depth analysis of what the groups have in common and their areas of difference using some 16 characteristics for analysis that might point to possible discrimination.
FIGURE 1 Organisational chart of health care system in Republic of Croatia

Source: WHO, 1999, Figure 2.8
These include, among others, patterns of migration, age distribution, gender differences, housing and living conditions, and educational attainment. In examining differences in accessing and obtaining quality health and social care, we hypothesise that the Bosniak elderly might enjoy relatively worse health and social care provision than the other two groups. This is because most Bosniak elders are recent immigrants to Croatia and probably face great problems of cultural and political integration where they are now living, including discrimination from mainstream health and social care providers.

The Croatian health care system

Figure 1 summarises the basic organisational features of the current (transitional) health care system in Croatia.

*Primary health care* is delivered through health centres, emergency care centres, home care centres (with visiting nurses) and pharmacies. Each municipality has one health centre with a network of primary health care units, dentistry and pharmacy services. Health centres provide general medical consultation, primary care gynaecology, care for preschool children, school medicine and dental care. Some isolated rural health centres provide specialist outpatient services under the supervision of a hospital, and a very few also provide maternity care and temporary inpatient facilities. Recently, the number of private services, such as GPs, visiting nurses, pharmacies and diagnostic services, has grown. As for rates of use of health services, while visits to the doctor increased by 4.7% between 1994 and 1998, visits to other health professionals dropped by 3.2%. Home visits by doctors dropped by almost 7% and, most dramatic of all, by over 75% for other health workers. This latter is an alarming indication of the deterioration of the entire health care system, which would impact particularly on the elderly in remote rural areas.

*Secondary health care* facilities include hospitals, sanatoria (or spas) and independent outpatient specialist care centres (locally called policlinics). Hospitals may be either general or specialist. The former have facilities for obstetrics and gynaecology surgery and inpatient paediatric care, whereas specialist hospitals are organised around specific diseases, chronic illness or population groups. In addition to inpatient facilities, hospitals also have outpatient departments providing ambulatory services. Croatia also has a number of sanatoria offering preventative health care and rehabilitation based on the use of natural elements such as water, mud, sand or sea in combination with physiotherapy and massage.

*Tertiary health care* is provided in university clinics, clinical hospitals and clinical hospital centres at which the training of doctors, nurses and medical practitioners is conducted, together with research. These centres of excellence are obliged to develop their expertise and to provide support to other health care institutions. Clinical hospital centres are general hospitals in which more than half of the units are at teaching hospital level and which carry out university-level education in over half of their teaching programmes in the faculties of medicine, dentistry, pharmacology and biology.
Health systems resources

The ratio of hospital beds per 1000 is closer in Croatia to the West European average than to that of Central and Eastern Europe (WHO, 1999). There were 7.4 hospital beds per 1000 in 1990, dropping to 5.9 in 1994. The figure rose slightly to 6.2 beds in 1996 and fell again in 1997 to 5.4, partly due to health policy and partly because of the war. During the conflict, 29 hospitals and three rehabilitation centres – a total of over 3000 beds – were destroyed and much equipment was damaged.

Current estimates show that Croatia spends approximately the same proportion of its GDP on health care as the average for EU member countries (8.1% compared with 8.2% respectively). Similarly, the current hospital capacity of the Croatian health system approximates the level of EU member countries (the per capita:hospital bed ratio in Croatia is 169 compared with 171 on average in EU member countries; Lang, 2001). As Lang, a leading authority on health, argues:

Although its population is small and economic indicators poor, in the field of health care Croatia compares relatively well with Europe. In Croatia the death rate is higher than the birth rate. ... Life expectancy is about three years shorter than in most developed countries. If the present trend continues, our population will be smaller by roughly one million in the year 2050. Today, the role of health policy is to maintain what has been achieved but also to help the integration of Croatian health care into the European health network. Support of all aspects of population needs should gain more attention within health policy (increasing birth rate, quality of life and the active social participation of older people). In the next century, Croatian health must set its goals beyond those of the present health care, becoming thus an important part of overall strategy of Croatian development. High quality care should become one of the most important parts of Croatian economic development (health tourism, environmental health, healthy food, occupational health). (Lang, 2001: 96)

Services for the elderly

For the elderly population, primary health care is the main source of service provision. As pointed out earlier, the number of geriatric patients referred by GPs for additional specialist examinations and hospital treatment decreases with age, despite this age group's increased morbidity (Tomek-Roksandic, 1988). It has been estimated that around 35% of geriatric patients in old people's homes ask specialists to visit them there (home visiting) rather than be transferred to a hospital (Tomek-Roksandic, 1995). This would suggest that the elderly tend to underuse hospital services and, in most cases, prefer to entrust their health care to primary physicians. In the opinion of GPs, most urban elders requiring social welfare home services need assistance only in performing difficult household chores, but that proportion does not exceed 16% (Budak and Tomek-Roksandic, 1994).
The social welfare system

The Social Welfare Act (in force since 1997) regulates the bulk of social provisions using a combination of two traditional approaches: institutional care and community-based care. The latter shares its basic premises with ‘social medicine’ (Jaksic, 1984). According to official definitions, the following major types of social welfare institutions are currently functioning in Croatia:

- Social welfare centres or social welfare offices are institutions that provide different forms of professional and welfare services to persons in need, which can include one-off financial support, assistance in qualifying for work and rehabilitation or assistance in finding accommodation in other social welfare institutions. A professional team consisting of social workers, psychologists, special teachers, physicians, lawyers and other professionals provides such services.

- Social welfare homes for children and youth are homes that provide accommodation, food, emotional support, health care, schooling, training and professional support to children and adolescents deprived of parental care, mentally and physically handicapped children and adolescents with behavioural difficulties.

- Social welfare institutions for adults and elderly persons are institutions that provide accommodation, emotional support, rehabilitation, health care, assistance in qualifying for work and finding employment for disabled adults, as well as accommodation, food, emotional support, help, health care, relaxation, recreation and various other professional services for the mentally handicapped, alcoholics, old and dependent persons (Central Bureau of Statistics, 1999: 472).

Article 10 of the Social Welfare Act specifies the following categories of intended recipients or beneficiaries of social welfare:

- Individuals or families who do not have sufficient resources to meet their basic needs and are not able to obtain these resources either by working or from unearned income.

- Physically or mentally handicapped or sick children, as well as children taken into care or correctional care.

- Physically or mentally handicapped or sick adults, the elderly or infirm who, because of permanent changes in their health, cannot meet their basic needs themselves.

- Any person who is the victim of dysfunctional family relationships, is dependent on alcohol, drugs or other opiates or cannot function properly because of behavioural disorders or other causes.

Article 11 of the Act recognises three categories of those who can receive benefits: 1) citizens of Croatia; 2) foreigners with permanent residency rights; and 3) other temporary beneficiaries.
The social care system in transition

Critics point out that the system of social care in Croatia is not adequate at present (WHO, 1999). The major shortcomings are as follows. First, and perhaps most important, there is only limited social care provision for the dependent elderly on low incomes and for those with special needs such as the mentally ill or physically handicapped. As a result, people who need social care fill beds in hospitals. Second, there is a gap in the coordination of health and social care. The care of people suffering from serious long-term illnesses or severe disabilities is covered by health insurance through contracts with inpatient facilities such as the geriatric wards of hospitals. Health care for persons in social care institutions is provided separately through contracts with health teams in these institutions or through contracts with local health centres. Third, elderly clients as a group are randomly and illogically mixed with all other groups of welfare beneficiaries. And, finally, it is not possible to discern from the statistics available the differing ratios of client groups that have different demographic, ethnic and other profiles.

The number of traditional, ‘closed’ institutions for the social care of the elderly (such as old people’s homes) is still on the increase, but new forms of ‘open’ (community-orientated) care are also emerging. These cover a wide range of various forms of home care provided by a mixture of health professionals, including GPs, dentists, physiotherapists, nurses, medical assistants and social workers. However, the bulk of these new (home-based) health and social care programmes seem to emerge mainly from private (for-profit) initiatives and less from government and/or voluntary sector initiatives. To illustrate this fact, we may note that, in the period between 1994 and 1998, the number of privately owned ‘doctor’s offices’ increased from 1531 to 4428 (a net increase of 189.2%) and, within them, the number of registered home health care services grew from 34 to 123 (a net increase of 267.6%; Central Bureau of Statistics, 1999: 461). In the sector of social care only, new services are usually established and managed by nurses and physiotherapists. They typically employ two or three medical doctors, registered nurses and medical technicians. By the end of 1995, there were 14 home care agencies employing over 600 nurses, under a contract with the Croatian Health Insurance Institute, and about 132 private nurses. Few social workers are registered as partners of these private (for-profit) working teams, if any. Private, fee-paying forms of provision are expected to increase, according to the European Observatory on Health Care Systems’s report on Croatia (WHO, 1999).

Perspectives for research into minority elderly care

At present, Croatia’s health and social care system faces problems similar to those in virtually all CEE countries. These include controlling health expenditure, balancing the development of different sectors of care, health promotion, and so on – all in the context of the introduction of a free market economy. However, Croatia’s early experience of developing decentralised and integrated primary health care, a decentralised health insurance system, education of general and family practitioners and its long tradition of innovation and implementation of public health measures make the country’s health service regionally distinctive.
A breakthrough in the care of minority elders, however, must take into account two factors. First, it needs to reckon with the new priorities for health and social welfare reform applicable to most CEE countries. As one critic has pointed out, Croatia, unlike Hungary, Slovakia, the Czech Republic and Slovenia, is the only CEE country in which the quality of care has not begun to be monitored, nor is any assessment of the quality of health care technology or patient satisfaction carried out (Elder, 2001). Oreskovic (1998), in his analysis of nine CEE countries, in which he examines the strategies for setting priorities in health care, concludes that Croatia needs ‘extremely urgent’ reforms in three areas: 1) privatisation; 2) health promotion; and 3) modernisation of the health information system. Less urgent, but still necessary, are strategies for financing health and social care and developing new patterns of primary care. When looked at in the context of care for the ‘forgotten’ minority elderly, all these priorities take on an even greater urgency. Yet, of course, it is still necessary to work within the present model for the promotion of health care for the elderly developed by Croatian public health researchers and gerontologists.

Current research and policy making in Croatian social gerontology seem to focus on two major issues (Tomek-Roksandic and Cota-Bekavac, 1990). One is how to achieve a well-organised model of primary health care that will embrace the coordination and better targeting of all health measures and systems. The other is the application of preventative health measures and how to provide ‘open’ or community health care. In this respect, better integration of health and social care services is envisaged, including funding. The essence of these innovative models is to understand health care for the elderly in its newly emerging social context, including the natural social support systems of which elders are a part. Thus, good health does not come just from public health and social institutions, via primary or inpatient/outpatient care; it also derives from the level of funding, through pensions and disability insurance, available to pay for it and the level of research and education into people’s needs and how best to meet them. This is a holistic view which seems to have the best chance of becoming the leading paradigm of Croatia’s social gerontology, including minority elderly care.

Conclusion

Croatia’s inclusion in the MEC project may introduce a new way of thinking about what is entailed when dealing with ‘minority/majority’ issues in societies and communities that have historically been multiethnic, such as exist throughout Central and Eastern Europe. Croatia’s inclusion in the scope, aims and methodology of this pan-European project is a valuable exercise in learning how minority elders have managed their lives, health and social welfare during and after the terrible war which threatened them with mass murder and ethnic cleansing. Last, but not least, Croatia can only benefit from the endeavour to compare its own health and social welfare system, in regard to minority elders, with that of the more developed countries of the EU.
Introduction

To understand how immigrant elders in Switzerland access care and social and medical services, it is useful to place the question in a wider context and to adopt a multidisciplinary perspective. First, we need to take a historical approach, looking at why and how these elders have spent their active lives in Switzerland. Where did they come from and when? How were they received? What migration policies have been put in place? Did they have the same opportunities in the labour market as the local population?

Our second concern is demographic. How significant is the ageing of the immigrant population compared to the ageing of the population as a whole? Which national minorities are most affected now by a larger proportion of elders among them and which will be affected in the near future? Is there a tendency for foreigners – or for specific national minorities – to concentrate in particular regions or districts? Answers to these questions will help us to predict in which areas the provision of health and social care services to foreign elders needs, if possible, to be prioritised.

It is necessary to approach the issue from a sociological standpoint. We need to inquire about the present living conditions of foreigners – immigrant elders in particular – in Switzerland. What are their socioeconomic situations, their housing, health, family life and leisure activities? This will help to inform us about their resources as well as their difficulties, and allow us to uncover their specific needs, as well as the potential demand on social and medical services.

How far foreign elders can achieve security in their lives depends not only on current social security legislation and practice, but also on their legal status as foreigners. Do they have the same rights as the Swiss or are they subject to specific constraints? Do the regulations governing foreigners vary according to their national origin and/or their status? Investigating this will help us to specify the formal rights foreigners have as protection against some of the consequences of old age.

Each country has a particular system of minimum benefit provision whose workings and structure have to be understood. Here, we need first to describe Swiss old age policy at a broad institutional level. In other words, we need to make a comprehensive assessment of the health and welfare services
intended for the whole elderly population and then to investigate whether foreign elders are well informed about these services and how far they are entitled to use them. Finally, and this is crucial, we shall try to find out to what extent foreign elders already make use of health and care provision and the main obstacles to their access.

Historical and general context

Switzerland has been constructed as a nation state through the recognition of its ethnic diversity; this diversity is considered the very source of its national identity. The variety of languages, religions and traditions present on the national level is counterbalanced by a cultural homogeneity at the local level. A certain diversity is the cornerstone of the Swiss political settlement. Nevertheless, very precise divisions are drawn between the ethnic differences that are socially acceptable and those that are excluded from the national social dynamic (Bolzman and Fibbi, 1991). Thus, four national, territorial, ethnic linguistic groups – Swiss-Germans, French, Italians, Romans – are clearly recognised, while other ethnic minorities are not considered part of the Swiss nation such as immigrant groups, gypsies, and so on.

As far as native ethnic minorities are concerned, many possess multifaceted identities based on religious and/or political affiliations, cantonal identity or social position, which prevents any single group becoming ‘marginalised’. These overlapping social divisions, prevalent among national minorities, are judged not to exist in the foreign population. In particular, their belonging to an ethnic minority is coterminous with belonging to the lowest social class. Hoffmann-Nowotny (1980) calls this phenomenon ‘Unterschichtung’; immigrants enter Swiss society at the very bottom and form its lowest stratum.

In the next section, we present a historical overview of immigration into Switzerland. We shall also describe how the Swiss state has dealt with immigration over the last 50 years and the main social consequences of its immigration policy.

A brief history of immigration in Switzerland

Like most European countries, Switzerland has an age-old tradition of emigration stretching back to the late Middle Ages and which went on to the 19th century, taking, towards the end, the form of migration to the Americas. Towards the end of the 19th century, the number of emigrants decreased and it was only in the last decade of the 19th century that large-scale industrialisation in Switzerland began to reverse the process, resulting in a net migratory balance.

The first major inflow of migrants in modern times, which occurred at the beginning of the 20th century, brought the foreign presence up to 15% of the total population (slightly lower than today’s 20%). The Swiss authorities’ approach during the first phase of immigration was characterised as that of the ‘open door’; a blueprint was also formulated for an immigration policy that never came into force, making naturalisation compulsory for second generation immigrants settled in the country (Garrido, 1987).
This wave of immigration was followed by a sharp fall due to the First World War and then the Depression. It was during this period that Switzerland adopted an explicit policy towards foreigners, the influence of which can still be felt today (Castelnuovo-Frigessi, 1978; Weil and Grunberg, 1997).

Until the 1960s, most foreign immigrants came to Switzerland from its neighbouring countries, namely France, Germany, Italy and Austria. Migration from these countries, however, decreased to 75% of migrants in 1970 and to just below 37% in 2001. From the late 1970s onwards, migrant workers started to come in increasing numbers from Portugal, Turkey and Yugoslavia. During the 1980s, people from these three countries started to come for family reunification. Finally, significant numbers of refugees came to Switzerland from Southeast Asia, Sri Lanka and the Middle East. See Table 1 overleaf.

Changes in immigration policy: legal consequences

While the early policy on immigration did not distinguish between various categories of foreigners, it came to be replaced by a policy that differentiated according to nationality, economic and political criteria and the particular characteristics and attributes of immigrants; that is, by place of origin, culture, professional skills, and so on. The first gradations made among foreigners authorised to reside and work in Switzerland were introduced in 1924 and were facilitated by bilateral agreements. Shortly after the Second World War, a number of explicit measures emphasised the distinctions between different groups of foreigners. The strong economic expansion of the 1960s fostered the growth of labour-intensive industries. The number of workers needed to sustain this growth increased: migrant workers now came mainly from Southern Europe, first from Italy then from Spain.

With European economic recovery, Switzerland found itself competing with other European countries for an insufficiently expanding supply of foreign workers. In 1964, in order to secure labour from Italy, Switzerland entered into a migration agreement that eased restrictions on work permits and family migration (Papademetriou, 1988). Similar treaties followed with Spain and Portugal.

The period of residence required to obtain a permanent residence permit (C permit) is a good illustration of the unequal treatment applied to foreigners according to their nationality: five years for foreigners whose settlement is encouraged – that is, citizens from EU countries – and 10 years for those coming from countries whose settlement is to be discouraged – Eastern Europe and the Third World. The most favoured status was granted to Italians in 1984. When this migration flow dried up, this status was granted to the Spanish in 1989 and finally to Portuguese nationals in 1990 in order to attract the last remaining source of Western European immigrants. At the same time, severe restrictions were placed on Turkish immigration in the early 1980s (after the military putsch) and on Yugoslavian immigration in the early 1990s.
### TABLE 1  Foreign residents as a percentage of all residents (1900–2000)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total residents</th>
<th>Foreign residents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900</td>
<td>3,321,443</td>
<td>383,424</td>
<td>11</td>
</tr>
<tr>
<td>1920</td>
<td>3,653,358</td>
<td>402,385</td>
<td>11</td>
</tr>
<tr>
<td>1941</td>
<td>4,265,703</td>
<td>223,554</td>
<td>5</td>
</tr>
<tr>
<td>1960</td>
<td>5,429,061</td>
<td>584,739</td>
<td>11</td>
</tr>
<tr>
<td>1980</td>
<td>6,365,960</td>
<td>944,974</td>
<td>15</td>
</tr>
<tr>
<td>2000</td>
<td>7,204,055</td>
<td>1,424,370</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: OFE, 2001
In fact, the reduction and stabilisation of the inflow of foreign workers in the 1970s were followed by a tendency for recruitment to extend to more distant and diverse regions. This entailed a further delimitation of the ‘traditional areas of recruitment of foreign labour’, which prevented labour immigration from countries outside these ‘traditional’ recruitment areas (Western Europe, USA, Canada, Australia; see Cosandey, 1989).

At the beginning of the 1990s, the categorisation of immigrants according to geographical and cultural criteria became even more precisely defined with the introduction of the ‘three circles’ immigration policy. According to this concept, the ‘first circle’ is composed of immigrant workers from EU and EFTA countries, who benefit from free movement. For them, settlement in Switzerland is very easy. ‘Second circle’ immigrant workers are nationals from industrialised countries such as the USA, Canada, Australia and Japan, who are entitled to work in Switzerland under certain conditions, and ‘third circle’ immigrant workers are nationals from Eastern European and Third World countries. Recruitment from these countries was barred because of ‘huge cultural differences’. This concept was severely criticised during the latter half of the 1990s by the Federal Commission against Racism and, since then, the authorities have merged the second and third circles into one ‘exterior circle’.

Thus Swiss immigration policy has become characterised mainly by a liberal approach towards entry per se, combined with a restrictive approach inside the country itself. In other words, severe restrictions on mobility were imposed on foreign workers after fairly straightforward admission to the country (Hoffmann-Nowotny, 1985). However, numerous internal restrictions were gradually abolished, finally giving way to a policy of stabilisation from 1970 onwards. The major outcome of this is that a sharp distinction is now made between that category of foreigners whose status is insecure and precarious, who are submitted to special restrictive measures, and that category with a stable and secure presence in the country. This latter population, although not the beneficiary of any special supportive measures, benefits from its general inclusion in the distribution of social goods. The main discrimination it suffers remains the absence of political rights and the necessity of undertaking a long and difficult procedure to acquire Swiss nationality.

The non-settled or ‘precarious’ group includes seasonal workers (A permit), cross-border workers (G permit), holders of permits of less than one year (L permit), asylum seekers (N permit), temporarily admitted persons (F permit) and those with a yearly permit (B permit), all of whom are subject to strict administrative control. They are not allowed to change their line of work or even their employer or to move from one region to another. Their access to housing is restricted, as is their right to family reunification. All these permits are easily revocable. The turnover of immigrants among these categories is still high. There is also another category of extremely insecure and vulnerable workers which has recently been growing in number: the ‘illegal’ category.

The settled proportion of the foreign population, on the other hand, includes the holders of time-restricted, but almost automatically renewable, residence permits (C permit). In theory, those who fall into this category enjoy the same rights as Swiss nationals as far as participation in the labour market is concerned. During the last decade, the percentage of holders of permanent residence permits has increased and some 75% of foreign residents now hold such a permit.
Socioeconomic consequences of the immigration policy

The flexibility that this distinction between the temporary and permanent categories confers on the management of the immigrant population proved economically and politically extremely useful for coping with the economic crisis of the 1970s. Between 1975 and 1976, an overall reduction in employment of 7% led to a 75% decrease in foreign temporary labour which absorbed 5.2% of the fall in employment, a reduction in the settled labour force (i.e. Swiss and settled foreigners) of 1.2% and an increase in unemployment of 0.6% (Flückiger, 2000). In all, almost 200,000 foreign workers left the country, the great majority having only restricted legal status. Most of the residence permit holders stayed in Switzerland. A similar phenomenon took place during the crisis of 1982–83; 47% of the reduction in employment was due to the exit of migrant workers from Switzerland.

Thus immigration management involves a high turnover of new immigrants (seasonal workers, cross-border commuters, those with L permits, asylum seekers, illegal immigrants), while reinforcing the economic integration of the settled foreign population who have passed through the numerous status barriers. The constant renewal of the most vulnerable and insecure sector of migrant workers leads to an improved legal status for the individual migrant who succeeds in remaining in the country. Obtaining a stable residence permit often goes hand in hand with upward social and professional mobility; the removal of geographical and occupational limitations results in an improved socioeconomic status. A study by Levy et al. (1997) on social stratification in Switzerland demonstrates the relationship between the type of permit held and one's social and professional status.

The parallel between improved legal status and access to social mobility is sustained by an ideology of gradual assimilation, adopted as part of Swiss immigration policy. Improvements in legal status are impeded by the barriers to naturalisation – a long, meticulous and expensive procedure – the achievement of which is then viewed as an exclusive reward for successful individual assimilation, conferred by a benevolent state. Consequently, only a small minority of foreigners become Swiss. A rapid decrease in the foreign population because of naturalisation, as has happened in the ‘classic’ countries of immigration, has never occurred in Switzerland.

Thus, official legal discrimination against immigrants does exist in Switzerland. This policy has led to what Hoffmann-Nowotny (1973) calls the ‘neo-feudalisation’ of Swiss society, in the sense that social status is not achieved through performance or capacity, but through membership of a certain ethnic group and the type of permit assigned.
Demographic trends

The total size of the resident population in Switzerland was 7,204,055 in 2000. Resident foreigners totalled 1,384,382 (19.2% of the resident population); after Luxembourg, Switzerland has the highest proportion of foreign residents in Europe (OFS, 2001). It is noteworthy that, since 1945, about 2 million immigrants have come to Switzerland. Without this immigration, it is estimated that the Swiss population would be 5.2 million instead of its current 7.2 million (Wanner, 2001).

A look at the distribution of the total foreign resident population in Switzerland (see Table 2 overleaf) shows that today the main foreign national groups residing in Switzerland are Italians and former Yugoslavians. In particular, the Yugoslavian community has increased drastically over the last 10 years, while the percentage of foreigners from other European countries has decreased. This change is mainly related to family reunification and to the high number of asylum seekers that sought refuge during the war in Yugoslavia.

Emergence of an elderly foreign population in Switzerland

It is well known that much of the foreign resident population in Switzerland is settled. Of the 1,384,382 foreigners living in Switzerland in 2000, 75% had long-term residence permits. This process of settlement is accompanied by the emergence of another phenomenon, the gradual ageing of immigrants. The number of foreigners aged 55+, especially among the Spanish and Italian communities but also those from the former Yugoslavia, Turks and Portuguese, has grown continuously since 1975, both in absolute terms and as a percentage of their respective groups. This trend is not as marked as in the Swiss population, but it indicates the transition from transitory, work-related migration to long-term settlement, at least among the Spanish and Italians.

The number of those aged 55–64 grew regularly until 1995, but the increase slowed down during the last years of the 20th century. The number of foreigners aged 65–74 has increased only since the latter half of the 1980s, while the percentage of those 75+, after a slower rate of growth during the 1980s, has increased by 20% in recent years.

Table 3 provides data on foreign elders in the five major national groups in Switzerland. Italian elders are the most numerous in the three age groups listed; Spanish are the second most numerous in all three age groups; with Yugoslavians third. Portuguese and Turks are more represented among the ‘young elderly’, but less so among the other two categories.

Settlement patterns

Two-thirds of the Swiss live in urban areas. Among foreign residents, four-fifths live in towns and just one-fifth in the country, this distribution remaining unchanged since 1980 (OFS, 1990). Most of the 1,384,382 foreigners domiciled in Switzerland in 2000 are settled in the Swiss-German part of the country (64%), 30% in the French part and 6% in the Italian part (OFE, 2000).
### TABLE 2  Resident foreign population by national groups (2000)

<table>
<thead>
<tr>
<th>National groups</th>
<th>Number</th>
<th>% of foreign population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italy</td>
<td>319,641</td>
<td>23</td>
</tr>
<tr>
<td>Former Yugoslavia</td>
<td>190,731</td>
<td>14</td>
</tr>
<tr>
<td>Portugal</td>
<td>134,675</td>
<td>10</td>
</tr>
<tr>
<td>Germany</td>
<td>108,815</td>
<td>8</td>
</tr>
<tr>
<td>Spain</td>
<td>83,405</td>
<td>6</td>
</tr>
<tr>
<td>Turkey</td>
<td>79,476</td>
<td>6</td>
</tr>
<tr>
<td>France</td>
<td>59,813</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: OFS, 2001

### TABLE 3  Main foreign residents by national and age groups (2000)

<table>
<thead>
<tr>
<th>Group</th>
<th>Number</th>
<th>% of total foreign population</th>
<th>Aged 55–64</th>
<th>Aged 65–74</th>
<th>Aged 75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italy</td>
<td>319,641</td>
<td>23.0</td>
<td>49,582</td>
<td>24,930</td>
<td>9835</td>
</tr>
<tr>
<td>% of FR</td>
<td></td>
<td>41.0</td>
<td>46.0</td>
<td>40.0</td>
<td></td>
</tr>
<tr>
<td>% of Italians</td>
<td></td>
<td>15.5</td>
<td>5.0</td>
<td>3.0</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>83,405</td>
<td>6.0</td>
<td>8948</td>
<td>3318</td>
<td>1028</td>
</tr>
<tr>
<td>% of FR</td>
<td></td>
<td>7.0</td>
<td>6.0</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>% of Spanish</td>
<td></td>
<td>11.0</td>
<td>4.0</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>Yugoslavia</td>
<td>190,731</td>
<td>14.0</td>
<td>6929</td>
<td>1657</td>
<td>300</td>
</tr>
<tr>
<td>% of FR</td>
<td></td>
<td>6.0</td>
<td>3.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>% of Yugoslavians</td>
<td></td>
<td>3.0</td>
<td>0.8</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Portugal</td>
<td>134,675</td>
<td>10.0</td>
<td>2060</td>
<td>425</td>
<td>114</td>
</tr>
<tr>
<td>% of FR</td>
<td></td>
<td>2.0</td>
<td>0.7</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>% of Portuguese</td>
<td></td>
<td>1.5</td>
<td>0.3</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Turkey</td>
<td>79,476</td>
<td>6.0</td>
<td>2969</td>
<td>1021</td>
<td>261</td>
</tr>
<tr>
<td>% of FR</td>
<td></td>
<td>2.5</td>
<td>2.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>% of Turkish</td>
<td></td>
<td>4.0</td>
<td>1.0</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>Total FR</td>
<td>1,384,382</td>
<td>100.0</td>
<td>120,961</td>
<td>53,837</td>
<td>24,446</td>
</tr>
</tbody>
</table>

Note: FR = foreign residents  
Sources: OFE, 2000; OFS, 2001
The proportion of foreigners to the whole population varies greatly from one canton to another. In Geneva, more than one-third of the resident population (37%) are foreigners. In Basle and Ticino, this proportion is one in four (28% and 25% respectively). At the other end of the spectrum, the proportion of foreigners is below 15% in the cantons of the Mittelland (for example, 12% in Bern) and the cantons of Zentralschweiz; Nidwalden has 10% and Luzern has 15% (see Table 4) (OFE, 2000).

Segregation or ghettoisation in the cities is relatively uncommon in Switzerland compared to the situation in other European countries for two main reasons. Cities in Switzerland are relatively small and housing policy is usually not based on concentrating huge buildings or large estates in specific social areas, as is the case with social housing in France for instance (Haug, 2001). Districts are more mixed in Geneva, where the proportion of foreigners is the highest, but less so in the large cities located in the German part of Switzerland (Zurich, Basle, Bern). Here some districts have a high proportion of foreigners as well as a larger share of lower-class inhabitants. In these areas there is evidence of ghettoisation by ethnicity and social class (Haug, 2001).

The trend towards segregation of the Turkish and Yugoslavian populations greatly increased in all Swiss cities between 1990 and 2000, but has decreased in respect of the Italians, Spanish and Portuguese (Schuler, 2001).

As with the Swiss, so foreign immigrants are getting older. Population projections show that the proportion of foreign elders both in the foreign population and among the elderly in general will continue to rise and that the proportion of elderly women in particular will increase.

**Sociological perspective**

As we have seen above, immigration policy, especially in relation to permits, has led to the emergence of an insecure and vulnerable section of the foreign population. In the long run, this will result in lasting inequalities, even for the most settled foreigners. These inequalities may be observed when immigrants become older, as they become overrepresented among the vulnerable, marginalised and poor sections of the population.

In Switzerland, the presence of immigrants is evaluated mainly in terms of costs and benefits to Swiss society; the situation and needs of immigrant elders are issues that did not arouse much interest until recent years. Many Swiss politicians and social scientists view immigrants purely as a labour force that will help to rebalance the age structure of the population and finance the old age and survivors insurance (OASI).

It is noteworthy that we do not usually speak in Switzerland of ethnic or black minority elders, but of immigrant elders or ‘Gastrentner’ (guest pensioners). This distinction is not only semantic, but implies that these elderly are not a settled population, not part of the national reality, as is the case in the UK or even the Netherlands. In those countries, they are seen as a minority who suffer the burdens of age and perhaps poverty, often compounded by racism, and who need specific social and health care.
<table>
<thead>
<tr>
<th>Cantons</th>
<th>Total residents</th>
<th>Swiss residents</th>
<th>Foreign residents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Région Lémanique</td>
<td>1,316,400</td>
<td>946,200</td>
<td>370,200</td>
<td>28</td>
</tr>
<tr>
<td>Geneva</td>
<td>413,800</td>
<td>216,700</td>
<td>155,400</td>
<td>37</td>
</tr>
<tr>
<td>Mittelland</td>
<td>1,665,700</td>
<td>1,426,600</td>
<td>239,100</td>
<td>14</td>
</tr>
<tr>
<td>Bern</td>
<td>946,100</td>
<td>486,700</td>
<td>116,200</td>
<td>12</td>
</tr>
<tr>
<td>Nordwestschweiz</td>
<td>999,300</td>
<td>795,200</td>
<td>204,100</td>
<td>20</td>
</tr>
<tr>
<td>Basle</td>
<td>187,600</td>
<td>135,700</td>
<td>51,900</td>
<td>28</td>
</tr>
<tr>
<td>Zurich</td>
<td>1,227,900</td>
<td>956,100</td>
<td>271,700</td>
<td>22</td>
</tr>
<tr>
<td>Ostschweiz</td>
<td>1,047,400</td>
<td>857,900</td>
<td>189,500</td>
<td>18</td>
</tr>
<tr>
<td>Saint Gallen</td>
<td>452,200</td>
<td>362,100</td>
<td>90,100</td>
<td>20</td>
</tr>
<tr>
<td>Zentralschweiz</td>
<td>689,600</td>
<td>584,800</td>
<td>104,800</td>
<td>15</td>
</tr>
<tr>
<td>Luzern</td>
<td>349,600</td>
<td>295,500</td>
<td>54,100</td>
<td>15</td>
</tr>
<tr>
<td>Nidwalden</td>
<td>38,400</td>
<td>34,700</td>
<td>3700</td>
<td>10</td>
</tr>
<tr>
<td>Ticino</td>
<td>312,200</td>
<td>232,600</td>
<td>79,600</td>
<td>25</td>
</tr>
<tr>
<td>Switzerland</td>
<td>7,258,500</td>
<td>5,799,400</td>
<td>1,459,100</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: OFS, 2002a
In Switzerland, they are seen as ‘birds of passage’ and, consequently, it is not judged necessary that social and health policies incorporate special measures to improve their quality of life during old age. This approach does not tally with reality, but there are few studies of this area. We carried out a survey of 442 Italians and Spanish who were approaching retirement on their way of life and future plans. Two-thirds of the respondents, who were living in Geneva and Basle respectively (two urban areas with significant immigrant populations), had either already decided to stay in Switzerland or to continue to live there one way or another (Bolzman et al., 1998, 1999).

Socioeconomic situation

Our survey shows that Italian and Spanish immigrants were perceived mainly in terms of their economic roles as workers, as consumers and as contributors to tax and social insurance. Some of them had managed to gain a better professional position; about one-third of the men and one-fifth of the women had become independent workers or assumed positions of responsibility by the age of 45. However, when we looked at their situation as they approached retirement, it became obvious that some were in a precarious social and economic position or in outright poverty. The first indicator of this was the high proportion of those who were forced to retire early because of long-term unemployment or health problems. Men were particularly affected; 20% of those aged 55–59 had already left the world of work compared to about 10% of the total resident population of the same age.

In general, foreign workers suffer more from unemployment than do Swiss workers. During the crisis of 1991–93, they were four to five times more likely to lose their jobs than Swiss workers (Haug, 1995). This situation changed somewhat during the 1990s because a large majority of foreign workers obtained permanent residence permits (permit C) and unemployment insurance became compulsory (this was not the case during the oil crisis of the 1970s). As a consequence, most unemployed foreigners now receive unemployment benefit which provides them with a minimal income, although their chances of finding work again are very low. Today unemployment is still much higher among foreigners than among Swiss, although the overall Swiss figures for this are relatively low; 5.3% for foreigners compared with 1.3% for Swiss nationals in 2002 (La Vie Economique, 2002). Long-term unemployment becomes particularly common between the ages 50–64. Just under 44% of the unemployed in this age group have been unemployed for over a year (27% among the younger unemployed; La Vie Economique, 1995).

The main reason for early retirement is ill health. More than 75% of men who have already left the labour market before the official retirement age receive a disability allowance. According to our survey (Bolzman et al., 1998), the most severely affected foreign workers are those in the construction sector, of whom half receive a disability allowance. Generally speaking, 15% of men and 9% of women get disability allowance, which is very difficult to obtain in Switzerland. This is three times more than the level for the total resident population of the same age living in the canton of Geneva (Fibbi et al., 1999).
Immigrant workers (especially women) approaching retirement are also overrepresented among low income categories. The proportion of people whose personal monthly income is lower than SFr1000 and well below the poverty line was 8.4% in our sample (two-and-a-half times more than the resident population of the same age). A national study on poverty confirms these results. The likelihood of foreigners aged 60+ falling into poverty is twice as high as for Swiss nationals of the same age (Burri and Leu, 1997). This reflects the general situation of immigrants in Switzerland; the proportion of working poor within the foreign population is twice as high as within the Swiss population – 12.2% compared with 6.2% (OFS, 2001). It is not surprising, therefore, that the foreign population appeals more frequently to the social services. In 1999, 3.4% of foreigners, as compared with 1.8% of the Swiss, received benefits from the Geneva social services (Bolzman et al., 2002).

Housing

Compared to other European countries, the percentage of homeowners is very low in Switzerland; 31% compared with France’s 54%, Italy’s 59% and Spain’s 69% (OFS, 2002b). This is true of both the Swiss and foreign populations. Nevertheless, the elderly are more likely to own their own housing (39%), but no statistics about this are available for migrant elders.

Foreigners are slightly more dissatisfied with their housing situation than the Swiss; approximately one-third of them would like a change of housing compared with 25% of the Swiss. The most frequent reason given by both population groups is the unsatisfactory nature of the apartment or house or its environment. For 18% of foreigners, the main cause of dissatisfaction is overpriced rents, a reason given by only 9% of Swiss interviewees (Branger, 1998).

Foreign residents have less living space than the Swiss. In 1990, the average living space for foreign residents was 30 square metres compared with 42 square metres for the Swiss (OFS, 1990). In terms of density of occupation, 20% of foreigners live in a reduced space, which is the case for only 7% of the total resident population of the same age group. Italians and Spanish aged 55–64 come between the two; some 11% of them live in a reduced space (Bolzman et al., 1998).

Health situation

Health problems are a daily preoccupation for elderly immigrants, arising either because of their age or from the aftermath of their working life. According to our survey, health was an important issue for 78% of Italians and Spanish (75% for men and 82% for women). In fact, of seven issues judged to be the most important, ‘being in good health’ and ‘having a harmonious family life’ were the most frequently mentioned (83%). The preoccupation with health among our survey sample is not coincidental. Industrial accidents are known to be more common among immigrants, who are more likely to be manual workers in high risk environments. Twenty-three per cent of foreign workers have industrial accidents compared with 16% of Swiss workers (Bollini and Siem, 1995).
Self-assessment of one’s state of health is a subjective but reliable indicator of both physical and mental health and is a standard procedure in social research. Various cantonal-level studies published in the 1980s showed that 7–11% of persons aged 65+ considered their health to be poor (Rapport de la Commission Fédérale sur la Vieillesse, 1995). The Italian and Spanish respondents in our survey, although younger (55–64 years old), demonstrate a higher incidence of health problems, affecting 19% of our interviewees, more than half of whom (11%) receive disability allowance (see Table 5 overleaf).

This situation has been described as the ‘exhausted migrant effect’ (Bollini and Siem, 1995). Such persons arrived in Switzerland in good health (it was those in better health who left their countries of origin and the newcomers underwent strict health controls at the Swiss border), but are today exhausted after 20 or 30 years of hard work, difficult living conditions and insecure legal status. A recent study of Geneva shows that life expectancy is shorter among semi-skilled or unskilled workers; that is, mainly among immigrant workers (Guberan and Usel, 2000). Another survey of Spanish elders in Switzerland reveals that 30% of those surveyed are disabled or ill; among those under 65, the proportion is 44%. The majority of cases are related to industrial accidents or to the nature of their work (Embajada de España en Suiza y Famaes, 2001).

Family and household structure

Family life is obviously an extremely important factor in the general situation of the elderly. Below we analyse the family networks of immigrant elders and the way they mobilise them on the basis of the survey discussed above (Bolzman et al., 1998).

The family network can be seen as a ‘reservoir’ used to satisfy different kinds of needs – material, symbolic, emotional – and is of great potential value to its members (Coenen-Huther et al., 1994). This does not mean, however, that it can be put into constant use; some factors may impede this such as the small size of the network, geographical distance between family members, a lack of affinity between them or reluctance to ask for help. See Table 6 overleaf.

On average, the Italian and Spanish interviewees in our survey have 10 or 11 individuals in their ‘close’ network: mother or mother-in-law, three brothers and sisters and the same number of brothers- and sisters-in-law, two children, one of them married with one child. Apart from children living with their parents or nearby, the other members of the family network usually live further away. Some mothers, mothers-in-law, brothers, sisters and brothers- and sisters-in-law live close to the interviewees, but most are still living in the country of origin. Those who have more than half of their family living in the vicinity are in the minority (25%). On average, only three family members live in the same area as our respondents. However, when children leave their parents’ homes, they tend to settle closer to them than do Swiss children.

Half the adult children of Italian and Spanish parents see them several times a week; the same is true of one-quarter of Swiss offspring. The importance of family relations across the generations becomes evident also in the numerous exchanges that occur between immigrant parents and their children.
### TABLE 5  Studies of self-assessments of health by elders

<table>
<thead>
<tr>
<th>Studies</th>
<th>Age group</th>
<th>Population</th>
<th>% in poor health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geneva, 1978</td>
<td>65+</td>
<td>Swiss</td>
<td>7.0</td>
</tr>
<tr>
<td>Zug, 1982</td>
<td>57+</td>
<td>Swiss</td>
<td>7.0</td>
</tr>
<tr>
<td>Switzerland, 1993</td>
<td>50–64</td>
<td>Swiss</td>
<td>4.2</td>
</tr>
<tr>
<td>Switzerland, 1993</td>
<td>50–64</td>
<td>Foreigners</td>
<td>7.6</td>
</tr>
<tr>
<td>Geneva, Basle, 1993</td>
<td>55–64</td>
<td>Italians/Spanish</td>
<td>19.0</td>
</tr>
</tbody>
</table>


### TABLE 6  Location of family members of Italians and Spanish aged 55–64 (%)  

<table>
<thead>
<tr>
<th>Place</th>
<th>Children</th>
<th>Type of kinship</th>
<th>Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Brothers/sisters</td>
<td></td>
</tr>
<tr>
<td>Home country</td>
<td>4</td>
<td>35</td>
<td>80</td>
</tr>
<tr>
<td>Home country + region</td>
<td>8</td>
<td>60</td>
<td>4</td>
</tr>
<tr>
<td>Region</td>
<td>87</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>In other countries</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Number</td>
<td>391</td>
<td>434</td>
<td>215</td>
</tr>
</tbody>
</table>

Source: Bolzman et al., 1998
Some forms of support are given mainly by parents to their children, often in the form of financial help and babysitting. Other forms of support are two-way and include moral support in difficult situations, shopping, helping with housework, minor household repairs, driving and gardening. One form of support is given mainly by children to parents, namely help in dealing with Swiss bureaucracy (Bolzman et al., 1997).

We also asked the interviewees if they could rely on family help at times of sickness. Some 90% of them expect the support of their spouse and also their children, while 50% expect some help from other relatives. Such support can be moral, practical or emotional, but material support as well as a certain level of health care are expected from social security agencies and from social and medical services. Immigrants refuse to become a ‘burden’ on their children in a society where the material conditions that would enable family members to take on a heavy burden of care are lacking.

When immigrants reach retirement, they are more likely to have low incomes and poor health than the Swiss, especially women. However, systematic information on these issues does not exist. Nevertheless, foreign elders have some social resources (their families, social networks) that enable them to face the problems of old age with some support but, when serious financial and health problems occur, they rely mainly on social security and public services.

Legal context of entitlement

Given the development and growth of the welfare state, social security has become the main means of protecting individuals from poverty and insecurity. In this section, we outline the Swiss legislation on social security, especially as it affects the elderly, and examine to what extent and under what conditions foreign elders are entitled to social security benefits.

The Swiss social security system has two aspects: social insurance and social welfare.

Social insurance

The cornerstone of social insurance is the three-pillar system, organised around three methods of funding financial support. It is a threefold system of public, occupational and private insurance.

Old age and survivors insurance (OASI) and invalidity insurance jointly make up the first pillar, with pensions intended to cover basic living costs. When these are insufficient, there are supplementary benefits to top up income to the required level. The first pillar is complemented by a second pillar, occupational benefit plans to cover old age, survivors and invalidity. The first two pillars together should amount to at least 60% of the beneficiary’s most recent earnings and allow pensioners to maintain the standard of living to which they are accustomed.

The first pillar is compulsory for all, including the self-employed or people not in gainful employment (parents of either sex who take care of the home and children, for example). The second pillar is only obligatory for salaried workers.
The third pillar – individual provision to meet further needs – is optional but, unlike other forms of savings, offers certain tax benefits. The three-pillar system, embodied in the Swiss Constitution since 1972, is intended to ensure a decent standard of living for people of retirement age and other pensioners.

Social insurance therefore covers four main areas: provision for old age; provision for dependants (widowed spouses, children and the disabled); provision in case of sickness or accident; and unemployment insurance and family allowances. Since we are concerned with the elderly, we shall examine only the first two areas.

These forms of insurance grant financial benefits (pensions, compensation for loss of income) and cover costs in cases of sickness or accident. Social security benefits, in particular those granted in lieu of an income from paid employment, are mainly financed out of salary-based contributions. Health or sickness insurance, as it is called in Switzerland, is financed from individual premiums paid by the insured. The federal authorities and cantons participate to a greater or lesser extent in financing social security (old age insurance, invalidity insurance, sickness insurance). Supplementary benefits are financed completely out of federal and cantonal tax revenue. The occupational benefit plan (the so-called ‘second pillar’ of social security) is a fully-funded system.

Social welfare

Social welfare or social assistance is always means tested. Based on the principle of subsidiarity, it aims to provide everyone with the means to meet their basic needs, in particular people who are not covered by any other form of social security – those outside the welfare ‘safety net’. To a large extent, social aid is administered by the cantons. Cantonal regulations differ widely and the disparity between the benefits granted is great. There are, of course, other cantonal and municipal institutions as well as private charities which supplement the two primary sources of social security.

Foreign elders in the social security system

Today, foreign residents in Switzerland are net payers into the OASI scheme, receiving less at the moment than they are contributing. However, the number of pensions to be paid to foreigners will rise sharply over the next few years because the migrant workers who came to Switzerland in the 1960s will be entitled to draw their OASI pensions. However, foreigners’ pensions are relatively low, since the amount of pension depends on the length of time that contributions have been paid, and most immigrants have worked for only part of their active life in Switzerland.

The most significant difference between Swiss and foreign elders lies in their access to supplementary benefits. Since 1965, legislation has been in place for cantons and communes to pay supplementary benefits to those whose old age pensions are insufficient to cover their basic needs. These pension supplements are part of social security and beneficiaries are legally entitled to them. They make up the difference between expenditure and income. However, although they constitute a right, some may feel that this is a charitable dole and resent having to ask for it. In the case of foreigners,
access to supplementary benefits depends upon nationality, length of residence in Switzerland and on the canton. Foreign elders need to have an unbroken 10-year residence in Switzerland to qualify for supplementary benefits. Those who come from countries without a bilateral social security convention with Switzerland must be recipients of an old age, survivors or invalidity pension in order to be legally entitled to them. Refugee elders, however, are entitled to receive these benefits after five years of residence in Switzerland.

Unlike the OASI, the second pillar works on a money purchase system. The pensioner receives a pension based on the amount of money contributed by they and their employer into the pension fund, plus the interest yielded. Contributing to the ‘second pillar’ has been compulsory since 1985, but only for those with a yearly income of at least SFr24,000. Thus, many women, especially foreign women, do not benefit from this provision, since they earn less than this amount working in unskilled and part-time jobs.

Health insurance gives everyone living in Switzerland access to adequate health care in the event of sickness, maternity or accident, where these are not covered by accident insurance. Every resident in Switzerland is legally obliged to take out this insurance regardless of age or nationality. Each family member is insured individually.

The level of personal contributions varies from one canton to another and from one insurance fund to another, but the benefits of basic health insurance are the same. Within each insurance fund, the amount of contribution levied is the same for all members and no distinctions are made according to age, sex or nationality. Individuals may also take out supplementary health insurance which gives access to private or semi-private rooms in hospitals or to additional care (for instance, natural medicine). In the case of home nursing and care, the costs of assessment, advice and counselling, primary and therapeutic care, are covered by the health insurance fund. Foreigners are less likely to have supplementary health insurance than the Swiss, the main reason for which is probably its cost.

In short, even if foreign elders started working at an earlier age than the Swiss, they would not fully benefit from OASI and ‘second pillar’ funding because they start to contribute to the Swiss system later in their lives or because they earn less than SFr24,000 per year. As has been noted, women are particularly affected. In addition, foreigners are not entitled to supplementary benefits if they do not fulfil the conditions of length of residence and thus they are more vulnerable to poverty.

Service providers for the elderly

Since Switzerland is a highly decentralised, federal state with largely autonomous cantons and communes, there is no single model of service provision that covers the whole country. However, there are major similarities between cantons and we describe below the main types of services available to the elderly in most Swiss cantons. We also examine the provision made there for foreign elders and the role played by immigrant organisations and NGOs in service provision.
Nursing homes

Nursing homes, whose users are physically and/or mentally dependent elderly, are organised on a cantonal basis, but function in a similar way throughout Switzerland. They are run by specialist and professional staff (medical, social, housing, catering, administrative). Some of them depend on the public sector for funding, others on non-profit organisations and some are private institutions.

Nursing homes are expensive because their costs include medical and social care, such as drugs, specialised equipment and the provision of organised social activities, as well as accommodation, meals, laundry, and so on. In general, they are financed from three sources: residents’ contributions, health insurance and state subsidies. Many people are unable to afford the cost of staying in a nursing home; in such cases, requests may be made to the cantonal office for elderly people for cantonal or federal supplementary benefits. Most of the residents of nursing homes are women and 78% of residents are aged 80+ (Geneva Social and Health Department, 1999). The average length of stay is about 38 months. The vacancy rate is very low; below 2% in Basle and below 4% in Geneva. Waiting lists are usually long.

There are no statistics on the nationalities of nursing home residents, but male immigrants, whose life expectancy is shorter than that of the Swiss, are probably underrepresented in this type of institution. Moreover, according to some professionals, migrants from the underdeveloped South are more reluctant to enter nursing homes, since negative stereotypes have developed about such homes. Our research will allow us to explore this issue more fully.

Housing for elders

There are other types of housing for elders who need little or no care. This mainly consists of specially adapted housing or sheltered accommodation, with some elements of social care. This is usually provided by the public sector or non-profit organisations. Elders’ homes are for those who are still largely physically independent. Such homes might, for instance, be suitable where one member of a couple is independent, but the other less so. Residents live in their own apartment or room and share common facilities such as the dining room and lounge. People live in medium-sized blocks of generally 50–200 flats and may be provided with social or light nursing care. Single people live in one- or two-roomed flats, couples in three-roomed flats.

The cost varies widely and is financed by residents’ own contributions. Financial support is available through supplementary benefits and/or public assistance for elders who cannot meet the costs. Most residents are women; in Geneva, for instance, they comprise 75% of the 1179 residents. There are no data on the numbers of foreigners in these residences.

There are also serviced flats (senior apartments) which offer various household services such as cleaning and catering. This sort of housing is provided by the private sector and is aimed at those with high disposable incomes.
Help and home care services

Most of the elderly prefer to live in their own homes for as long as possible and social policies are geared to that end. The aim is to bring basic help and home care services to the elderly in order to allow them to continue their everyday lives in their usual environment. These services are organised at the cantonal level and are coordinated at the federal level by the Swiss Association for Help and Home Care Services, founded in 1995. Within the cantons, such services are usually organised at the district level. In the cantons of Geneva and Basle, there is a social service and a home care service in each district. In Geneva, 75% of the funding for the help and home care services comes from public money.

People of all ages are entitled to housekeeping or household help and therapeutic care. This mainly consists of physical care, first aid, nursing treatments, therapeutic care as medically prescribed, support for everyday activities, helping people make contact with families or the wider social environment, support during convalescence and palliative care. Costs are paid by the health insurance fund. Users pay a small fee, depending on their annual cover plan.

Day care centres

One of the aims of social policy is to allow elderly people to stay at home as long as possible. Day care centres were created to realise this purpose. Clearly oriented towards the support of elderly people living at home, they collaborate with help and home care services and with social services. Most users of these centres are women aged 80+, but again no statistics are available on users’ nationalities.

Day care centres are usually run by non-profit organisations which get financial support from the state. Because of this the centres are able to offer their facilities at low prices. The price covers psychosocial follow-up, daily transport to and from the centre, breakfast, lunch and a light meal in the afternoon.

Social services

The role of social services is to assist the socially disadvantaged in various ways, informing them about their rights, the kinds of services available to them, advising and supporting them when they are faced with problems, offering financial assistance, acting as mediators between users and institutions, and so on. The provision of social services is normally organised according to district, and social services are meant to meet the demands of different kinds of populations living in a particular area. However, it is possible to find some specialised social services that are focused on the needs of specific populations such as women, elders and immigrants. In the case of the elderly, the not-for-profit organisation Pro Senectute was established to meet their specific needs.
Pro Senectute has a central place among the national institutions that support the elderly. It has been in existence for almost a century. At the beginning, its role was mainly to provide financial support but, since the introduction of OASI in 1947, this role has broadened. Today, the main aims of Pro Senectute are to improve the quality of life of the elderly and to develop services that allow them to preserve their autonomy. Pro Senectute also tries to promote a policy for elders appropriate to the modern world and is an advocate for solidarity between the generations.

According to Pro Senectute’s annual report (2002), 28,000 persons sought their assistance in 2000, of whom 70% were aged 70–89. The proportion of foreigners contacting it has risen since 1999, from 8% to 12% (see: http://www.pro-senectute.ch). Pro Senectute delivers lectures on preparing for retirement that allow elders to consider all the issues related to retirement in general and to early retirement in particular. In some cantons, Pro Senectute collaborates with immigrant associations and social services to set up specific programmes, adapted to immigrant communities, on preparation for retirement. Italians have so far been the main beneficiaries of these programmes.

Minority providers

In Switzerland, minority providers do not play a major role in delivering services to elderly migrants and most housing and care services are delivered by mainstream providers. However, the role of minority providers is important in the social services, mainly in the field of social work.

The great majority of nursing homes are administered by mainstream providers. In cantons like Geneva, where there has long been an ethnic minority presence, there are some nursing homes oriented to the Italian and Jewish communities, although all nursing homes are open to all elders in principle, regardless of religion, language or national origin. In the field of care – care centres, day care centres, home help and home care services – there are no minority providers either. Although significant numbers of those working in such services, especially in the less skilled tasks, are immigrants, they are managed by mainstream providers.

The situation is somewhat different in the social services, where there are some specific services for immigrants and for immigrant elders. Historically, such services have been created by institutions in their countries of origin (trade unions, the church and the state), by immigrant associations or by private non-profit-making organisations. Thus, even today, immigrants from some countries still rely on services that originated in their home country in order to cope with officialdom because the shared language makes them feel better understood. This is particularly true of Italians, the largest and one of the oldest immigrant communities in Switzerland. It has at its disposal a wide network of social support. For instance, when Italian immigrants officially retire, they seek support mainly from the ‘patronati’, community social services linked to Italian trade unions. There are also some private not-for-profit organisations delivering social and community services to elderly immigrants and refugees, such as the Red Cross. Many of these initiatives are promoted by social workers who are themselves of foreign origin.
Nonetheless, at the present time, immigrant elders are not self-organised, but rather participate on an individual basis in immigrant associations, local trade unions or associations for the elderly.

To sum up, a complex system of health and social care for the elderly has progressively been built up in Switzerland through a combination of public, non-profit and private organisations which covers the various needs of the elderly. In regards to accommodation, health care or help in the home, mainstream providers have so far paid little attention to elderly foreigners, although some private social service institutions, like Pro Senectute, pay more heed to the specific needs of foreign elders, and some NGOs, particularly focused on the needs of immigrants, give them information about their rights. However, very few services are directed towards foreign elders.

Access to services

Even if mainstream providers meet most of the needs of elders, their services are not always easily accessible to immigrant elders for many reasons: adequate information about services, adapted to people with other languages and with little education, is not available; no policy of integration has been developed in relation to this generation of immigrants; many immigrant communities distrust Swiss bureaucracy because of the country’s harsh immigration policy; mainstream institutions do not pay enough attention to elderly immigrants; and there is a lack of training in multicultural approaches to health and social work.

In general, the foreign population is less well educated than the Swiss, mainly because of the nature of the migrant workforce’s recruitment. The PRI survey (Bolzman et al., 1998) referred to earlier revealed that Italians and Spanish aged 55–64 had low levels of formal education and 70% of them did not progress further than compulsory education. Most began working early in life and many did not speak standard Italian or Spanish fluently, but rather a dialect (Bolzman et al., 1999).

Immigrants have few dealings with the civil service. When they need help, they turn to their families (especially children) or to trade unions. They seldom contact officialdom, either the social services or their consulate, and look only occasionally for advice or help from immigrant associations. Italians use trade unions and the ‘patronati’ system for help more than the Spanish use their equivalent. This is probably because the Italian community in Switzerland is longer established and more structured in its organisation than the Spanish one.

In addition, contact with mainstream society appears more difficult in the Swiss-German region than in the French-speaking one. A survey of Spanish elders confirms this. Those who have most difficulty in speaking the local language live in the Swiss-German region: one-third cannot communicate in German and this proportion is even higher among those aged 70+ (Embajada de España en Suiza y Femaes, 2001). Some hospitals are now training professional interpreters to ease contact between doctors and patients, but such practices are usually not seriously considered. However, professionals in various health services are becoming increasingly aware of linguistic difficulties.
TABLE 7 Statistics on the three groups researched (2000)

<table>
<thead>
<tr>
<th></th>
<th>Total resident population</th>
<th>% Aged 55+</th>
<th>% of total national group</th>
<th>Urban/rural</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italians</td>
<td>319,641</td>
<td>4.0</td>
<td>84,347</td>
<td>26.0</td>
<td>Mainly urban</td>
</tr>
<tr>
<td>Spanish</td>
<td>83,405</td>
<td>1.0</td>
<td>13,357</td>
<td>16.0</td>
<td>Mainly urban</td>
</tr>
<tr>
<td>Yugoslavians</td>
<td>190,731</td>
<td>2.5</td>
<td>8886</td>
<td>5.0</td>
<td>Mainly urban</td>
</tr>
</tbody>
</table>

Source: OFS, 2001
A recent study of the access of foreign elders to supplementary help and home care in Basle shows that they know little about these services. A large majority think that the only possibility left to them is to spend their old age in a nursing home (Jacobs Schmid, 2001). The problems that elderly immigrants have in accessing services reflect the lack of any serious integration policy, a lack which has important long-term consequences. Another survey demonstrates that 83% of Italian respondents believe that the Swiss state has done nothing to make integration easier for them and that, if their present situation is reasonable, this is due to their own efforts (Colonies Libres Italiennes en Suisse, 2000).

Prospects for further research

A general examination of data on immigrant elders in Switzerland led us to choose three national groups to look at more closely: Italians, Spanish and those from the former Yugoslavia. These three national groups were chosen for historical, demographic and cultural reasons and because of the forms of their community organisation.

The Italian community is the largest and oldest immigrant group in Switzerland, with the highest number and proportion of elders. Italian immigration first began at the end of the 19th century, with a new and significant wave of ‘guestworkers’ coming after the Second World War. Italian immigration is still continuing today, but at a slower pace. Italians live in all regions of the country, are well organised at the community level and among them are some minority providers offering social and care services.

The Spanish also represent a significant history of immigration, mostly as ‘guestworkers’; the proportion of the elderly in this community is high, coming second only to the Italians. Spanish immigration really started in the 1960s and early 1970s. Most entered as guestworkers, but there were also those who had been politically persecuted by the Franco regime. Current Spanish immigration is, like that of Italians, at a fairly low level. The Spanish mainly live in French-speaking Switzerland and – this is the great difference between they and the Italians – have few community services of their own.

Those from the former Yugoslavia are the second largest foreign minority in Switzerland, one which has grown rapidly during recent years. Yugoslav immigration started in the 1970s, initially as guestworkers. Due to the recent war, many erstwhile guestworkers decided to remain in Switzerland and bring their families. In addition, a new group of asylum seekers arrived during the 1980s and 1990s. Many of them have remained in Switzerland under various temporary and precarious statuses. Thus, the number of Yugoslavs living in Switzerland has increased rapidly during the last 10 years and, in the future, they may well become the most significant ethnic minority in Switzerland. Today, they already account for the third largest number of elderly immigrants. Many were already fairly old when they came to Switzerland, where they encountered a number of problems. They form, today, one of the most stigmatised and discriminated against minorities in Switzerland. A majority of them – Albanians from Kosovo and Bosnians – are Muslim, which causes specific difficulties with mainstream services. They have no social and welfare services of their own, but some NGOs have created specific services to help and support them. Most live in the German-speaking part of Switzerland.
Switzerland is a federal country with 26 highly autonomous cantons and four main linguistic regions: German, French, Italian and Roman. Most foreign residents are concentrated in the urban cantons. Residential segregation within cities is higher in German-speaking than in French-speaking areas. Therefore, it is important to select one canton, mainly urban, in each of the two main linguistic regions to carry out further research. These are the cantons of Geneva, located in the French-speaking part of Switzerland, and of Basle, located in its German-speaking district.

We aim to collect data on the three groups of immigrants already discussed in these two cantons. In Geneva, Italians and Spanish are well represented and, to some extent, those from the former Yugoslavia. In Basle, Italians, Spanish and former Yugoslavians are well represented. Since each canton has its own health and social care system, it is important to choose two cantons about which we already have a certain knowledge of the system. In addition, these cantons have each built up one of the most advanced systems of elderly care in Switzerland. They are also the most open to migrants. Thus, we hope to explore and describe ‘best practice’ in Switzerland in respect of immigrant elders. If, in these two cantons, the gap between the needs of minority elders and the provision of mainstream services is still considerable, one can readily predict how far other cantons will need to go if they are to offer adequate support to minority elders.

Conclusion

Historically, a large number of immigrants came to Switzerland after the Second World War. They were recruited to work mostly in unskilled jobs and suffered severe legal restrictions. There were limitations on family reunification, geographical and professional mobility and access to social security and public assistance. The immigrants also met hostility from sections of the native population. The Italians, who came during the 1950s and 1960s, and the Spanish, who came during the 1960s and 1970s, were the groups most affected by this institutionalised and popular discrimination. In spite of all these problems, they settled with their families in Switzerland.

In the 1980s and 1990s, the focus of hostility shifted towards asylum seekers and immigrants from Eastern Europe. After the beginning of the war in the Balkans, major immigration took place from this region to Switzerland. Immigrants from the former Yugoslavia are today most at risk from legal restrictions and discrimination.

From a demographic point of view, sections of the population of foreign workers are becoming older and, contrary to official expectations, many will remain in Switzerland after retirement. Moreover, according to statistical projections, the percentage of the foreign population and of the elderly in general will increase over the next 20 years. Those most affected by this process are the Italians and the Spanish, the most numerous national groups that came to Switzerland after the last war and those with the longest history in the country. Those from the former Yugoslavia today account for the third largest group of elderly immigrants residing in Switzerland.
The socioeconomic situation of foreign elders is strongly linked to the conditions in which they have lived and worked. They are overrepresented among the poor and the sick. Nonetheless, they benefit from family support and from participating in informal ethnic networks. However, neither their children nor the members of these informal networks are able, in a systematic way, to take care of them in the event of disability, illness or other age-related problems. In fact, immigrants expect their main support in case of difficulty to come from social security and mainstream services. Having contributed by their labour power to the prosperity of Switzerland, they believe themselves deserving of the support of health and social institutions.

Officially, most foreign elders have the same right to social security as Swiss elders. However, because of their shorter residence in Switzerland and lower wages, their OASI pensions and occupational benefits are lower than those of the Swiss. Moreover, they are not always entitled to supplementary benefits, even when their income is very low, because they have not resided for long enough in Switzerland. Sometimes they are entitled to benefits, but do not realise their right to claim them. Many elderly immigrants hesitate to ask for social welfare, even if this is a constitutional right offered to people in need, because they fear losing their residence permit if they need long-term assistance. In a way, elders who are foreign and poor are expected to find a private, individual solution to their poverty.

In Switzerland, a complex system of health and social care for the elderly has progressively been built up. Until now, little has been known about how mainstream services support elderly foreigners because there is no systematic data or research. As far as we can ascertain, however, it seems that social services are more sensitive to the specific problems of immigrant elders than are nursing homes or supplementary help and home care services.

Today, local social services are becoming more aware of the problems of elderly immigrants. This shift is probably due to many reasons: growing recognition of the fact that most of the ‘younger’ immigrant elders will stay and use these services; the presence of foreign social workers in the social and welfare services; and a greater sensitivity to ‘multiculturalism’ at the local level.

This new sensitivity is more attuned towards newly retired immigrants. Immigrant elders of the ‘fourth age’, persons in their eighties and over, are not affected by this new trend. For instance, there is no policy in respect of access for elderly immigrants to old age services, no study of their specific needs and preferences for living arrangements. No one knows how many immigrant and ethnic minority elders are still living with their families and how many are living in nursing homes. The question of living arrangements for those immigrants of the most advanced ages is a vital one and demands to be explored in a more systematic way.
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