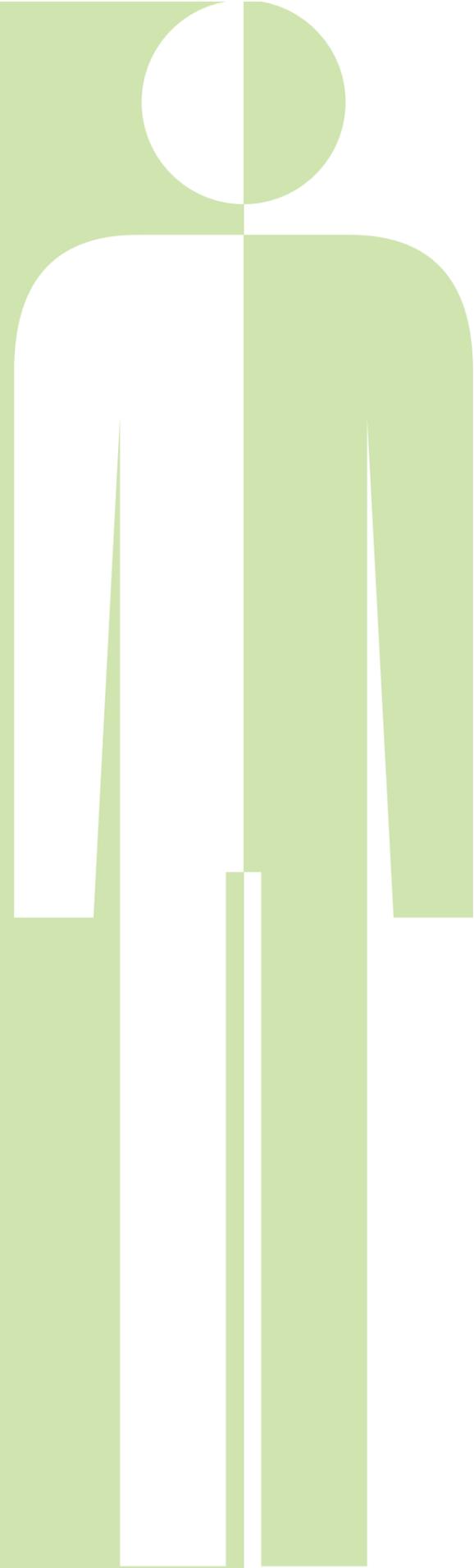


DEMOGRAPHIC  
CHANGE  
&  
SOCIAL  
AND  
HEALTH  
SERVICES  
IN  
EUROPEAN  
CITIES



INCLUSIVE  
CITIES  
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EUROCITIES is the network of major European cities. Founded in 1986, the network brings together the local governments of over 130 large cities in some 34 European countries. EUROCITIES represents the interests of its members and engages in dialogue with the European institutions across a wide range of policy areas affecting cities. These include: economic development, the environment, transport and mobility, social affairs, culture, the information and knowledge society, and services of general interest.

# DEMOGRAPHIC CHANGE & SOCIAL AND HEALTH SERVICES IN EUROPEAN CITIES

December 2008

Ian Goldring

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## 0\_Executive summary

This study explores current approaches, in selected European cities, to adapting to the impact of demographic trends on health and social services. It looks at the impact of changing demographics in different areas of Europe and on different types of cities, presenting examples from five cities to demonstrate how these are adapting their health and social services to the pressures of demographic change.

Throughout Europe the population is ageing, although there are elements of variation in terms of severity and timing. At the same time, migration is changing European societies and altering policy agendas, although it is being experienced in very different, even opposite, ways in different cities. Parts of Europe have a long modern history of receiving immigration, and are adapting their policies and services as the situation evolves (e.g. Southampton, Stockholm and Vienna); others are only recently experiencing significant foreign immigration, and are trying to catch up in terms of adapting their services, policies and planning (e.g. Barcelona); other areas of Europe have only negligible immigration and are in fact more affected by emigration (e.g. Krakow).

Looking one by one at the sample cities chosen, Barcelona stands out as a significantly changing society, combining an ageing population with a strong influx of immigration, which is recent and unprecedented in scale and character: immigrants now account for almost all population growth in Barcelona. Much of the innovation that this study identified in Barcelona comes from front-line service providers and from the city overall, as it faces new and rapidly changing circumstances, and is under great pressure to generate effective proactive strategies and tools in dealing with the demographic challenges.

Krakow is experiencing a mild decline in population and tighter available resources; emigration is more of an issue than immigration. Likewise, the city gives the impression of being mainly reactive to its circumstances. Krakow is the city and administration about which it was most difficult to gather information.

Southampton is fairly representative of general demographic trends in Southern England: its population is ageing, and immigrants are arriving at rates that place the city in something similar to a median position in terms of this study. Administration emphasises a 'joined up' coordinated approach, and the city has been enjoying a long cycle of robust economic performance and strong labour markets, which attracted immigration. The recent economic downturn raises questions about future directions.

Stockholm manages to combine a relatively high birth rate with a growing population of older people. Notably, elderly issues very much occupy the political spotlight, being the cause of local restructuring of political and administrative institutions. The country also faces the risk of growing labour shortages, which increases the pressure for maximum labour activation among immigrants and older people.

Vienna was the most well documented of the cities, in terms of demographic trends, impacts, and programmes developed to deal with the new challenges presented by such trends. The city is ageing somewhat ahead of much of Europe, and is being very proactive in planning and innovating for greater efficiency and coordination, to meet the challenges in terms of need and in terms of budget stressors: this makes Vienna a rather interesting laboratory for its peers, especially those facing similar challenges now or in the near future.

### Questionnaire results:

Wider consultation with EUROCITIES Social Affairs Forum members has drawn a range of feedback on how:

- Demographic trends, that are impacting on services and changing needs, are being studied: the methods are largely in line with the 5 main cities examined.
- Regarding the role of European Union NAPs (National Action Plans for Social Inclusion) in local policy, it emerged from responses to the questionnaire that the way the cities make use of their NAP is inconsistent at best: for the most part, the role of the NAPs as a tool or reference is weak, though there are some exceptions, particularly where the city has provided input in terms of drafting the NAP.
- Intercultural mediation and training is practiced by most of the respondents: but the way they do so is inconsistent, showing different approaches and different levels of priority.
- Deprivation is understood and monitored by the participants, and shows general similarities at a basic level: there are some local variations which are of interest, in terms of identifying the links between different deprivation factors.
- Cities that responded to the questionnaire are all adapting their resources and administrative structures to better cope with the impact of shifting demographic trends; the reforms are broadly similar thematically, but with variations of local emphasis, due to differences in context, priorities and approach.
- When asked about how their cities have put an 'Integrated Approach' into practice, explanations often lacked detail, although some of the administrations contacted are in the process of reorganising their structures to achieve an integrated approach.

# 1 Introduction and methodology

## Analysis and conclusions:

- There is a need for more data on the changing needs and impact on services caused by demographic shifts, rather than a need for more demographic data.
- There is a need for a continuous proactive initiative by local public administrations.
- There is a need for more comprehensive definitions and monitoring of deprivation and inequality issues and linkages.
- There are significant geographic disparities and divergences: between established immigration, new immigration, and emigration, and between different levels of resource availability and local competencies.
- There is a growing need to integrate intercultural competencies into effective programme design.
- Care reform is moving to more outpatient and at-home care, an integrated approach, and more emphasis on labour activation policies, as strategies for resolving growing resource pressures; local administrations are central to any viable solution involving these approaches, and thus should be involved, not just in implementing policies, but in designing policy tools, such as the NAPs.

## Case studies of programmes:

Included in Annex I is a series of case studies, mainly provided by administrations participating in the EURO CITIES Social Affairs Forum, as a result of consultation at the Forum's May 2008 meeting in Oslo. These examples are offered to peer administrations and practitioners, and highlight practical initiatives taken in these cities in response to the new and changing demands placed on Social and Health services: they illustrate the kinds of measures these cities have adopted 'on the ground'.

For instance, the use of intercultural mediation, in an example provided directly by practitioners at a Barcelona hospital, has been effective as a tool for dealing with new dynamics in health care delivery that stem from recent immigration.

Vienna offers two case studies:

- a\_ The use of counselling centres to help service users make the best care choices for themselves and their families, aided by intercultural competencies and non-German language skills.
- b\_ An intercultural women's health centre, offering a gender specific approach to health, and largely focused on answering the needs of female immigrants.

Southampton has an extensive programme for providing support to carers (i.e. private individuals in the community: mostly women, but not exclusively), and understanding their needs.

Stockholm has been innovative in creating an entire autonomous division for Elderly Affairs (formerly a sub-section of the Social Affairs department), accompanied by the post of Vice-Mayor for Elderly Affairs: this provides benefits in terms of greater cohesion in policy and implementation, and in available expertise due to specialisation.

This study is one of a group of studies, commissioned by EURO CITIES, on the impact of current demographics on different policy areas: in this case health and social services. It aims to identify the impact of demographic change on health and social services provision in five EU cities: Barcelona, Krakow, Southampton, Stockholm and Vienna. It examines the practical responses of these cities to the challenges posed by the demographic pressures of ageing populations and migration.

Generally, European populations are ageing, some at more severe rates than others, and with only a few exceptions due to local specificities. Across Europe, ageing is a major stressor to the resource equations of care delivery, as demand for care, often expensive care, grows on the back of a shrinking tax base. While the degree varies, and the phenomenon obviously mixes with other local specificities, this broad dynamic is found everywhere in Europe (see EURO CITIES' 2007 Demographic Change Survey).

On the other hand, migration paints a much more varied picture across Europe's societies, though without exception all of them are being affected by migration in some way. Some societies, such as in Ireland and Spain, which have long histories of supplying other countries with migrants, have completely reversed that familiar role, to become, albeit only relatively recently, receptors of significant inflows of migrants; this is resulting in a permanent transformation of their societies.

Other societies, mostly in Eastern Europe, have moved into the role of supplying significant outflows of migrants to the rest of Europe. This is significantly altering social, economic and demographic dynamics in countries like Poland, Lithuania and Bulgaria. Other parts of Europe, with a long modern history of receiving migrants, such as the UK, Sweden and Austria, are moving into a new phase of adapting to the impact of immigration: notably, they are now having to care for significant older populations from migrant communities. The care providers find themselves having to develop intercultural competencies in their care delivery services, at the same time as they adapt to numerically significant shifts in older age groups and resource equations.

Some cities, such as Barcelona and Vienna, are seeing all, or almost all, their population growth coming from immigration, rather than from population replacement through birth.

For cities, the key priority emerging from the research is for them to meet these challenges from a sufficiently proactive stance.

The main participants of the study - Barcelona, Krakow, Southampton, Stockholm and Vienna - were selected to provide a range of geographic, demographic, economic and social characteristics: Mediterranean, Northern, Central, and Eastern Europe; situations of immigration (old and new) and emigration; shrinking and growing populations; significant differences in the performance of their labour markets, levels of prosperity and availability of public resources; and of course in the competencies within their city administrations. Moreover, the exact constituents of the range of health and social services provided varies from one system to another.

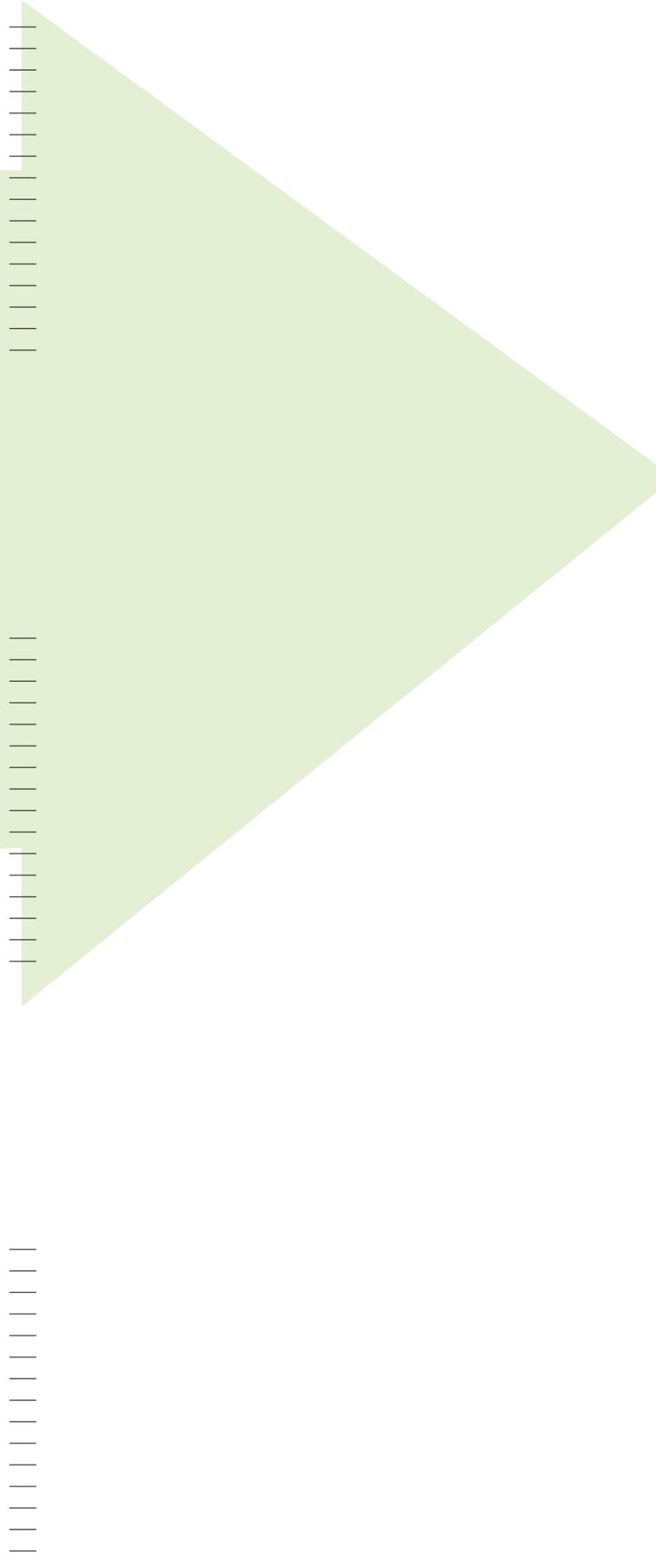
Likewise, the information available is quite heterogeneous: standardised side-by-side comparisons have been difficult, as the types and formats of documentation available vary widely. Thus, the approach to sources has been rather on a case-by-case basis, and use has been made of material applicable to larger administrative areas (i.e. regional or national reports and data) whenever this is deemed pertinent to the situation of the specific locality being studied, particularly the National Action Plans for Social Inclusion (NAPs).

To benefit from a broader frame of reference, additional information was collected through a questionnaire, with open questions regarding the demographic challenges most affecting the cities concerned, and the policies and programmes they were adopting to deal with them. The questionnaire was distributed via email to the members of EUROCITIES Social Affairs Forum: 14 cities responded. The results were then analysed comparatively: the findings are presented in the section 'EUROCITIES Social Affairs Forum Questionnaire Responses' and reflected in the conclusions of the report.

The first part of the report, is dedicated to profiling each of the five cities chosen. These city profiles outline the main elements of the demographic issues affecting the city, their service delivery model, and the main challenges facing it. The second section gathers together the results of the questionnaire and an evaluation of the main points arising; while the third section presents conclusions and closing remarks.

Annex I provides a series of case studies: these describe some of the programmes and initiatives which are being used to address the issues caused by the impact of current European demographic trends on social and health services. These case studies are of policy in application, chosen to sketch an overview of what administrations are currently doing, on a practical level, to adapt to demographic trends. They are offered as an exchange of experience among peers, by various members of the EUROCITIES Social Affairs Forum, largely resulting from contacts and discussions taking place in the Forum's May 2008 meeting in Oslo.

Finally, a list of sources is included at the end of this report.



## 2\_Profiles of Five Cities

### 2.1\_City profile

# Barcelona

# Barcelona

The population of Barcelona city, and its larger metropolitan and provincial areas, is ageing at a dramatic rate, with almost negligible growth by birth rate. Roughly 90% of population growth is the result of a recent and rather intense influx of immigrants, predominantly from Latin America and Africa, with immigration from Eastern Europe also on the rise, mostly on the back of a long period of strong Spanish macro-economic performance, which is now clearly over. In dealing with these significant pressures, Barcelona's administration is facing a strong challenge: it has to stay extremely proactive if it is to outpace the fast rate of change.

#### 2.1.1\_Demographics

##### Basic Demographic Data:

General population		
<i>Barcelona Municipality, as of 01/01/2007</i>		1,595,110
<i>Province of Barcelona</i>		5,332,513
<i>Life Expectancy,</i>	General:	80.8
<i>Province of Barcelona (as of 2005):</i>	Male:	77.31
	Female:	84.18

Source: Instituto Nacional de Estadística

Births, Deaths, as of 2006	
<i>Birth Rate, per 1000 inhabitants, Province of Barcelona</i>	11.69
<i>Births Minus Deaths, per 1000 inhabitants, Province of Barcelona</i>	3.57
<i>Average number of childbirths per woman, Province of Barcelona</i>	1.476
<i>Average female age at childbirth, Province of Barcelona</i>	31.08
<i>Average female age at first childbirth, Spain</i>	29.3
<i>Mortality per 1000 inhabitants, Province of Barcelona</i>	8.12

Source: Instituto Nacional de Estadística

The birth rate – at 1.476 – is below replacement rates by fertility.

Age Distribution, as of 01/01/2008		
<i>Largest segment</i>	30-34 years	at 487,243
<i>Smallest segment</i>	85 and over	at 107,452 (majority women)

Source: Instituto Nacional de Estadística

The most significant demographic trend in Barcelona (as throughout Spain) is immigration: the 2000's have been remarkable in terms of the unprecedented and accelerated growth of Barcelona's immigrant population. Currently, the Town Council calculates that 15.3% of Barcelona's population is foreign in origin ([www.bcn.es](http://www.bcn.es)).

#### Evolution in the number of foreign residents registered with the Barcelona City Council

Year	Foreign residents	Increase on previous year	% of total resident population	Interannual growth rate
March 2000	53,428	12,525	3.5%	30.6%
January 2001	74,019	20,591	4.9%	38.5%
January 2002	113,809	39,790	7.6%	53.8%
January 2003	163,046	49,237	10.7%	43.3%
January 2004	202,489	39,443	12.8%	24.2%
January 2005	230,942	28,453	14.6%	14.1%
January 2006	260,058	29,116	15.9%	12.6%
January 2007	250,789	-9,269	15.6%	-3.6%
January 2008	280,817	30,028	17.3%	11.97%

Source: Department of Statistics, Barcelona City Council

These figures refer to those immigrants that are officially registered with the municipality. While a proportion of migrants are likely to be present in the city without being officially documented (which is always a problem when dealing with migration figures), Barcelona's system of registry ('padrón' in Spanish) allows even those without residence permits of any kind to register (and thus have access to Health Services, see 'Services Delivery Model'); therefore Barcelona avoids the situation found in many other European cities, whereby authorities and planners may officially ignore thousands of irregular economic migrants living in their midst. Barcelona's administration therefore puts great priority on facilitating and encouraging the registry of migrants arriving in the city, and of those already present, in conjunction with partners from the NGO sector dealing with migrants.

At the time of writing this report, as a reaction to the current economic crisis, the Spanish government is preparing measures to cut back on immigration as much as possible and to encourage many immigrants to return home. (For example, on 19/09/2008 the Ministry of Work and Immigration announced a measure whereby those immigrants who lose their jobs can receive all their unemployment benefits in one lump sum, as long as they use it for the purpose of returning to their country of origin, <http://www.mtas.es/>). While the flow of immigrants might well slow, it is however doubtful that the immigration trend can now be substantially reversed.

Broadly speaking, in the space of just a decade or two, the society in Barcelona has undergone, and is still undergoing, a transformation that is comparable to that experienced by other Western European countries over several generations: going from a net supplier of migrants to one of the world's more significant receivers of immigrants.

#### Key trends:

Overall, the population of Barcelona is not changing drastically in numerical terms i.e. the 2007 figure is 1,595,110, compared with 1,642,542 in 1991, then 1,508,805 in 1996, and 1,578,546 in 2004. This means, for example, that the quantitative impact on the health system has been, and should remain, fairly manageable. The key change is in population structure: immigration is resulting in a younger population profile than it would otherwise be. The municipal authorities calculate that only 2.6% of migrants living in Barcelona are 65 or older, and also that the population of the city would now be about 1,350,000 without the presence of migrants.

#### Impact of immigration on Barcelona Social Services

	2002	2007	Increase 2002-2007
Immigration clients in homeless services	941	1,717	82.47%
Rate of immigration clients in homeless services in relation to total number of clients	36%	44%	8%
Intercultural mediation clients	25	1,400	5500%
Intercultural mediation community projects	2	5	150%
Immigration clients in primary attention social services	8,592	10,436	21.46%
Rate of immigration clients in primary attention social services in relation to total number of clients	20.9%	22.2%	1.3%
Clients of the municipal service SAIER (information and legal advice service for immigrants and refugees)	10,598	20,417	92.65%

Source: Barcelona City Council

#### Other indicators:

##### Exclusion

Population age 16 or over illiterate or without schooling	11.6%
Portion of those over 65 living alone	24.6%
Portion of those over 75 living alone	30.6%

Source: Barcelona City Council website [www.bcn.es](http://www.bcn.es)

In terms of analysis of exclusion and deprivation, Barcelona uses an “**Index of Social Inequalities**”, created in 1991 by Barcelona City Council, the methodology of which is based on the United Nations “Index of Human Development”. The Index is meant to be an instrument for decision-making, planning, programming and intervention, which takes into consideration social inequalities. The Index identifies social imbalances among inhabitants of different areas of the city, and detects situations of need, underdevelopment and poverty, expressed in terms of health, work and education indicators. The resulting analysis is expressed as a scale of ratios, allowing for the identification of imbalances and an evaluation of their importance.

Since the city’s first study of exclusion and deprivation in 1991, subsequent studies have taken place in 1996 and 2001, with the next exercise being planned for 2011. While the purpose of the Index is laudable, this report questions whether the irregularity of the data gathering and the length of time between studies (ten years between the current one and the next planned one) do not to some degree impair the value of the Index as a tool for ongoing policy development. Conversely, the city does follow up on other indicators on a yearly basis, which are then fed into the Index (i.e. training level, unemployment rate and life expectancy).

### 2.1.2\_Services delivery model

#### Service provision:

Although national legislation covers all Public Health Services in Spain, the actual provision of public health services is entirely the responsibility of the **regional** level administrations, or ‘Autonomous Communities’ as they are called. This decentralisation leads to certain variations in public healthcare provision across different parts of the country.

While Spanish municipalities do not usually have direct responsibilities for delivering health services, the situation in Barcelona is somewhat different. Historically the City of Barcelona had its own health system, dating back to the 19th century; and at present the city has a special status whereby health services are provided through a **Health Consortium**, in which both the regional Catalanian government (Generalitat) and the city government participate, as majority and minority partners respectively.

Furthermore, **preventive** health programmes and interventions (mostly awareness raising activities) as well as the **evaluation** of health needs in the city are carried out by the **Public Health Agency of Barcelona**: this is jointly organised by Barcelona City Council, as a majority partner, and the regional Generalitat, as a minority partner. A current example of the Public Health Agency’s activities is the 2008 deployment of health workers in preventing transmissible diseases, such as tuberculosis, through awareness-raising amongst the immigrant population. Likewise, the Agency produces brochures in various languages regarding access to the health system, vaccination, sexual and reproductive health, food manipulation.

An important part of the Public Health Agency’s work consists of the **yearly studies** it conducts on the city’s health situation. These studies include analysis of the impact of immigration on health services and issues. Additionally, the Agency has carried out various studies concerning health and immigration e.g. a study released in October 2008 on breast cancer and immigration.

In Spain, Public Health Services cover all **healthcare needs**, except for dental care, optometry and optional cosmetic surgery. Prescribed **medicines** covered by the Public Health Services are provided at a reduced price, which varies from Autonomous Region to Autonomous Region: in **Catalonia** (and therefore in Barcelona) it is **25%**, although for retired people there is a larger reduction (generally 90%).

In terms of access to health care, the approach in Spain is quite generous compared with much of the formal regulation found across the rest of Europe. **Immigrants have an established right to healthcare** (‘Organic Law 4/2000’ concerning Rights and Freedoms of Foreigners in Spain and their Social Integration):

- **Foreigners registered municipally** (‘empadronamiento’, which does not necessarily require a residence permit) have the right to receive the same health care as Spanish citizens, under the same conditions.
- **Minors** under 18 have the same right, regardless of ‘empadronamiento’.
- **Pregnant women** have, during their pregnancy, labour and post-labour period, the right to receive the same health care as Spanish citizens, under the same conditions.
- **Those not registered** have the right to use the **Emergency Wards**, should they contract serious illness or suffer an accident, and to receive the appropriate medical follow up/ surveillance until the initial medical problem is resolved.

The Individual Health Card gives access to all Spanish Public Health Services and the Pregnancy Assistance Card gives a woman access to pregnancy specific health care.

Barcelona’s municipal administration provides a range of **social care centres and services**, for children and youths, older people, disabled people and society in general, as well as services for social inclusion and the homeless, intercultural services and supplementary pension assistance. Since 2004, in keeping with European trends towards more outpatient or ‘at home’ care, the city has been developing a ‘Home Care Service’ programme, which mostly attends older people (83% of clients) and women (77% of clients). This service has grown from an initial 5,143 clients a year, to 9,692 so far in 2008 (at the time of writing this report). However growth has been even more remarkable in another programme: the ‘Telephone Assistance Programme’ has increased from 4,373 users a year to 40,578 so far in 2008, with a similar client profile (older people and women). Accordingly public expenditure for these two services has increased by more than 60% in four years.

Such steep growth rates would seem to indicate the presence of a very real demand for these services. However, the city will need to continue to make a vigorous effort to provide the required services, as the underlying demand driving growth is only likely to increase.

In terms of immigration, the 'Reception Plan' is a programme that Barcelona has developed (approved officially in February 2007, after a pilot phase) which involves and equips some 70 of the city's existing network of associations. The objectives are:

- a\_to orientate newcomers effectively (with information about legislation, the labour market, education, languages training, etc.)
- b\_to encourage the participation of newcomers in the traditional network of associations in the city as well as in new migrants' associations

In addition to targeting associations, the 'Reception Plan' programme also targets the broader social and economic activities of the city (e.g. general facilities for citizens, health and educational centres, security staff, social services, housing offices, employment centres, leisure centres, libraries and civic centres, entrepreneurs, trade unions etc.). The administration calculates that 44,550 newcomers were assisted by the programme in 2007. Note that this is in addition to the regular functioning of SAIER, the city's own information and support service for immigrants and refugees, which assisted some 20,000 persons in 2007.

#### Service provision:

Public health services users pay nothing directly for service use.

The Generalitat (regional administration of Catalonia) is responsible for Health Services, which it pays for with funds directly transferred to it by Spain's central government and from its own revenues.

In terms of resource management, authorities say they find Barcelona's Health Consortium system successfully facilitates the organisation and optimisation of resources, through the purchasing of services and through the provision of human resources and experience in managing associated companies.

Under the aegis of the 'Reception Plan' (see above), the City Council is currently providing total yearly funding of €600,000 to associations working with newcomers.

#### Challenges:

Now that the recent boom cycle is over, at the time of writing this report it is still an open question as to what the impact of the economic downturn will be: in terms of increased social problems, of financing public services and programmes, and of the effects on immigrants, who risk becoming the target of various tensions and are often especially vulnerable in times of economic downturn.

Spain's 2006-8 NAP (National Action Plan for Social Inclusion) identifies a series of challenges that are applicable to Barcelona:

- Rates of poverty risk are above European averages
- Outpatient services and support for carers: Barcelona has increased its Home Care Services for the elderly considerably in just a few years, but will have to maintain a determined effort to continue to develop such services, as it is starting from a position of trying to 'catch up' in a context of increasing demand; the NAP identifies Spanish community and residential social services as still deficient compared with other EU countries e.g.
  - \_only 6.5% of families caring for elderly dependents receive help from social services
  - \_only 3.14% of people aged over 65 receive assistance at home
  - \_only 0.46% have a place in a day centre
- Hence, the general situation is one where families continue to be the basic provider of informal care and support, although their ability to provide care is steadily decreasing and support for carers is low
- The ageing population is putting new strains on health and social services provision models and resources: this has an immediate linkage with the issue of underdeveloped outpatient services in Spain; most European administrations are developing the use of outpatient care as a key part of the formula for dealing with the strain on resources
- Social spending is still lower in relative terms, than European averages
- Early school leaving: the city has some of the highest rates in Europe
- Transnational healthcare: one of the major healthcare challenges in Spain, and of particular relevance to discussion at a European level, is patient mobility: both as a receiver and provider of services for those insured by other European countries' regimes, and as an exporter of sick people authorized to receive treatment abroad.

In terms of immigration and dealing with the challenges of an increasingly diversified society, the regional government's own 'Citizenship and Immigration Plan 2005-2008' states:

- "In general terms, residents in Catalonia have quite a negative perception of immigration."
- "Shortcomings in the welfare state cause competition between locals and those from abroad"

The same document recognises a need to improve immigrant access to ordinary services, and also the risk of existing services further degrading, due to increasing demand/demographics. While admittedly this is a document produced by the regional government, it articulates the broad situation in Catalan society, and in its capital Barcelona; and dealing with the dynamic just described is now a key challenge for the city's administration.

Access by migrants to social services is also strongly conditioned by legal limits; while the law guarantees the principle of equality of access for foreigners to social services and facilities (decree 188/2001 26th June), legal status, or lack thereof, places significant limits on de facto access. Only people with full residence permits can access the following:

- Non-obligatory education (pre-school, non-obligatory secondary school i.e. from aged 16 onwards, university and adult education)
- Certain social services (e.g. assistance for families, children, youths, the handicapped, seniors, substance addiction, etc.)
- Programmes facilitating access to employment are only available to those with work permits.

The situation of women is very specific, as the large-scale inclusion of women into the Spanish job market is still a relatively recent phenomenon.

The Institut Català de la Dona (Catalan Institute for Women, as cited the 2007 'Mapping Report of Policy and Practice in Barcelona') indicates that there is no real plan for receiving female migrants, and no plans for sufficient concrete action, either for simple problems such as language learning, or complex issues such as providing adequate accommodation. However, on a municipal level there is a network of Women's Information points, one in every district, providing support for women in general and thus available to migrant women as well.

Additionally, the municipality's immigration department is currently developing a programme to support the family reunification of immigrants ('Programa acompañamiento a núcleos familiares reagrupantes' which helps those bring children, spouses and parents into the country on a special permit). At present this programme is functioning in 4 out of 10 city districts, and is meant to be fully up and running in all districts by 2010. The programme contacts those beginning the family reunification process and invites them to participate in a meeting before the relative arrives; they are provided with relevant information (re. the educational system, various legalities, and so on), along with psychological and emotional support. If considered appropriate, a second meeting with more specific information takes place. Once the relative arrives, there is follow-up on the person's situation and initial integration.

Many migrant women come to Spain through such a family reunification permit, which does not allow them to work without obtaining a modification to the permit. However to get such an alteration in their papers, they must have a valid job offer for at least one year.

While not impossible, it is generally rather difficult for migrants to get such a job, as in practice most employers are apparently reluctant to provide a one year contract. However, the municipality has developed a procedure with a 'hosting network' (a network, supported by the municipality, of relevant NGOs and local organisations and representatives, which provides job offers) to accelerate the process with the Spanish central government office in Barcelona: this now takes about 15 days to undertake (the City Council reports sending dozens of such applications every month).

Conversely, those women (and men for that matter) who are unable to obtain such a job placement, find themselves effectively obliged to work without a work permit. This report's view is that the current policy requiring a one-year job offer (which, to be clear, is the creation of the central government) is unhelpful, confers no ostensible benefit, is in fact harmful, and an indictment of the quality of the legislative process from which it stems. While the problem does not in any way originate from the City Council, it is constrained to manage within the situation thus created.

As is often the case elsewhere, employment for women migrants in Barcelona is highly concentrated on care for the elderly (note the linkage between the two major issues concerning European demographics, ageing and immigration) and domestic service. These jobs are frequently 'informal', i.e. without any legal contract. By deduction, official statistics showing women migrants as unemployed or inactive must inevitably be somewhat flawed, though it is of course difficult to calculate by how much.

The 2005 'Pla de Ciutadania i Immigració', from the regional government, says that: official labour mechanisms are ineffective; labour market access in Catalonia has essentially been determined by market demands, and without any effective intervening management or regulation; and that official labour market intervention mechanisms are ineffective, largely due to the 'informal' nature of the job market in which so many immigrants find themselves. Conversely, the City Council reports that the vast majority of migrant residents in Barcelona work with work permits and pay their taxes and social security, with only a small number working in the informal economy. Furthermore, the city administration has detected some interesting social mobility patterns, where migrants tend to change to better jobs once they have settled in. The most important factor affecting the social mobility of migrants is found to be their human capital. The city reports that graduate migrants, which account for 27% of all migrants in Barcelona, are able to access better jobs (higher skilled and more professional).

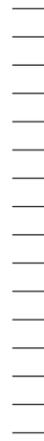
The City Council also reports a change in the last 3 years with regards to the arrival of new migrants: while in the early 2000s, illegal immigration was very common, since approximately 2005, there has been a decrease in illegal immigration and an increase in legal immigration. In 2007, family reunification was in fact the largest source of new arrivals, with some 8,300 residence permits being issued in the City of Barcelona.

**Undervalued social capital** is an issue at the heart of immigration in Barcelona, just as it is, to no small degree, throughout Europe. The Pla de Ciutadania i Immigració describes the **job prospects of immigrants** as 'very limited': they are largely condemned to employment in low remuneration and low qualification jobs. This situation can well be described in terms of undervalued social capital i.e. people who are not employed in a way that is commensurate with their qualifications (which are often high), skills, knowledge and potential. For instance, obtaining recognition of foreign degrees and diplomas is a process that relies on the resources and competencies within the central government, and can often take several years. The city's hosting plan supports and finances associations that are specialised in the subject of foreign diploma equivalencies, and which are able to provide counselling and orientation.

Concerning this issue of squandered social capital, data has been published claiming that "Immigrants to Spain" are twice as likely as locals to be over-qualified" (c.f. 'The brain drain', The Economist, February 28th 2008). Aside from the obvious human and moral implications with regards to those individuals who are disadvantaged, such findings are also significant in terms of compromising economic development and society's long-term, and not so long-term, interests as a whole. This needs to be underlined and explained more to political leaders, and through them, to the general public, particularly at a time, as now, when economic downturn is likely to fuel exclusion across Europe.

## 2\_Profiles of Five Cities

### 2.2\_City profile Krakow



Krakov faces demographic challenges similar to those of other European cities, with some specificities of its own that are more typical of the Eastern European A8 (the 8 states who joined the EU in 2004) and A2 (Bulgaria and Romania) societies, although in some ways Krakow's challenges are also comparable to Southern Europe. The key challenges are:

- The impact of emigration: although the situation is in flux (emigration flows are changing quickly, due to economic and other factors, and data is frequently outdated by the time it becomes available), emigration is more of an issue than immigration, as it is in much of Eastern Europe.
- The population is ageing, as it is throughout Europe.
- At the same time, traditional family-based care solutions (not unlike those predominant in Southern Europe) are in decline: this strong double stressor, similar to the situation in Barcelona, puts significant pressure on resources and the development of care delivery solutions e.g. the need for more and better outpatient and at-home care.
- Social and health service provision faces tighter 'resource equations' than in wealthier parts of Europe; likewise, the criteria for defining poverty are more demanding.

Though admittedly the margin for manoeuvre is tight, Krakow's administration needs to be proactive: local administration has no choice but to do more, and be more effective.

Krakov

### 2.2.1\_Demographics

#### Basic Demographic Data:

The city's population is in fact **contracting**, while births are going up.

General population			
2007	756,583	m. 353,922	f. 402,661
2000	758,715		
Natural increase (Births minus deaths) -> negative (i.e. more deaths than births):			
2007	-412		
2000	-1,101		
Population density over territory -> slight decline			
2006	2,314 per 1 km2		
2002	2,318 per 1 km2		
Population by gender -> rising female population			
2006 ratio of females to males	114		
2002 ratio of females to males	113		
Birth Rates -> up			
2007	6,755		
2000	5,806		
2007	9.2 births per 1000 population		
2002	7.8 births per 1000 population		
Death rate -> up			
2007	7,167		
2000	6,907		
2007	9.1 deaths per 1000 population		
2001	9.1 deaths per 1000 population		
Life expectancy			
Male 70.5	Female 78.8		
Age segments -> rising elderly population			
2007 largest age segment	70 and over		
2000 largest age segment	20-24		

Source: Krakow Statistical Office

#### Key trends:

Life expectancy in Poland is slightly below the EU-25 average, but is significantly lower than those EU countries with the longest life expectancy (see Polish 2006-8 NAP). Moreover, though life expectancy for men has been growing, there is still a significant difference in life expectancy by gender: about 8 years more for women than for men.

The difference in life expectancy for women and men means a high share of single person households among older widowed women.

As throughout the rest of Europe, the demographic dependency ratio (number of people 65+ per people of working age) is rising. Poland's 2006-8 NAP projects an increase, from 18.9% in 2005, to 51% in 2050. (While this is a national figure, it is also the broad demographic trend for the City of Krakow.) Krakow Social Services report that as the traditional Polish model of the multi-generational family is breaking down, the number of older people living on their own or without support from close relatives is rising. This, in combination with the growing overall population of older people, means the demand placed on public services to provide care is increasing significantly.

Such pressures are comparable with those being experienced in Spain i.e. where the family has traditionally been the main care provider, but is steadily less able to provide such care, mainly due to women's emancipation and shrinking family units, as well as a range of other socio-economic factors.

As a logical consequence, Krakow Social Services report the growing number of older people increases the cost of providing services for them, which results in the need to obtain more funding from the Municipality.

Ratios of Krakow elderly, young and working age:	2002	2003	2004	2005	2006
Pre-working age (young) population per 100 persons of working age	51.8	50.9	50.6	50.5	50.7
Post-working age population (elderly) per 100 persons of pre-working age (young)	94.4	98.9	103.5	107.3	111.5
Post-working age population per 100 persons of working age	25.2	25.3	25.7	26.2	26.7

Source: Krakow Statistical Office

**Emigration** (i.e. out-migration) and returning migrants are more significant for Krakow than immigration. However, it is particularly difficult to obtain accurate data on emigration and returning migrants, as the trend is hard to document and is highly fluid. For instance, there is extensive anecdotal evidence of an increase in returning migrants, stemming from the recent economic downturn in the UK and Ireland, but it is difficult to find hard data. To further muddy the waters and mask the true situation, migration is increasingly ambiguous: many migrants come and go regularly, not necessarily even viewing themselves as 'immigrants' in their new country but simply as 'working over there'.

Conversely, the lack of immigrants prevents meaningful comparison with the strategies of other cities for dealing with the challenges of immigration: it is a problem that Krakow essentially does not have, certainly not in the way a city like Barcelona does (with its new and sudden arrival of immigrants), or Vienna, Southampton or Stockholm (where long-established immigration is now generating and reshaping the need for elderly care services).

#### Other indicators:

In terms of **poverty** and the risk of poverty in Poland, the 2006-8 NAP describes the living standard of those people living in **poverty** as **lower** than the European average (i.e. Poland's poor are poorer).

**Older people** in Poland however, are **less** exposed to relative poverty **than EU** averages for the same ages. (Women, at a 7% poverty rate, are more often living in poverty than men, at a 4% rate.) Nonetheless, the situation with respect to **employment** of older people (**60+**) is systematically **deteriorating** in Poland, while in the European Union it has been improving since 1998.

In Poland the **employed** are relatively **more** often exposed to the risk of poverty. Polish **purchasing power** is still comparatively **low**, at 51.9% of the UE-25 average.

**Unemployment** rates for **young** people are fairly high: in 2005, 36.9% were unemployed in the 15-24 age group. The same 2006-8 NAP describes a dynamic where young people often have a high school diploma, but have limited professional experience and limited employment opportunities due to the presence of baby boom generations in the market. The NAP identifies, in the high unemployment rate among young people, a **risk of depreciation of acquired skills**, as with the long-term unemployed. While unemployment rates have diminished since 2005, the issues are still present.

### 2.2.2\_Services Delivery Model

As throughout Europe, Krakow's health and social services are attempting, (both for economic reasons and to provide better adapted care that favours the individuals' autonomy, empowerment, etc), to maximise the use of outpatient and community-based solutions: residential care becoming something of a last resort. Day care centres for older people and disabled people are, logically, an important element in this care delivery approach, providing a range of activities and therapies to seniors staying in their communities and homes.

Social services have also been turning to the volunteer community for help in creating care programmes, and are developing this relationship as an increasingly valuable element of service provision. In 2007, 1,241 hours were volunteered, largely used in assisting people with disabilities, older people and those living alone. Feedback from care receivers has often been highly positive.

#### Service provision:

Local authorities are responsible for the delivery of health and social services. The Municipal Welfare Centre in Krakow uses non-governmental organizations for carrying out various tasks e.g. running social integration clubs, shelters for the homeless or day care centres for children. NGOs carry out about 1/6 of social assistance in Krakow.

Coverage includes social benefits and aid, social networking services, analyzing and assessing demand for social benefits, taking actions based on identified social needs, and developing new social services and self-help approaches for those needs.

#### Financial Assistance takes place in the form of:

- Ongoing financial benefit for older people and disabled people
- Periodic/intermittent financial assistance for individuals and families whose income does not meet eligibility criteria
- Purpose-specific financial assistance granted to fulfil basic needs
- Exceptional purpose-specific assistance for those in an especially difficult situation, whose income exceeds normal eligibility criteria
- Benefits and loans to start small businesses
- Benefits for foster families
- Benefits for adolescents leaving children's homes (i.e. ex-public wards of court)
- Benefits for refugees.

#### Non-financial assistance takes place in the form of:

- Social work
- Home care services for older people and disabled people
- Organizing funerals for those homeless and/or without next of kin
- Specialist counselling
- Crisis intervention
- Shelters
- Help in kind e.g. clothing and food.

**Nutrition** has a growing importance in Krakow City Council's assistance programmes: since 2005 the administration has been providing **free hot meals**, on the basis of means testing. The formula used for this means testing is a monthly income not exceeding 150% of the criterion figures: 477 PLN/114.41€ for a single person household, 351 PLN/14€ for a person in a family. Obviously, a monthly income figure of 106.27€ or 144.42€ is quite low by the standards of the more prosperous parts of Europe, highlighting the fact that there is a wide variation in economic and social circumstances in the EU-27. At the same time, while we see this difference in income expectations, we see a certain consistency in terms of the issues that administrations across Europe are having to deal with, at least in terms of ageing. Although patterns of immigration are variable across Europe, with some cities receiving more migrants and some less, and some cities experiencing it as a recent phenomenon and some as an old one, across Europe all societies are ageing, albeit with some fluctuation in the intensity and speed of the trend.

Since 2006, subsidized food services have been extended to a wider circle of beneficiaries, by providing those with incomes of 150-200% of the above criteria with subsidized meals: the beneficiaries pay 25% of the cost.

In 2007, Krakow's main client groups for Social Services were, in terms of the numbers of clients, and with the largest group first<sup>1</sup>:

- The poor
- Disabled persons
- The long-term or seriously ill
- The unemployed demonstrating vulnerability.

Over the last four years there have been only minor changes in this structure.

#### Resources:

Services are paid for by central Government funds and Municipal funds. Poland's 'Social Welfare Act' ensures that citizens get most social benefits free of charge. The exception is home care services for those who have incomes above the eligibility criteria.

As throughout Europe, getting people to work more and longer is being placed at the centre of efforts to maintain a sustainable pension system. Accordingly, new pension formulae, based on a defined-contribution scheme (i.e. versus a defined benefit scheme), generate strong incentives to extend the period of activity on the labour market.

Putting Krakow in its broader national and European framework (see 2006-8 NAP), social spending in Poland is:

- Similar to EU averages in terms of total social spending as a share of GDP
- Structured differently from the usual patterns found in the EU-25
- Dominated by old age pensions and disability pensions, despite the Polish population being relatively young.

The lowest shares of expenditure go to:

- Benefits for the unemployed (4.0% of total spending or 0.9% of GDP)
- Families and children (4.7% of total spending or 1.0% of GDP)
- Housing purposes and groups at risk of social exclusion (0.2% of total spending)

This structure results in a significantly higher risk of poverty among children and youths and relatively low risk of poverty in the case of older persons.

#### Challenges:

Krakow has been the most difficult city to document, and concrete data has been less available than would have been ideal. Therefore the challenges that are identified here are somewhat general, and often based on deduction from information concerning Poland as a whole (particularly the NAP documents); however they do highlight the broad direction and circumstances affecting Krakow.

The following key factors are creating significant challenges for Krakow:

- The problems throughout Poland in creating employment for older workers and the long-term unemployed
- The social impacts stemming from these patterns of unemployment
- The fact that the viability of the pension system depends on people working more and for longer.

It is vital for social aid programmes to include an effective dimension of employment activation to help people find work.

The Social Economy, or 'Third Sector', needs to be better developed and tapped as a potential source of employment, particularly, though not exclusively, with a view to those less likely to find employment in other sectors.

Reforming social policy while keeping down poverty risk requires some deft manoeuvring: if all social benefits, including old-age and disability pensions, were excluded from the income of the general population, almost half of the population would live below the poverty threshold.

It is necessary to realign social spending within a delicate balance:

- to focus more resources on supporting those families, children and youths who are excessively at risk and under supported
- at the same time, to minimise poverty among older people, a group which, moreover, is growing.

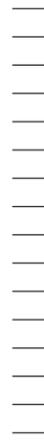
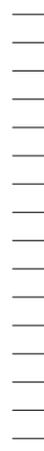
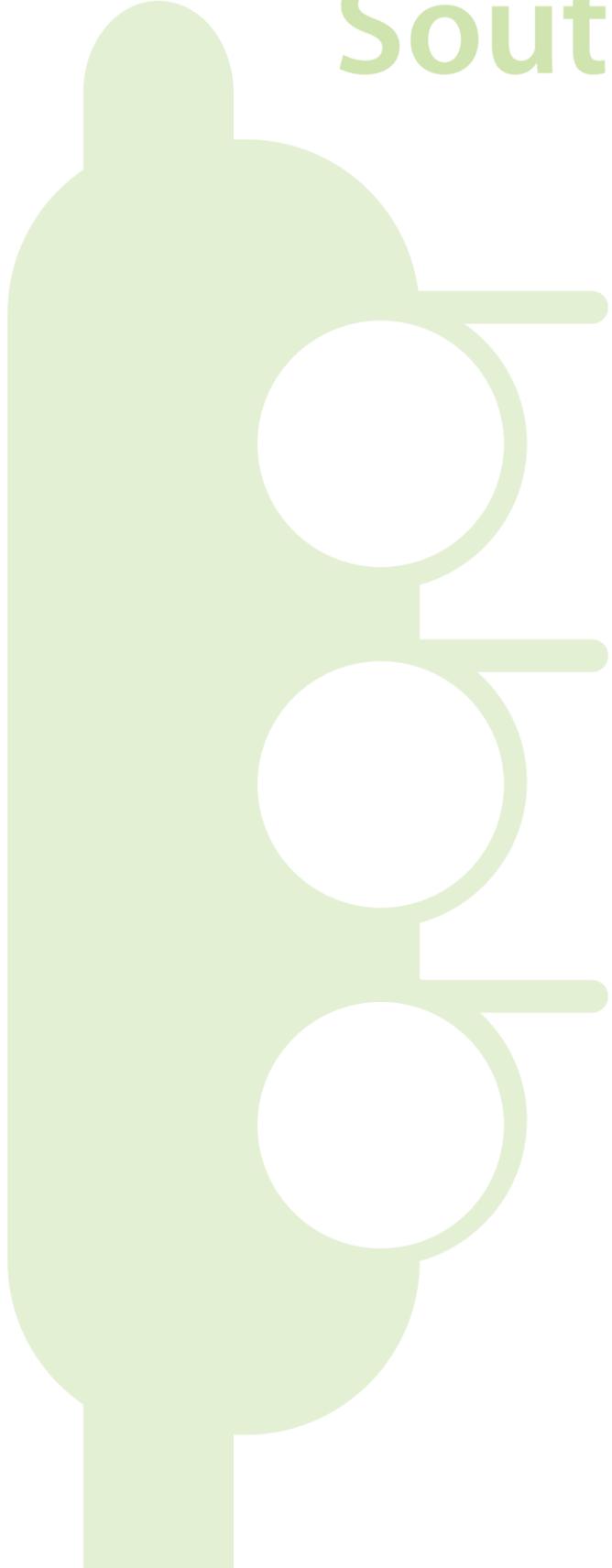
Local policy needs to become more active, because the front line of any effective social inclusion policy is at the local level.

Local government must become more of an initiator of social inclusion policy; this will require more and better co-operation between specialised public administration, the developing NGO sector, business, and local government. Fortunately, Krakow has been developing its partnership with NGOs and volunteers, so there is a foundation already in place to keep building on.

## 2\_Profiles of Five Cities

### 2.3\_City profile

# Southampton



Southampton is a city that is representative of British policy trends and particularly of Southern England's urban areas:

- The city functions within a national policy framework pursuing a co-ordinated, or 'joined up', approach, wherein economic, employment, health and social policies are mutually re-enforcing, and generally structured through the use of targets.
- Economic growth and job markets have been experiencing sustained strong performance: concurrently employment is at the heart of the social policy approach, the idea being that social and health services should function as a bridge towards labour activation wherever possible.
- Inequality and risk of poverty are priority issues as they remain above EU averages, although definitions of such figures need to be contextualised i.e. the standards for what qualifies as poverty are not the same as those operating in Krakow (see pg.38 'Other Indicators').
- Southampton's robust job market and economy have, logically, functioned as attractors of immigration, notably from Poland: this is an example of one local demographic trend being the flipside of another very different local trend both part of the same transnational dynamic.

Recent downshifts in UK economic trends pose questions about the future for a strategy so linked to the economy's growth performance.

### 2.3.1\_Demographics

#### Basic Demographic Data:

General population		
current population	228,000	
under 15 years of age	16%	
15 to 64	70%	
over 65	14%	
annual births	2,665	
annual deaths	1,976	
life expectancy at birth (2002-2004)	men 76.2	women 80.9
life expectancy at birth (2002-2004) UK average	men 76.6	women 80.9

<http://www.southamptonhealth.nhs.uk/publichealth/soton>

Southampton

As the table shows, Southampton's life expectancy is fairly typical of England as a whole. The largest age segment is currently 20-24: this is partly due to the location of two universities in the City.

### 2.3.1\_Demographics

#### Basic Demographic Data:

Migration and Population Movement:		
refugee communities*	4-6,000	predominantly from Somalia, Afghanistan, Iran, Iraqi Kurdish and other African countries
migrant workers from the EU 'accession' countries*	10-13,000	of which 8-10,000 are Polish
emigration rates	not known	
<i>Info supplied directly by Southampton Council</i>		
<i>* the local administration's documentation itself separates migrants into these 2 categories – refugee and EU accession – and the report uses the data as such, though with reservations about the adequateness of the terms, as far as completeness or accuracy in conceptualising migrant groups</i>		

As encountered throughout research for this report, migration entails a certain ambiguity: immigrant numbers are identified as approximate figures, and there are no figures at all for emigration.

#### Key trends:

Southampton identifies ageing as the demographic trend with the most impact on the present and future provision of health and social services in the city. According to statistics from the UK's 2007 NAP update, and reasonably indicative for Southampton:

- by 2024, around half of adults will be over 50 years old
- by 2050 there will only be about 2 people of working age per pensioner
- currently, there are about 4 people of working age per pensioner.

In terms of the national policy environment that Southampton is part of, this has meant a rising focus on facilitating older people working (over 1 million people are now working after State Pension age, and the state pension age is being increased over the next twenty years) and on fighting age discrimination, particularly in the labour market. This is referred to as 'ageism' (c.f. the national 'Age Positive' campaign) which is an emerging term, still without a translation in many EU languages.

Southampton is also following the general UK national trend of falling household size, stemming from the coinciding phenomena of an ageing population, an increase in separation/divorce and in people establishing family units at a later age.

In terms of migration trends, while transnational immigration is an old experience in Southern England (unlike in most of Southern and Eastern Europe, as seen in the case studies of Barcelona and Krakow), new challenges are nonetheless emerging as settlement patterns in Southampton have been changing. Increasingly, immigrants are moving, not into the central wards in the middle of the city that usually received them, but into areas with limited previous experience of black and minority ethnic (BME) communities. Moreover, the city is experiencing a rise in the numbers of second-generation BME communities. Migrant impact is reported by the administration to be mainly seen in housing, healthcare and schools: the impact as described would seem to be mainly in terms of visibility of presence.

Typical of the situation throughout the UK and Ireland is the fact that large numbers of Polish immigrants means that they have inevitably made their mark on the community. However, it is unclear how stabilised their situation is (i.e. how many will return to Poland). Conversely, immigrants from outside the EU would seem less likely to go back.

#### Other indicators:

According to a 2008 report for Southampton City Council on indices of multiple deprivation for 2007, the city ranks 91st out of 354 English Local Authorities (1 equals the most deprived) on the Index of Multiple Deprivation; this is an interesting tool that the UK uses for evaluating the combined impacts of different forms of deprivations. The city's local policy operates within the Index's conceptualisation and builds upon it.

Of the seven 'domains' that make up the Index, Southampton performs worst on the Education, Skills & Training domain (with 27 'Lower Super Output Areas' or 'LSOAs' being among the 10% most deprived in England).

Additionally:

- One area (in 'Bitterne' ward) has 64% of children living in income deprivation
- Southampton has the two worst areas in the South East for income deprivation affecting older people, both in 'Bevois' ward
- Child poverty levels in the areas nearest the boundaries of the two Southampton constituencies is some 25%.

Moreover, the city has relatively low income levels for SE England, but suffers from high private sector housing costs. Currently, approximately 30% of Southampton's population is accommodated in social rented housing.

These deprivation and income issues exist within a broader context: the UK's 2006-8 NAP states that the UK's 'population at risk of poverty and income inequality' rates are above the EU average, and identifies concerns over low wages, in-work poverty and debt levels. The same NAP emphasises the relationship between health inequalities and other social inequalities. This emphasis, from the local level through to the national level, highlights the interaction of factors in deprivation and vulnerability, and is something many other administrations could well learn from.

### 2.3.2\_Services Delivery Model

The services model, as it is evolving and presented here, is largely focused on the organisational management side of delivery. It seems not to address the issue of immigration in any very direct way, which perhaps it should consider. However, ageing, for its part, is pervasively implicit, in terms of adapting delivery and resource management, particularly in terms of growing outpatient and in-home care, to meet growing and changing demands stemming from rising populations of older people.

The national UK health and social policies, within which Southampton functions, have a detailed system of outcome-based **targets**, all of which are explicitly **linked to budgets**. These targets are generally underpinned by commonly agreed **EU and national indicators**, and are shared across Ministries and Departments (i.e. they are 'joined up'). The recent development of Local Area Agreements, between local government (working with local partners such as health services), and central government, seeks to establish linkages between national and local target setting and management.

Policy is **increasingly focused on decentralisation**: through the Local Area Agreements. At the same time, while the specific situations are different, one also sees, as in Austria, a trend towards **consolidating** dispersed activities to achieve greater efficiency and coherency.

Currently, in Southampton, as throughout the UK, funding and decision-making are increasingly devolved to a **local** level, and even to individual level, where people organise their own social care. Instead of receiving pre-determined care services, in certain circumstances people may choose to **take money** from their council to arrange and manage their own social care services: an approach known as '**direct payments**'. The idea is to give people greater **choice** and control over services received. This policy is being extended to everyone, through the 'individualised budgets' being rolled out over the next three years.

In Southampton, under general English legislation, all residents in the local authority's area are eligible for an **assessment** of their social care needs. Unlike healthcare, social services are not free to all, but are **means-tested**. There is a spread in how much users pay e.g. over 70% of older people living in care homes get all or some of their costs met by their local council.

As across Europe, with the growing population of older people and with all their various care demands, the trend is towards more **at-home care**, in tandem with an accelerating reduction in the use of residential care homes.

#### Service provision:

Funding for health services is provided from central government through the UK National Health Service (NHS). For Southampton, this funding is now allocated to the **Southampton City Primary Care Trust** (SCPCT), which is managed by a Trust Board of local representatives within guidelines provided by the Government, and which commissions services from other NHS, private sector and community organisations. These services are provided free of charge.

Trust budget	
approximate total per year	£350m (388.9m€)
acute (hospital) services	£150m (166.6m€)
primary care (General Practitioner/ family services)	£27m (30m€)
community based hospitals and care	£120m (133.3m€)
drugs and medicines	£40m (44.4m€)

*Info supplied directly by Southampton Council*

While discussing healthcare, it is worth noting that, in keeping with trends in labour market policy thinking that is emerging throughout Europe (see analysis & conclusion pg 69), the UK NAP identifies the healthcare sector not just as a cost but in terms of its value as a **contributor to employment**.

**Social Care:** Approximately **80%** of direct care services are commissioned by Southampton City Council from local **voluntary, community or private** sector agencies, while a core of key services are provided by the Council's own specialist workforce. The City Council also provides a variety of other social and community based services, often funded by grants to local voluntary agencies, providing a range of advice and community-based support services.

**Integrating Health and Care Services:** The national framework as it applies to Southampton is for **services to be increasingly integrated at a local level**, especially in cities where all local government services are usually provided by a single unitary council<sup>2</sup>. In Southampton, this is managed through the '**Health and Social Well-being Partnership**' of the Council and major local health and community organisations. This Partnership **agrees and monitors** local priorities and targets for the Southampton '**Local Area Agreement**' that has been established together with central government.

<sup>2</sup> Rural areas often have a 'County' council providing education, care and other services over a large geographical area, with local 'District' Councils providing environmental and housing services more locally

The 1999 Health Act introduced new powers to allow councils to set up **joint working arrangements** with the NHS to pool funds, delegate functions to enable integrated provision and lead-commissioning. The City Council and the Primary Care Trust work together, through a local **'Joint Commissioning Board'**, to plan and manage **investments** in integrated local community services. This is a growing joint programme and will probably eventually manage approximately **£200m** (€222.2m) worth of joint service commitments, primarily in community-based care.

**Partnerships with other providers:** UK health services have traditionally been provided through NHS organisations; this is now changing, and **private sector** organisations are encouraged to provide services. Specifically in Southampton, the main health service providers have been:

- The **Southampton University Hospital NHS Trust**, which is a major 'teaching' hospital providing general hospital services to Southampton residents, as well as a range of specialist services to a much wider area, in some cases to the whole of southern England.
- The **Hampshire Partnership NHS Trust**, which provides specialist mental health and learning disability services, and which again provides services over a larger geographical area.
- A major new service providing straightforward day-based surgery will open shortly in the city, funded through the NHS but operated by a private sector company.

While these providers are involved in local planning and consultation arrangements, the commissioning organisations (Southampton City Primary Care Trust and Southampton City Council: SCPCT and SCC) work separately to **design, commission and manage the performance** of the major local delivery programmes.

**Inspection and Monitoring:** All UK services are covered by two inspection organisations: for social care and health services respectively. However these organisations are soon to be **combined into a single Care Quality Authority**.

Southampton's local approach to improving health is currently being updated. In line with other areas in England, the Council and the PCT have jointly produced a 'Joint Strategic Needs Assessment'. This will result in a new **jointly-managed health and well-being strategy** for the city, which will increasingly **inform how resources are used** to improve health, and wherever possible to prevent declines in health that are largely associated with ageing, in order to:

- Enable people to live their lives to the full
- Reduce the costs of managing ill-health as much as possible.

**Resources:**

The UK's books are balanced. That is, there is no immediate crisis in UK pension finances. Pension spending, as described in the 2006-8 UK NAP, is projected to grow below EU25 rates: at 2% of GDP, UK pension spending is currently similar to the EU25 average, and this share is predicted to remain relatively **stable** so that by 2050, it will represent about two-thirds the average EU25 share of GDP by 2050.

Nonetheless, this stability in share of GDP does not mean there are no problems for pensions in the UK; in particular, millions are **not saving enough** for retirement. Government is thus pursuing various approaches to encouraging saving, but it remains to be seen how well these will work.

A new NHS tariff system is being developed, whereby **money follows the patient**: the idea is that good providers are rewarded and others are encouraged to improve, while also controlling costs. Conversely, the allocation of funds across the UK is partly **constrained** by a formula designed to improve the **geographic distribution** of medical resources.

**Funding breakdown for Adult Social Services, as provided through Southampton City Council**

UK Government grant	most remaining funding
local taxation ('Council Tax')	aprox. 1/3
means tested charges to users	2%
total cost	£80m (~88.9m€)

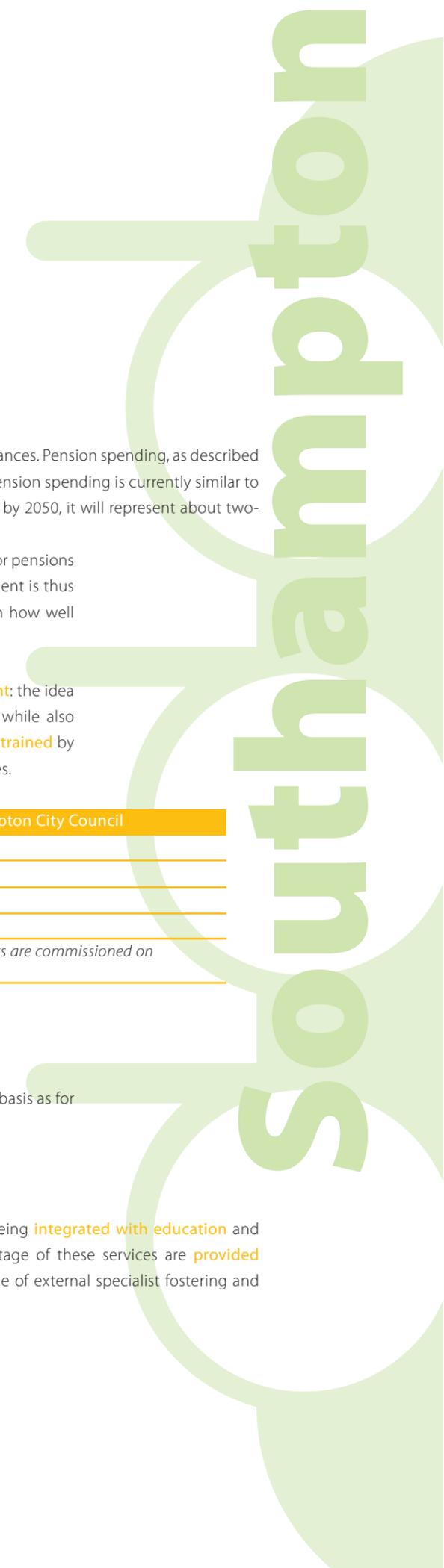
*Approx. 80% of local social residential and community-based care services for adults are commissioned on a competitive basis from local voluntary and private sector providers*

*Info supplied directly by Southampton Council*

**Children's social services** funding is provided through the Council on the same basis as for adult social services (see above):

- but this funding is not means **tested**
- this funding amounts to approx **£27m** (~30m€).

However, children's social services are increasingly being **integrated with education** and other **youth services**. In addition, a greater percentage of these services are **provided directly by the City Council**, though use is also made of external specialist fostering and residential care services when appropriate.



### Challenges:

There are a number of general UK challenges that are affecting Southampton. Existing social policy depends heavily on the recent long run of robust and stable macro-economic performance (the UK's 2006-8 NAP points out the UK's recent records for sustained GDP growth, low inflation and high employment rates, which surpassed the EU's Lisbon Strategy employment goals for women and older workers). Economic strength has facilitated **increased spending** on education, health and long-term care, although (at the time of writing) economic slowdown is now adversely affecting those growth rates. The scale of the downturn, and its ramifications for social and health policy, is yet to be seen; but the challenges of the new economic climate can reasonably be seen as a **test for the sustainability** of current economic, social and health policies, and of the relationship between them.

In terms of immigration, economic downturn is a particular threat to integration based on labour market participation and the associated feelings of acceptance and 'buy in', as immigrants are often particularly vulnerable in the downswings. For example, Dublin City Council (in answering a questionnaire sent out as part of this research) has reported just such a concern. Obviously, Ireland is particularly close to the UK's economic cycle, but the downturn is being felt widely and deeply throughout Europe, and the UK example will and should be watched closely.

One outstanding concern, central to the issue of ageing, is clearly the emerging phenomenon of people **not saving enough** to provide adequate retirement incomes. Tackling undersaving will be challenging in the face of factors such as high debt levels, housing prices and job instability. In particular, people (mainly women) who are unable to work and save because they are staying at home to provide care, require special consideration. This raises many open **questions as to future social policies and needs**: while public finances may be sound in terms of current patterns of use, if vulnerability among the elderly were to spiral, there would presumably be an inevitable pressure to do something about it and take action to address the problem.

In line with Southampton's local focus, Britain's 2006-8 NAP identifies the following priorities:

- People, especially children, living in **jobless households**
- Reducing **poverty risk**: especially among children (the goal is to eradicate child poverty by 2020) and among pensioners
- **Employment** rates of **lone parents**, and by extension the provision of childcare, benefits and tax policies that help facilitate lone-parent employment
- **Discrimination**: this is understood as directly linked to deprivation e.g. action to prevent discrimination of disabled people is a priority
- Narrowing **health inequalities**: complex, intractable, persistent health issues linked to a broader web of social disadvantage.

Locally, **Southampton has identified health inequalities as a major challenge**. Substantial differences, based on income and geographical location, in health morbidity and mortality, are found across the city's population. This involves such priorities as:

- The **needs of carers** (i.e. non-professional carers, such as family etc) **as a growing population of older people live with dementia** (see case study)
- Birth weights of babies
- Quality of early childcare and support (e.g. increasing the level of breast feeding)
- Dental health, particularly in children
- Obesity, in all age groups: improving diet and access to exercise
- Cardiovascular disease
- Mental health, especially related to unemployment
- Alcohol misuse: a growing trend, particularly among young people
- Teenage pregnancy, with poor parenting often resulting
- Growing levels of sexually transmitted infections
- Growing levels of drug misuse and related psychological difficulties

While not questioning the necessity of the above priorities (they are all laudable enough, clearly being real needs), this report does wonder if the main trends of current demographics that Southampton identifies as most affecting the city (i.e. ageing and immigration) could not be more explicitly reflected and referred to in these priorities.

## 2\_Profiles of Five Cities

### 2.4\_City profile

# Stockholm



Stockholm

While Stockholm, the Swedish capital, is experiencing the same generalised issues of ageing and immigration as its Western European peers, the situation has its specificities:

- In Stockholm, as throughout Sweden, the population is growing.
- A relatively high birth rate coincides with a growing ageing population: triple digit ages are becoming less unusual.
- Age-related issues have moved to the centre-stage politically:
  - \_ Central government declares that it is an objective for Sweden to become the world's best country in which to grow old
  - \_ Stockholm City has specifically created an entire Department and Vice-Mayoralty for Elderly Issues, an initiative which is spreading to other Swedish cities, and discussed later in this report
  - \_ Resources dedicated to older people are growing, across the system.
- Sweden's economy has enjoyed strong growth: public finances are currently healthy, but as elsewhere, the impact of the present economic downturn is yet to be properly gauged.
- Strong growth also points to an expected future shortage of labour and consequently a need to increase labour supply: logically this has implications for older people (they can work longer), immigration, and the general labour activation element of social and health policies.

As underlined by the country's 2006-8 NAP, the supposition underlying the national policy framework, which includes Stockholm, is that universal welfare provides the basis on which to create social cohesion and equal opportunities for everyone.

### 2.3.1\_Demographics

<b>General population</b>	
Stockholm City	795,163 (≈8.6% of national population)
Stockholm County	1,949,516 (≈21% of national population)
<b>Population growth 2006</b>	
Stockholm City	11,847
Stockholm County	28,159
<b>Births 2006</b>	
Stockholm City	12,144
Stockholm County	26,983
<b>Deaths 2006, as portion of births -&gt; positive growth</b>	
Stockholm City	7,449 (≈ 61.3% of births)
Stockholm County	15,658 (≈ 58% of births)
<b>Average Swedish life expectancy 2005</b>	
82.78 years for women	78.42 years for men

Source: Stockholm Office of Research and Statistics

Source: 2006-8 Swedish NAP

Stockholm shows a strong rate of births over deaths and a high life expectancy: the best of the 5 cities examined. Krakow has the lowest life expectancy, and the comparisons are clear: Stockholm shows a smaller difference in life expectancy between men and women (a difference of around 4 years, as opposed to 8 years in Krakow), and there is a significant difference between male life expectancy in the two cities (at 70.5 in Krakow, again, a difference of about 8 years).

Migration and Population Movement: 2006		
<b>Immigrants</b>		
Stockholm City	56,742	of which from abroad – 13,989
Stockholm County	63,419	of which from abroad – 27,721
<b>Emigrants</b>		
Stockholm City	49,493	of which to abroad – 8,346
Stockholm County	46,461	of which to abroad – 15,777
<b>Immigrant surplus (immigration minus emigration)</b>		
Stockholm City	7,249	
Stockholm County	16,958	

Source: Stockholm Office of Research and Statistics

Of particular note is that Stockholm documents and distinguishes between **internal and external immigration and emigration** (e.g. Southampton, Krakow and Barcelona offer no such readily available data on emigration).

This approach to collecting detailed migration statistics should be an example to other European cities. The lack of attention that emigration often receives in statistics which are otherwise very detailed and exhaustive, is a methodological failing, and one that is generally found across many cities and countries in Europe.

Likewise, the consideration of internal and external migratory flows together, is commendable (obvious as it might seem); most of the other cities studied offered little or no such information, or at any rate not correlated.

Migratory demographic data that omits calculations of emigration or fails to adequately include internal migratory flows into the mix, is compromised from the outset in terms of its potential meaningfulness.

**Key trends:**

Population projection for 2016 (as of 2007)	
Stockholm City	852,125 (over current 782,885)
Stockholm County	2,100,394 (over current 1,918,104)

Source: Stockholm Office of Research and Statistics

The 2006-8 Swedish NAP, in addressing the overall national context and policy framework that includes Stockholm, discusses children, women and the elderly, and the direction that policy needs to take, in order to accommodate their needs within an efficient economic strategy. The main issues identified in the framework that concern demographic impact, and that are in line with Stockholm's specific situation, are:

- A rising **birth rate** since 1999 (after falling in the 1990s).
- A high **female participation** in the labour force, and the highest ever women's retirement age (the 2005 national statistics show the average age of women exiting the labour market as 62.6 years, and 64.8 years as the average age at which women begin drawing a pension; the respective figures for men are 63.5 and 64.7).
- More older people of an advanced age: triple digit ages are becoming a less rare phenomenon; and in 10-15 years time the numbers of over 80's, and hence the **need for long-term care**, will be increasing at an even faster rate than at present.
- **Smaller pensions** being paid out will make it necessary for people in older age groups to **stay in the labour market even longer**.

As a response, the 2006-8 Swedish NAP argues for policies based on a few key suppositions:

- Improving **opportunities to combine family and work** will **encourage** people to have **children**.
- **Individual pension projections** increase awareness of the link between contributions and benefits and should be promoted.
- Incentives for employees to **work longer** will contribute to economic growth.

The argument made for this last point is strengthened by referring to the fact that Swedes in their sixties are now **more highly educated** than older generations and are occupied in **less physically demanding** ways. Furthermore, and in stark **contrast to the Polish situation** where employment of older people (60+) is systematically deteriorating, Sweden already has a **high employment rate amongst older labour-active people**. The 2005 average employment rate for older people cited in the 2006-8 NAP for those aged 55-64 is 69.5% ( 72.4% for men, 66.7% for women), against an EU average of 42.5% overall (51.8% for men and 33.7% for women).

The current **vitality of older workers** to be found in a city like Stockholm, and their apparently already high level of effectiveness as a work force, would seem to point the way to a viable future of social and health policies, emphasising labour activation of older workers, in Stockholm itself, and possibly as an example to be followed, to some degree, throughout Europe.

Locally, Stockholm is dedicating more **specialised resources and administration** to elderly issues and more political involvement through the creation of a dedicated Elderly Affairs division and a Vice-Mayor for Elderly Affairs. Nationally, the stated aim is for the combined resources for older people to increase gradually by 10 billion Swedish kronor (≈0.92 billion Euro) over ten years.

#### Other indicators:

The Swedish economy has been growing strongly: at 3.6% in 2006 and 3.0% 2007. At the same time, public finances have also been developing strongly, and central government debt has been decreasing. Employment has been strong and **labour market shortages** have become a real risk to future growth.

### 2.4.2\_Services Delivery Model

Stockholm is fairly similar to Southampton in terms of the local administration's responsibilities in health and social services, with an overseeing role of the central government. The resource base formula is also somewhat comparable, involving a mainstay of tax-based revenue complemented by the use of fees.

#### Service Provision:

In terms of **education**, municipalities are responsible for childcare and schools, while central government legislates, inspects, follows-up, and evaluates, and also provides incentive grants and development work undertaken by government agencies.

The **running of care services**, including care of frail older people and long-term care, is decentralised to municipalities and county councils. According to the Health and Medical Services Act, municipalities are responsible for the inpatient healthcare that is handled by a nurse (not medical attendance by a doctor) and for the care within the municipality's special elderly housing and day-care facilities, while county councils are responsible for providing medical services in peoples' own homes.

Stockholm has created a special Elderly Committee, which is discussed specifically in the case study in Annex 1. In parallel with the Social Services Administration responsible for social care/services, there is also an Elderly Services Administration with corresponding responsibilities for elderly care/services.

#### Healthcare use:

*Every year nearly 1 million inhabitants, 56% of the county population, have contact with local healthcare.*

*The Public Dental Service is used by most children and youths, and approx. 1 in 4 adults*

*All dental care for children and young people is covered by the County Council*

*Source: Stockholm County Council [www.sll.se](http://www.sll.se)*

The Stockholm District Administrations are generally responsible for citizen welfare, working in close connection with the Social Services Administration. Their roles are broadly as follows.

#### The District Administrations:

- **Provide support** on social issues, including individual and family support and legal services, adoption and child custody, care for disabled people and frail older people
- **Place clients** for treatment and rehabilitation at the appropriate facilities
- **Provide services** for homeless people, substance abusers, families, youth and children at risk, clients with physical and mental disabilities, and people in need of work rehabilitation.

#### The Social Services Administration:

- Is a **political body** made up of local elected officials
- **Supports the District Administrations** and the city-wide social welfare programmes
- **Supports the City Council** in preparing briefings and background materials
- Provides **€13m per year** in support of some **150 NGOs** working in Stockholm (in addition the Elderly Committee distributes about €804,000 to 27 NGOs)
- **Runs emergency social services** when the District Administrations are closed, during evenings and weekends
- Organises a unit for homeless people, a crisis centre for battered women, family and substance abuse counselling units and the coordination of social projects related to the EU.

**Cooperation** between **municipalities and county councils** regarding long-term care is enforced by legislation (Health and Medical Services Act, 01/01/2007):

Municipalities and county councils are required to work together to provide individuals with:

a\_Care and treatment, including rehabilitation

b\_Social care, by integrating the county council's **specialist** and **primary** care services, and the municipality's **primary** care and **social** services

To raise national health care quality and use resources more effectively, such care is increasingly coordinated nationally. This trend is comparable to Vienna/Austria's focus on nationally coordinating regional resources and delivery platforms, to raise quality control and consistency, and to benefit from economies of scale.

County councils have **contractual obligations** towards municipalities regarding doctors in special housing and in day centres; where the municipality is responsible for in-home care, and the county council fails to meet its obligations, the municipality may engage the services of a doctor to be **reimbursed by the county**.

**Housing** with special services for adults is one of the most common forms of assistance provided for persons with functional impairments. The trend in Stockholm is towards more people living in the same housing with specialist services.

Sweden's government is developing plans for specially targeted **grants for municipalities** that put in place **rent guarantees** to aid those at risk of exclusion from the housing market e.g. young people and newly arrived immigrants.

**Outpatient care is in continual expansion.** Over the last 15 years, the main thrust of change in Stockholm's healthcare and long-term care has been to eliminate residential inpatient care as much as possible, and instead offering accommodation and other support adapted to the individual's needs. Despite the differences between, on one hand, cities like Stockholm and Vienna, and on the other, Krakow (i.e. cities with fewer resources), this broad strategy is essentially the same across these different cities: reducing cost and providing better adapted care, by shifting to tailored support and outpatient care. The obvious difference is one of resource capacity and programme development e.g. Barcelona, which is similar to Krakow in this regard, recognises that it has to move towards more and better outpatient care, but is still struggling to deploy such care effectively and shift the necessary resources.

**Resources:**

County councils and, to some extent, the municipalities, are responsible, through **taxation**, for the principal funding of care services. (Municipal taxes fund elderly care, disability care, care for alcohol and drug addicts and the placement of children and young people).

County councils also levy care **fees** from patients: generally, lower fees are charged for primary care visits than for visits to hospitals or specialists. The Health and Medical Services Act sets the maximum amount payable by a patient, over a 12-month period, at 900 Swedish kronor (≈83€). Costs for those under 18 in the same family are aggregated, and those under 20 pay no fee in outpatient healthcare.

Local tax, 2007	
30.05%	of the total tax burden
17.78%	for the Stockholm Municipal Council
12.27%	for the County

Source: Stockholm Office of Research and Statistics

HR:	
County Council has about 42 000 employees	96% work in healthcare
of which are women	≈ 80%

Source: Stockholm County Council [www.sll.se](http://www.sll.se)

**Asylum law** makes temporary support funding available for municipalities with increased refugee influx; the standard compensation was raised in 2007 to improve refugee treatment and support faster integration into Swedish society. With regards to **housing for older people**, in all cases the **individual pays rent and a fee** for support, care and food; and anyone wanting his or her own room is entitled to it.

**Challenges:**

The goal, declared in Sweden's 2006-8 NAP, of full labour activation for men and women of all ethnic backgrounds, and especially for the long-term unemployed, young people, immigrants and disabled people, is a means of both addressing social problems and of easing the resource constraints of social services. This emphasis on maximum labour activation is found across Europe; however there are nuances: for example, Stockholm places more emphasis on the principle of universal welfare and the use of public intervention than say, Southampton.

At any rate, since it is **young people in economically disadvantaged urban areas** who have the most difficulty in entering the Swedish labour market, the issue of labour activation will continue to be of **direct concern to Stockholm's municipal administration**. Added into the mix is the **expected future shortage of labour**, which will only increase the pressure to increase the labour supply.

Also in discussions rather similar to Southampton's, **health inequalities** are an issue in local care delivery for example, just as in Vienna and Southampton, those born abroad are over-represented among those receiving sickness and invalidity benefits. To provide more effective and inclusive care, one of the outstanding challenges is to ensure Stockholm **Municipality and County council work together** more efficiently in long-term care, as they are obliged to work in tandem to provide it.

In terms of older people, a **clearer picture** is needed of the enhancements to the quality of life that health care and social services should aim to achieve for **older people**. The NAP proposes to do this via a national policy document to guide health and social care personnel and to set fundamental values. Moreover, current **statistics** do not make it possible to:

- a\_Assess to what extent other initiatives, such as respite, personal alarms, meals-on-wheels, companion services etc. **reach** those who do not have home help or suitable housing
- b\_Draw far-reaching conclusions on the services that should be provided for long-term care or the real impact of any new initiatives.

Finally, with regards to **exclusion**, the Swedish NAP takes the position that people from vulnerable groups must have a greater opportunity to **have their voices heard** and to influence their situation, and that **how people are treated** can sometimes be more important than the actual action taken. The challenge to Stockholm, as for local administrations right across Europe, will be to take the broad approach set out by policy-makers, and translate this into real and effective action on the ground.



## 2\_Profiles of Five Cities

### 2.5\_City profile Vienna

Vienna is facing many of the problems that other European cities are, or soon will be, facing:

- Ageing of the population is happening ahead of much of the rest of Europe.
- Immigration makes up most of the city's population growth, as in Barcelona.
- The city is proactive in planning for, and documenting, its own demographic dynamics, and in developing suitable new structures and practices.
- Vienna offers a view into an administration that is trying to make a more integrated approach work, by cross-coordinating different services and policy areas, in a somewhat 'holistic' approach, and with a very local level of focus and execution.

Austria's strategy, which provides the broader framework within which Vienna finds itself, includes an approach for containing costs stemming from demographic shifts that seems to rest on 2 major principles:

- i\_Achieving greater efficiency through coordination and harmonisation of delivery systems;
- ii\_Including more people in the labour market and ensuring longer working lives, so that the redistribution of taxes from people of working age to older people will rise only slightly as the society ages.

#### 2.5.1\_Demographics

Despite increasing birth rates and significant immigration of younger people, Vienna's population is ageing. This development is projected to continue, and from 2020 onwards ageing will even accelerate. Population growth primarily stems from immigration.

<b>General population:</b>		
City (2007)		1,664,146
Region (2004)	3,451,273	≈ 20% of which are foreign nationals
<b>Birth and Death Rates 2005 -&gt; positive natural growth</b>		
births 16,750		deaths 16,000
<b>Life Expectancy, 2006 -&gt; on the rise</b>		
men		76.4 (1991, 71.4)
women		81.7 (1991, 78.1)
<b>Migration and Population Movement</b>		
Immigration minus emigration, 2006		12,000
Naturalisations, 2005		12,240
<b>City population of migration background</b> – i.e. residents with a foreign nationality (immigrants and second generation migrants) and naturalised migrants		
≈523.000 persons		31.4% of population
<b>Age segments -&gt; Foreign resident population is significantly younger than the native one</b>		
15 - 30 years old	28% of foreign citizens	17% of 'native Austrians'
60-75 years old	6% of foreign citizens	16% of 'native Austrians'

Sources: Vienna City Administration and Statistics Austria

While the main element of population growth in Vienna is clearly immigration, the city's net birth rate has been positive since 2004. Nonetheless, the impact is rather moderate, given that annual net births are still well below 10% of annual foreign naturalisations. Logically, ageing and immigration are the two priority issues in Viennese demographics, as is reflected in the health and social services case studies included later in this report.

Also, the difference between male and female life expectancy (well below Krakow's) has been contracting.

#### Key trends:

Vienna manifests demographic trends that are similar to those seen throughout Europe. However, the rise in the percentage of older people in the city's demographic structure is happening earlier than in much of Europe, being not so much a projection as a current phenomenon.

Trends and projections for Vienna	
<b>Ageing -&gt; strong increase, particularly of very elderly</b>	
<i>over 60 (in Austria)</i>	
2004	1.8 million
2030	2.7 million (≈ 50% increase)
<i>over 75, Vienna</i>	
2020	increase ≈24%, or 30,700 persons
<i>over-85, Vienna</i>	
2005	30,803
2030	55,250
2050	80,472
<i>Income earning age population (20-64)</i>	
2035	decline of ≈ 14%
<i>Viennese population</i>	
2005	1.626 million
2010	1,718,200
2030	1,931,600
2050	2,050,800
<i>Vienna's urban agglomeration population</i>	
2005	2.215 million
2035	2.698 million (≈22% increase, or half a million)
<i>Single person households -&gt; increase</i>	
2006	46,2%
2030	≈ 50%
<i>Households with children -&gt; decline</i>	
2007	29%
2030	24.6%

#### Youth -> increase

##### *under 15*

2004	14.6%
------	-------

2045	15%
------	-----

##### *under 19*

2035	increase by 28%
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##### *Diversity: percentage of foreigners -> increase*

2007	20.1%
------	-------

2015	24.6%
------	-------

2030	27.4 %
------	--------

Sources: Vienna City Administration and Statistics Austria

The apparently contradictory **increase in the youth population**, despite fewer households having children, is linked to immigration.

The **ageing population**, particularly the numbers of very elderly (aged over 75), is leading to more need for health and long-term care services. In fact, the number of people with the **highest demand for care** and benefits has already been growing: from 2001 to 2005, the number grew by more than 15%, or from about 6,500 to 7,500. Logically, given rising life expectancy, the number of people facing multi-morbidity (i.e. suffering from two or more chronic conditions) and dementia will rise.

This combination of strong immigration inflow and an ageing population, with population growth being primarily due to immigration, is roughly **similar to the situation in Barcelona**; moreover, the two cities are of comparable sizes in terms of population. However, public economic **resources** and the general **economic circumstances** with which migrants have to contend differ considerably. Vienna is among Europe's more prosperous cities, thus resources and opportunities, while never enough, are nonetheless broadly greater than in Barcelona (e.g. Vienna's per capita gross regional product for 2004 was 40,281€ compared with an EU-25 average of 21,503€ [Vienna in figures 2007]; Greater Barcelona's 2001 figure was 22,900€ [Barcelona Statistics Department, www.bcn.es]).

**Other indicators:**

According to Austria's 2006-8 NAP, Austrian social finances are solid. Austria's aggregate social spending (healthcare, long-term care, education, pensions), as a share of GDP, will not rise significantly: projections indicate a rise from 24.4% in 2004 to 25.4% in 2030 (ECOFIN). Furthermore, contrary to forecasts, social health insurance accounts showed a 'profit' for 2005 (i.e. surplus funds).

Economic indicators for Vienna are strong. Vienna's 2005 gross regional product at production prices was 41,076.7€ (21,170€ for the EU-25). 2004 average annual net earnings per Viennese employee were 18,489€ (21,033€ men, 15,684€ women), and per pensioner 16,412€ (19,684€ men, 14,284€ women). In 2003, Vienna received 61.1% of Foreign Direct Investment in Austria, by market value (Vienna in Figures 2007). On a national level, Austria's economy is one of Europe's strongest, with unemployment rates consistently below EU averages.

**2.5.2\_Services Model**

As a national response to the stresses caused by an ageing population, **pension reforms** introduced between 2000 and 2004 **raised retirement age** and introduced incentives for people to work longer.

Care delivery is moving towards more outpatient care and more care counselling for users and users' families.

Under **Viennese Social Welfare**, an extensive range of services is provided, including:

- Welfare assistance
- Municipal nursing homes
- Housing facilities for the homeless
- Women's shelters.

In terms of **Health Services**, Vienna has:

- 54 hospitals and nursing homes. 27 of which are managed by the Vienna Hospital Association (KAV)
- 219 outpatient facilities, covering a wide spectrum of diagnostic and therapeutic services
- A district nursing service to facilitate the sick **remaining at home**, with 110 **nurses carrying out home visits**
- 10 mobile midwives to assist mothers-to-be.

**Service provision:**

Broadly, the Austrian Health Care System is planned and supervised nationally, with the bulk of facility management and care delivery being provided by regional and municipal authorities. Social Health Insurance is compulsory: authorities state that 99 % of the population is covered by health insurance, under a principle of equal access to health services. Access to health services is normally through the possession of a health card. Health Care spending is roughly 10% of GDP.

Emphasising **more choice**, service individualisation and user empowerment, a wider range of services and facilities are being created. These are being tailored to different needs and life situations e.g. intergenerational housing and flat shares, and, from 2008 on, Austrian parents will be able to choose to receive a higher child-care benefit for a shorter period of time.

Vienna is moving towards **more outpatient care** (in the broadest sense, including preventive care and counselling), which is consistent with all the cities studied and surveyed in this report, whatever the relative variations in their demographic and resource circumstances.

- Vienna City Administration is, at present, developing its '**release management initiative**', for people in need of **long-term care after their release from hospital**, so as to improve the cooperation of the different services offered.
- Health and welfare policy in Vienna is developing additional **health promotion** measures, so as to prevent or delay chronic disease and the need for care.
- More than **80%** of individuals in need of nursing care are now being nursed at home. Consequently, plans for further improvements in this area are under development (i.e. care at home, halfway care and assisted living).
- Following the introduction of Vienna's "**staying at home as long as possible**" policy (echoing almost verbatim Krakow's policy of inpatient treatment as the care of last resort), supportive out-patient and home care **services were rearranged** to meet with the growing and diverse needs of long term care patients and their families, and plans for further improvements in this area are in progress.
- Moving into **in-patient** care happens later, at an older age, and in the majority of cases is caused by multi-morbidity.

To **avoid continually relocating patients**, services need more flexibility to meet patients' changing needs throughout their residence: this requires **integrated coordination** of services, and thus a higher quality infrastructure and better qualified staff.

As such, adapting Vienna's health and social care system focuses primarily **on qualitative improvement** of services **rather than quantitative** extension. Besides being more flexible and individualised, future services will be based on **interdisciplinary** or holistic approaches, and will be better integrated into local communities.

**More caregiver support** is and will be necessary, as more long-term care at home logically means the needs of caregivers (largely women) will only grow. The support can take many forms, including:

- Helping women return to work after a time of caring for frail older people or newborns
- Preferential pension insurance options for periods when nursing close relatives
- Financial support for substitute care, when a caregiver is unavailable for a certain period, or needs a holiday.

In its general approach and concerns, the planning and implementation of such support mechanisms for carers closely parallels similar issues emphasised in Southampton and its support programme.

**Care counselling services** are being developed and extended, due to the success of initial pilot schemes. In effect, this means providing counselling for those needing care, and for their family members, and helping them to choose from a range of services available.

An **integrated approach** has also led to **planning across different specialist fields**. Since 2007, Vienna's urban development and cross-sectional planning activities have brought together several very different departments: Health, Youth, Welfare and Urban Planning.

An interesting example of Vienna's integrated approach is a partnership of the Department for Urban Development and the Department for Health Promotion; in cooperation with two pilot districts and their local populations, the two departments are working on a new concept to improve the accessibility of public space, particularly for older people. (Known as 'sALTo', this project is covered in greater depth in a sister report to this one, 'Demographic Change & Urban Mobility and Public Space'). Similarly, Vienna's newly reorganised Department for Health and Welfare Planning is developing instruments to use in requirement and demand planning, in order to enhance its integrated approach to tackling the challenges of changing demographics and to ensure quality of life for older people in the future.

**Resources:**

Health revenue	
private health insurance	3%
out of pocket and co-payments	26%
taxes	25%
statutory health insurance	46%

Source: Vienna City Administration

Since the late 1990's, the Austrian health system, in conjunction with local and regional administrations (Vienna has a special status as a city and region), has pursued a policy of centralised coordination of **supply chains**, in conjunction with **co-payments** and other charges, to keep costs down. Getting the relationship right between **inpatient and outpatient** services has posed some challenges in terms of achieving a successful **integrated approach**.

When using certain healthcare services, insurees have to make co-payments or patient deductibles. The turnaround in **social health finances** owes much to revenue increases or stability, stemming from general contribution hikes or enhanced patient co-payments. This is balanced by needs-based exceptions and caps on individual burdens e.g. a **ceiling of 2%** of the income of those concerned is to be set for prescription charges, as from 2008.

Sets of principles, policies and plans, in the form of **'Health Platforms'**, have been established at provincial level, to improve healthcare planning and control and to take advantage of better economies of scale in purchasing. This is a coordinated model of control, involving the federal state, the provinces and the social health insurance system. The long-term objective is **"one-stop financing"** i.e. bundling together all health-insurance contributions and earmarked taxes, to enable joint control, planning and funding of all benefits and services, at various healthcare levels. Health system reform is also aiming for equitable access, through performance standards that are meant to guarantee uniform distribution of services. (Austria's use of Health Platforms is also discussed in the EU Commission's 'Joint Report on Social Protection and Social Inclusion 2008').

Vienna's **public financing system for service provision** has changed from 'object compensation' (where resources are granted directly to providers, and clients are referred to a given provider/location depending on various criteria) to **'subject compensation'** (where resources are allocated to individual clients who can then choose from among a range of providers and locations). Such a shift in criteria, whereby funding follows users so they can exercise choice, is a trend that is ever more widespread throughout Europe, particularly in the UK, where administrations such as Southampton are particularly familiar with the thinking behind such an approach and with putting it into practice.

**Housing policy**, however, has certain specificities in Vienna: here, it is an important component of the city's social welfare system, and one that sets it apart from many other cities in terms of the high level of housing stock at the administration's disposal. The city's housing structure is uniquely dominated by subsidized housing and by state owned housing: about **50% of all flats in Vienna belong to the city**.

**Challenges:**

Ageing migrants are emerging as an important challenge to care services: although most of the migrant population consists of young people of employable age, it also comprises a growing group of older people.

**Elderly immigrants in Vienna -> growing population**

<b>over 65</b>	
in 1994	22,600
in 2005	45,500
<b>over 75</b>	
in 1994	7,600
in 2005	15,000

Source: Vienna City Administration

Therefore, existing care services have to be adapted for the needs of these groups, for example, by increasing the number of qualified staff, and by recruiting more staff who speak migrant languages. (See the case studies later in this report, largely involving intercultural competencies).

**The City of Vienna has identified as specific challenges:**

- Keeping and developing high quality of life standards, especially in education and employment, in order to **attract qualified migrants**, as international migration is an important component in stabilizing future population: this kind of **positive** focus on immigration, as a resource to be actively developed and pursued, is commendable. Such an approach seems to be entirely **missing in Barcelona**, despite the need to develop policy thinking on immigration.
- Developing different and better strategies for immigrant empowerment, in terms of education, housing, employment etc., in order to help ease the integration of immigrant workers.
- Providing elderly citizens with **affordable** services.
- Developing locally focused social and health infrastructure at the urban planning level, and investigating new forms of housing for older people.
- Providing and financing health care, social infrastructure and education, without losing or risking the social services of the city, is seen as the most important challenge for the future.

Furthermore, Austria's 2006-8 NAP articulates a series of issues pertinent to Vienna, and echoing concerns felt across Europe:

- **Life expectancy** of some 'heavy manual labour' groups is less than that of other employee groups: this is currently being investigated and there may be implications for the revision of such groups' access to retirement, if findings do show a clear difference.
- **Disparities** in health status, stemming from social, regional or gender factors, needs to be dealt with by enhancing **preventative** healthcare services for specific **target groups**, and by resolving interface problems in service delivery, and between health and nursing care sectors. This is very much the focus of the Viennese case studies that are included later in this report, as well as being similar to Southampton's focus on **health inequalities**.
- Higher **poverty** risk among **immigrant** groups calls for targeted measures to develop German **language** skills and employability.
- The clear link between **female and child poverty and female unemployment** (the poverty risk of households with unemployed mothers is three times that of households with working mothers). Hence the need to provide and improve **child care services, as an effective means to facilitate female employment** or return to work, in addition to such care being of itself a favourable preparatory setting for children.
- Given that health and social service **finances depend** on robust **employment** levels and extending working lives, there needs to be a closer link between income support and employment **activating** measures, through skills training and other support services.

- **Labour market participation** of **older people** is necessary for the financial sustainability of Austria's welfare state. Boosting the career opportunities of older workers is a special challenge, as an above average number of older people have insufficient **training** and **poorer health**. This contrasts somewhat with Stockholm's relative optimism in arguing for the employability of its older workers.
- Ageing means the issue of **dementia** and care for persons with dementia is a major rising socio-political challenge for the future, creating a need for low-threshold and fundable assistance services.
- With **families providing long-term care** (for those with Alzheimer's, dementia etc.), new care structures must ease the burden on care-giving family members. Again, this is in line with the case study from Southampton on care for carers.
- In home **ambulatory** care (i.e. medical care delivered on an outpatient basis) will have to be upgraded, and the **transition from inpatient** hospital care to home nursing (i.e. **discharge management**), will need to be improved. This will require continued **harmonisation and quality** control in the training and career profiles of caregivers.
- A **skills bottleneck** is being, and will be, created, by the increased demand for nursing staff for home, ambulatory and intramural (residential) care, and for health counselling. Nursing and social care occupations therefore need to be **made more attractive**. Conversely, this problem should not be highlighted only in terms of the negative: it also represents a significant **source of potential employment**, particularly for groups with difficulty accessing the labour market: more than 13,000 unemployed people have been trained to become qualified nurses, and care work is making a disproportionately high contribution to employment growth.
- Reliance on a **coordinated approach** to maximise efficiencies will require better service delivery **integration** (e.g. better integration of **outpatient and inpatient** care), better coordination skills between policy domains (see Vienna's sALto project), and more involvement of stakeholders in the design, implementation and evaluation of policy objectives.

The challenges described above could just as easily apply to any of the other cities being looked at in this study.

# 3\_EUROCITIES Social Affairs Forum Questionnaire: Responses

The following information was gathered from responses to a questionnaire distributed to members of the EUROCITIES Social Affairs Forum and from direct consultation with its members. The cities that responded were Aalborg, Belfast, Dublin, Eindhoven, Gothenburg, The Hague, Leeds, Malmo, Munich, Newcastle, Plovdiv, Rotterdam, Southampton, and Vienna.

In general, understanding the nature of the main demographic trends affecting European cities is not a major problem; all the administrations contacted throughout this study say that they do understand their city's demographics. Local administrations know whether their population is ageing, growing or shrinking and, although the full facts of migration are almost always subject to some degree of ambiguity, the essential trends of immigration and emigration are usually known, or knowable. Where the problems can begin is in understanding how the demographic trends affect health and social services, and the need for these services. Although most administrations say they understand the dynamics of demography as it affects service requirements, some administrations openly recognise an inadequate understanding: either because they do not have enough detailed information, or because their competencies limit them.

Among those cities that claim to understand the impact of demographic change, the detail and specifics vary. For example, in Sweden, Malmo undertakes significant research in this field, including an 'insight' report every six months on demographic development in the city and region.

In the Netherlands, Eindhoven identifies the simultaneous need to adapt elderly services to an increasingly older-older population, as more and more people reach advanced ages (i.e. 80+) , and at the same time to adapt to a shrinking body of people available to provide healthcare. In contrast, Rotterdam is still relatively young, although, as in Eindhoven, the elderly population is achieving higher ages; its services need to adapt to the immigrant population, with education, language, European/Dutch culture courses, health and housing, and, increasingly, care for frail older people, being the priorities.

In Malmo, the 'older-older' population is projected to remain stable during the next 10 years, and there will be more focus on adapting services to meet the needs of younger healthy pensioners. Only Southampton pointed out that, while yes, they understood the broad current trends, the extent and impact of economic migration is very dependent on economic factors, which are unpredictable; similarly, the true demands of an ageing population are also dependant on shifting and unpredictable factors and parameters, such as improvements in medical knowledge/ technology, and changes in social patterns, aspirations, expectations, etc.

**Key trends:**

In terms of identifying the top two or three trends with the most impact on the present and future provision of health and social services in their cities, most respondents alternated, unsurprisingly, between ageing and immigration in first and second place. A minority mentioned other trends, such as braindrain (Belfast), rising numbers of second generation black and minority ethnic communities (Southampton), inter-EU migration (Malmo) and emigration (in Poland and Bulgaria).

It is well known that emigration is, for the moment, largely a phenomenon of Eastern Europe. However, not long ago it was an issue elsewhere (e.g. Ireland and Spain), and in addition, the emigration that Eastern European cities are currently experiencing is merely the flipside of immigration elsewhere in Europe: it is part of the same migratory flows affecting the whole of Europe.

Furthermore, inter-EU migration is largely ignored in discussions within an EU framework, in spite of a) its importance, and b) its relevance to one of the EU's 'four freedoms' (i.e. the free movement of persons: the others being goods, capital and services): free movement is meant to be a central principle for the EU.

**Planning and assessment:**

Despite the high potential usefulness of concrete data and/or future projections on the changing needs that social and health services currently face and will face as a result of changing demographics, this study has found that this type of information is all too frequently unavailable. What there is of such data is generally lacking in concrete implications (e.g. how many more beds an institution might need by a given year, how many workers of a given category might be needed, etc.), and is often incomplete and inconsistent. Exceptions to this include Aalborg's [in Denmark] estimates of future sheltered housing needs for older people), and Southampton's (in the UK) formal 'Joint Strategic Needs Assessment' which informs health and social care commissioning, by identifying key service demands.

Likewise, comparative 'before and after' data on the benefits of adopting or not adopting a programme is too scarce. However some cities do collect this type of data. For example, Leeds (in the UK) collects a certain amount of 'before and after' data, often referred to as 'outcome focus'; and Southampton identifies the benefits of its programmes through performance management processes. Many respondents, when asked if they generate such data, seem unused to the concept.

This shortage of what is ultimately fundamental data, has important methodological implications for policy development, and also, because such data can be an extremely powerful tool in negotiating funding and political support, for the lobbying process.

**NAPs:**

In establishing and reviewing policy, local administrations and stakeholders do not take into account the EU's 'National Strategy Reports on Social Protection and Social Inclusion 2008-2010' (commonly known as National Action Plans, or NAPs) in a consistent way. Most take the NAPs into account to some extent although 'not very actively' or only 'sometimes' e.g. Newcastle's Social Inclusion team does refer to the NAPs. But Leeds and Munich report not referring the NAPs at all), Rotterdam, which is actively involved in developing the new 2008-2010 NAP, reports attaching more importance to the document as a reference for the coming period.

Logically, city-level administrations, which have to deal with most of the impact of social protection and inclusion strategies, need to be active stakeholders and participants in developing any meaningful action plan, and not just the recipients of a plan that has been developed elsewhere.

**Mediation and intercultural dynamics:**

Most city administrations that were consulted use some level of intercultural mediation, and also engage, or have engaged, in intercultural training programmes. Typically, in medical settings, this means that trained speakers of immigrant languages act as health mediators (e.g. Barcelona, see case study), or brokers (e.g. Rotterdam) or consultants (e.g. Eindhoven), supporting communication between patients and healthcare staff. Intercultural mediation is typically used to calm conflict situations, but also to combat phenomena such as forced marriages, early school leaving or violence against women.

Rotterdam focuses its social and health care intercultural training programmes beyond simply awareness or acceptance of cultural differences, to include how to deal with those differences. Belfast provides language-training classes to frontline staff. Munich has an Intercultural Quality Management System project, organized by an external institute. In Barcelona, a hospital management representative reports that, where healthcare workers perceive the practical applications for their intercultural training, and the usefulness of mediation support staff in finding solutions to the challenges of daily healthcare work, there is a good acceptance of such programmes and a demand for more. Southampton makes a considerable investment in intercultural mediation, although pointing out that it is difficult to say whether it achieves positive results, and that it is more a matter of there being an absence of negative results (e.g. riots, gangs etc.).

Newcastle provides intercultural training that is focused on practical needs in care provision (e.g. diet, health concepts etc.), for in house home care service workers, as has been standard practice in Southampton for many years; and Aalborg includes an intercultural component in general training for social workers, with specialised follow-up courses for those working specifically with immigrants. However, Leeds reports that specialist intercultural training, as such, is being **abandoned**, in favour of incorporating an intercultural approach in all mainstream training; whether this will be a future direction taken by others remains an **open question**.

### Intercultural issues and older people:

In terms of providing elderly care services adapted to the specific needs of elderly immigrant groups, the situation is somewhat varied. Countries with little, or only recent, experience of immigration (e.g. Bulgaria, Spain, Ireland) are, in particular, less likely to offer such tailoring, as they simply do not have a significant elderly immigrant population.

However, there are also cities, such as Munich and Aalborg, which have significant elderly immigrant groups, yet do not tailor their services. Those cities that do tailor their services, offer different degrees of tailoring: it varies from just providing native language advice as to service options, which otherwise remain largely the same (Vienna), to adapted dietary services, through to dedicated facilities, such as special elderly care home wards for people from a specific cultural background, and even mono-ethnic elderly care homes e.g. in Rotterdam, for older people originating from China).

While there might be some legitimate debate as to how, and to what degree, ethnically segmented care services are desirable, broadly, an awareness of varying culturally-determined needs among care clients is on the rise, and seems likely to continue to so increase. However, as Southampton points out, practices such as dedicated care facilities are not always popular or effective in meeting everyone's aspirations.

### Deprivation:

Most of the administrations that were consulted (in particular, in Sweden, Austria and the Netherlands), actively calculate the level and/or nature of deprivation in their city. However, some of the cities consulted (e.g. Dublin), for reasons of differing resources and competencies, just use national statistics supplied by the national administration. Obviously, using national data may give only a broad picture, and this can cause problems: deprivation is likely to be no less a concern in these societies as in the cities that make detailed measurements of their deprivation levels.

The differences in the priority that is given to measuring and understanding deprivation, needs to be tightened up: differences in how an issue is approached and conceptualised is one thing (and can even be beneficial, as the variety in the 'European laboratory' often results in greater comparative learning and insight); however, gaps in available knowledge are of no apparent benefit.

In terms of those cities that do prioritise deprivation and are active in measuring the situation, of particular interest is the wide variety of approaches they take in calculating the impact of a mix of deprivation factors, and in assessing the links between them. For example, cities like Leeds and Southampton, in the UK, refer to a '**Multiple Deprivation Index**' system, which combines a number of indicators to give a single deprivation score for each small area of the UK; in Leeds the index is used to customise local targeting, based on '**Super Output Areas**', in conjunction with a local Neighbourhood Vitality Index, currently being developed.

Munich conducts a report on poverty every four years, in conjunction with continuous and regionally-differentiated monitoring.

The Netherlands is also active in measuring deprivation. The Hague combines a nation-wide formula, using a mix of variables to calculate the 'deprivation-rate' in 40 areas across the country, with a similar local process for all of the city's districts. Eindhoven has developed a '**neighbourhood-thermometer**', calculating the health of its neighbourhoods (either healthy, at risk, or in poor health) based on various municipal statistics and data (such as population, housing, level of income, unemployment, education, reported health status etc.); the neighbourhood 'temperature' then generates an integrated approach to improving inhabitants' living conditions. Rotterdam conducts '**longitudinal poverty research**' (at 2 year intervals), and multiple forms of deprivation are now under research, in a study focusing on children in deprived households, and the effects on their life chances ('intergenerational poverty').

As services and tools adapt to shifting needs that are tied to demographic trends (e.g. deprivation pertaining to specific elderly or immigrant groups), the importance of understanding the links between deprivation factors is clear, as is the need for joined-up thinking and governance in health and social services: these services are necessarily as interrelated as the issues they attempt to address.

### Resources:

In terms of **adapting resources** to meet increased and/or changing demands due to demographic shifts in the population, the general trends are fairly consistent: investment in **prevention** of the need for services; an emphasis on maximising **labour activation** (moving the unemployed into work, and enabling older people to working longer), thereby increasing available resources (i.e. increasing the tax base and perhaps the numbers of available healthcare workers) and decreasing the need for resources; a move to more **direct payments** into personal or family budgets and **means testing**; building **capacities** and partnerships in the community (to enable people to manage on their own and on community based resources for as long as possible); support to family **carers**; and a mix of outsourcing and economies of scale in purchasing, where viable.

The Hague sets out short and mid-term (1-4 years) 'wellness' plans based on forecast demographic changes, to which it then asks its key partners to adapt: the focus is on shifting activities rather than just on budget changes. The Hague takes the same approach for health services as for social services, though the financial process is complicated by the fact that there is direct funding for health from the national government.

Dublin City Council works through a system of priority lists that are the results of an ongoing review (e.g. Dublin City Council recently commissioned a demographic analysis of new communities/economic migrants in the city and produced an integration strategy in June 2008). Meanwhile, Belfast emphasises: **benchmarking** against other cities; multi-stakeholder partnerships (e.g. a Migrant Forum, Older People's Panel, Youth Forum, which help in monitoring trends and impact on service delivery); and needs-prioritising, through very local-level consultation (the city's 'Strategic Neighbourhood Action Programme' divides Belfast into 11 'city places' and consults local populations on their needs at that level).

Conversely, Southampton identifies its resource challenges as stemming from: the fact that central government grants that partly fund social care have not moved in line with inflationary costs or growing demands; the fact that the negotiations concerning local income-generation through local taxes can be difficult; and also, importantly, the fact that there are significant **differentials in income amongst older people** (i.e. the comparative wealth of those with private pensions and who own their own homes, versus the increased poverty of those without independent pensions or their own property).

When asked to identify the main '**resources stressors**' related to demographic shifts that their city has to deal with, it is not surprising that the bulk of respondents focus on a shrinking tax-paying base, versus a growing dependent older population. Some cities go on to focus more specifically on recruitment problems in the social services sector (Aalborg), a shrinking body of working-age healthcare professionals, and even concerns about an accompanying decline of a spirit of solidarity in their society (Eindhoven).

New receivers of migrants (e.g. Spain and Ireland) focus on the need to adapt resources to the still relatively recent phenomenon of an increasing migrant population: Dublin highlights the importance of the current **economic downturn** (which is a broader issue affecting cities across Europe), and in particular, its effect on vulnerable migrants. Belfast highlights the **brain drain** issue: the reversal of this is a key strategic focus, with, currently, a growing retention of young people in the city.

**Organisational change:**

To deal with rising challenges of immigration flows and ageing populations, some cities are moving from the usual social affairs and health departments, to the creation of **subject specific departments** (see case study on Stockholm's department for elderly affairs). This move towards a subject-specific focus is still inconsistent. Across Europe and even within the same countries, some cities are refocusing organisational structures and some are not (i.e. they are continuing to share the relevant competencies across various separate departments). Amongst those creating specialised departments (or other equivalent administrative units), some cities adopt this practice for elderly care, some for immigration, and some for both, for example, Munich, which finds the subject-specific approach helps to clarify responsibilities.

Other cities, such as Aalborg (with its Elderly and Disabled Department), or Malmo (which on 2008 started its Department for the Elderly, find that this allows for the provision of a more skilled and specialized service. Meanwhile, Southampton has a very small 'Later Years partnership' (which identifies more strategic programmes such as prevention, engagement etc.), and an Inclusion Services team (which address immigration issues but is not well funded for this work). Eindhoven is presently reorganising its structure, moving from the usual array of departments, to a system of '**expertise centres**', in order to enhance its integrated approach and improve service provision to the citizens, starting 1 January 2009.

Evidently, the advisability of creating a new department depends on the context and on a multitude of considerations. Although the results of subject-focused specialisation and departmental restructuring are, and will be, interesting to observe, it remains to be seen how successful these specific initiatives will ultimately be, as well as how, when and where such formulae for organisational change would be suitable for others. Nonetheless, it does emerge as clear that, for an integrated approach to be seriously viable, real mechanisms for guaranteeing overall cohesion and 'joined-up-ness', both in delivery and in conception, are required. Moreover, while such administrative mechanisms can presumably take various forms, to be meaningful they must be provided with the necessary authority and resources.

## 4 Analysis and conclusions

### Integrated Approach:

On the ground, the application of an integrated approach to coordinated service delivery usually involves public employees performing a type of 'double duty'. For example, in Rotterdam, Social Affairs case workers, while visiting clients at home, also check and report on issues like safety in the house (e.g. electricity, heating, and hygiene), children attending school, signs of violence towards children or women, social isolation, visible illnesses etc. Dublin offers an example of a type of 'one stop' approach, in the form of area offices, which provide a full range of services and are established at a very local level.

Other cities, such as Munich, Aalborg and Vienna, pursue a process of closely **coordinated policy** development between traditionally very different departments e.g. social and health services and urban affairs. Newcastle has 'co-located' the Director of Public Health's office into the Adult Services Directorate, where they increasingly share research and policy development resources. On another level, such coordination can simply be a question of **joint procurement** and hence economies of scale.

When asked if their organisations encountered difficulties and resistance to the re-arrangement of existing structures and practices caused by adopting a new more integrated approach in service delivery, most cities said they had not encountered problems. However, some cities recognised that they did have such difficulties. For example, Plovdiv pointed out the challenges of bureaucracy, a shortage of **qualified** staff and problems with personnel **motivation**; to deal with this, the city's leadership is elaborating stronger rules, based on quality management and financial subsidiarity, as well as looking for European funding opportunities to strengthen its capacities.

Eindhoven recognised it had some of the challenges that are normal to rolling out any new system: as the administration worked towards the 2009 implementation of its new 'expertise centre' system, it emphasised the need for staff to be **included** in the process of adaptation. Aalborg also emphasises the inclusion of staff and unions in the process of organisational change. Rotterdam recognises that a more integrated approach causes some confusion and resistance amongst personnel, and the city relies on **training** to help cope with new issues in staff workload: its leadership tries to be pro-active in increasing the support amongst personnel for the integrated approach, through memos, speeches, training courses, conferences etc.

Dublin has developed a **communication** strategy to disseminate all necessary information throughout the organisation. Belfast's councillors participate in, and lead, multi-agency partnerships, such as the Good Relations Steering Group, to ensure that relevant agencies are working towards the city's inclusion goals; at the same time, management is conducting research into best practice and benchmarking exercises to learn from other cities' experiences in this regard. Southampton makes use of performance management programmes; and Newcastle has a programme of a "One Council" culture-change, designed to combat service isolation and narrow "silo" thinking.

This report seeks to move discussion and debate forward with regards to the issue of demographic trends as they affect social and health services in Europe's cities. The following describes the main recommendations and observations from the research conducted, highlighting the key concerns and the direction that policy and practice should take.

### Diversity of circumstances:

Given the varying degree and format of information available when preparing this report, and the difficulty in finding and comparing variables across different countries and systems, one immediate conclusion is that of a need for a tool that allows for standardised comparison, across the EU, of indicators of the impact of demographics on social and health services. This would allow for easier ongoing comparison and analysis, with less effort needed for simply gathering comparable data on changing care needs and demands. While the Urban Audit already exists, it does not cover the impact of changing demographics.

In general, basic demographic data, both current and projected into the future, is relatively easy to access, across Europe. What is needed is *extrapolation* of the demographics into concrete need, as it is growing, declining or changing. While such projections are inevitably imperfect, administrations, along with stakeholders, still need to forecast what the future will mean, in practical terms.

Repeatedly, the availability of relevant and reliable research was shown, by this study, to be the necessary point of departure for any successful initiative: when contacted, front-line staff consistently support this view.

Secondly, while there is great heterogeneousness in the competencies of administrations and the resources available to them, the issues and dynamics of **resource constraints** are generally the same, usually varying more in degree than in nature. Comparison is therefore possible amongst what are roughly similar situations (e.g. a shrinking tax base and growing elderly population needing care). Furthermore, it cannot be accepted that resources are entirely to blame for a delayed adaptation of services to current and future needs (e.g. more outpatient care, more support for families providing care, more intercultural competences in care delivery structures); the reason is rather a lack of agility and initiative in city administrations, and this must be addressed.

Thirdly, while all European societies are experiencing roughly the same broad phenomenon of ageing, they are experiencing migration in very different ways. In terms of migration, there are **three** distinct general groups of cities in Europe which are reflected in the cities studied: experienced receivers of immigrants (e.g. Southampton, Stockholm, Vienna); new receivers of immigrants (e.g. Barcelona); and cities of high emigration (e.g. Krakow).

**Migration:**

In the cities examined where **immigration** is generally an **older** phenomenon, this has meant:

- greater **familiarity** with key challenges, but also problems where negative dynamics become set, or stuck, in established dysfunctional patterns (e.g. certain dynamics for Rotterdam's Antillean community)
- a significant presence of minority and immigrant groups amongst the **older people** receiving care
- a demand for intercultural adaptation in elderly care, as people from minority communities reach retirement age.

For example, as a city beginning to receive significant external immigration only recently, Barcelona is in a position somewhere between, on the one hand, cities like Southampton, Stockholm or Vienna (which have long histories of immigration and compared to which, Barcelona is rapidly **catching up**), and on the other hand, cities like Krakow (which are more concerned with emigration and have only minor levels of immigration, whether old or new). As a result, the deployment of adequate policy initiatives in Barcelona has had to be put in place relatively quickly, in order to keep up with the pace of immigration, which is already well advanced. The risk is that cities can be overtaken by circumstances and forced into a reactive position. Conversely, the newness of the phenomenon is also an opportunity, albeit one that will quickly disappear: a city like Barcelona has the chance to learn from the mistakes as well as the successes, of its peers, and thus avoid such mistakes and negative patterns before they become established.

**Emigration** stands out as the **weakest** category of available migration data: it is often entirely unavailable and is generally not understood, even by administrations that are acutely affected by it. Emigration is in fact becoming a more ambiguous concept. For example, in Poland one finds examples of labour working abroad in quite fluid patterns, either in short bursts, or combined with work at home, in such a way that workers may not necessarily view themselves as migrants: at times this dynamic might be described as verging on a type of **extreme commuting**.

It is possible that we are seeing the emergence of a **new pattern** of internal EU migration: an ebb and flow of people between different parts of the EU, where members of one country (e.g. Polish people migrating to the UK) move easily within the European Union, due to differences in job opportunities (i.e. going from places where jobs are scarce to where labour markets are currently better performing, then easily going back as disparities in opportunities level out). Return to their country of origin may be due to economic improvement in the country of origin, or a downswing in the receptor state (some commentators have used the metaphor of the water in a bathtub shifting back and forth as the tub tilts in one direction then another). Obviously, more time and research are needed before attempting to draw any firm conclusions. However, the issue is hardly insignificant as it goes to the heart of some of the original objectives of the European project, which many people may not be aware of: the right to move, work and reside freely throughout a single European space.

One thing found consistently throughout the research for this report, is that facts on migration entail a certain ambiguity. It is probably inevitable that migrant numbers are so often inexact, unknown or unknowable as, typically, migration escapes accurate documentation: immigrants are calculated in approximate figures, and often there are no figures for emigration at all. In most cities, it is generally unlikely that the official numbers of migrants registered as residents is an entirely accurate figure: at best the figures are 'good enough' to give a true overall picture of the scale, direction and trend of current migration patterns. Administrations to some degree find themselves caught between dealing with official figures and the reality.

Likewise, **internal** migratory flows (people moving within the same country), and external migratory flows, are often tabulated and presented separately, so there is no single cohesive demographic picture.

**Care delivery:**

In terms of care delivery and the change-management of social and health services in the face of current and coming demographic trends (i.e. ageing populations and shrinking tax bases), the most consistent thread found running through all the policies examined is the move to maximise the use of community care (in the broadest sense), and minimise residential, or inpatient, care.

**More community care:**

Consequently, the direction of much present and future best practice is and will be refining community care and integrating different care solutions, competencies and needs into shared platforms e.g. Vienna's elderly day care centres.

The shift towards more outpatient care stems from:

- a\_the need to do as much as possible with scarce resources (i.e. residential and inpatient facilities are more costly)
- b\_the belief such a community-based approach can result in better quality care that is better tailored to people's needs and is more empowering (providing more choice, allowing people to continue their own autonomous lives in the community).

### Support for carers:

The dilemma is well known: as circumstances and strategies are leading families (in practice, disproportionately more women) to shoulder more care burdens at home in order to minimise the cost of public services, women are also expected to continue having children and to work. Necessarily then, if care delivery strategies are going to be sustainable, **at-home and outpatient care will have to be accompanied by an extensive and effective support for carers** (hence the inclusion of Southampton's Care for Carers as one of the case studies). Often, discussions on 'empowerment' for those needing care can become somewhat abstract. However, practical support for caregivers, helping them to really cope (be it through holidays, breaks, help back to work, counselling, having pension gaps covered, or whatever the case may be) provides concrete practical solutions.

**Local administrations are eminently suited** to providing such support for caregivers; the role of providing, managing and supervising such caregiver support would, logically, become a growing focus of their activities. The reality of the situation across Europe in terms of administrations providing such support for caregivers is mixed. Among the cities studied, Vienna, Stockholm and Southampton are at a more advanced stage in developing such programmes than Barcelona; Krakow's case is more unusual, as although public resources are constrained, an unusually large proportion of these resources is spent on the elderly (i.e. in comparison to the situation in most of the EU), and it is young people who are more at risk of exclusion (according to Poland's 2006-8 NAP).

### Third sector and health jobs:

While rising demand represents considerable pressure on care delivery, the issue, however serious, should not be discussed exclusively in negative terms: care provision and the social economy is a growth sector with serious potential for job creation, often for those with difficulty accessing the labour market. While all the appropriate provisos must be added in terms of maintaining care qualifications and standards, social and health care support work is emerging as a supplement to traditional labour market stimulation policies. Austria, for example, reports a disproportionate amount of its job creation in recent years to be taking place in healthcare.

### Different approaches:

While administrations can be looked at simply in terms of how proactive they are, amongst the initiatives being taken there is a range of approaches and relative emphasis, not one single homogeneous formula being carried out with different degrees of enthusiasm.

Vienna, for example, has found the use of patient co-payments very effective in steering service use and controlling costs. This approach is balanced by a system of caps on the proportion of a users' personal income they are required to spend on pharmaceuticals, treatment or any given form of service (i.e. the individuals and their families know they are guaranteed not to have to pay more than a given maximum, and thus will not be punished should they develop 'excessive' care needs). It is the view of this report that this kind of ceiling or cap, which is understood publicly and transparently, greatly strengthens the **credibility** of co-payment policies, thus gaining acceptance with the public and therefore likely to provide long-term sustainability in practice.

Vienna, Southampton and Stockholm all put great emphasis on developing individualisation of treatment and increasing choice. However, it must be said that the inevitable flip side to this is greater complexity. Developing tools and platforms that can effectively manage the complexities of individualised treatment will be a growing challenge to the practical application of an integrated approach.

### Intercultural competencies:

The case studies from of Barcelona and Vienna put the development of **intercultural competencies** at the centre of their approach. In both cases, practitioners developing the programmes emphasised that initial, very local, studies were key to an ultimately effective result.

Since, as mentioned above, different areas of Europe are very different in terms of immigration trends (i.e. much or little, established or recent), the need for, and experience of, **intercultural training and mediation** are at **different stages** and have **different approaches**. Some cities are moving away from intercultural training (Leeds) and integrating it into most of their general training. Others are putting significant emphasis on an intercultural approach (for example, Southampton, and also Barcelona, with its case study of hospital-based intercultural mediation), while others put little emphasis on it (Munich). So the study clearly found no **general trend**, in terms of practice.

However, the **demand** for an intercultural approach, which such training and mediation is meant to meet, seems only **likely to rise**: for example, care services in Spain will eventually have to start dealing with the specific needs of different cultural groups as users of elderly care services (not just providers, as is more the case at present), much as such services already do in Vienna, Newcastle or Stockholm. Ideally, administrations should be looking at what their peers are doing, and prepare themselves proactively, rather than wait for the problem to reach a point where they are forced to take a reactive approach.

The priority should be to deal with **practical considerations** e.g. dietary considerations for the elderly, cultural factors as they influence healthcare diagnosis or treatment, basic communication etc. Where intercultural training and mediation addresses such practical concerns, based on the day-to-day implementation of health and social services, **acceptance** of such programmes appears to be high, both among newcomer populations and front-line staff.

### Deprivation and inequality:

While deprivation is necessarily of the utmost concern to all European societies, the approaches to deprivation also vary widely. There is a clear need for more information on deprivation, which takes into account different deprivation indicators and the interrelationship between different deprivation issues, for example, in how **health inequalities** are linked to other inequalities. This is a central theme in Southampton's health and social policies; and similarly the Austrian NAP and the local Viennese programmes such as 'Counselling on the Corner', address the issue of the health disparities of many migrants and workers in certain job sectors.

Some administrations have developed conceptually comprehensive tools ( e.g. Southampton's use of the UK's interesting **Multiple Deprivation Index** system), to identify and publicly articulate the interdependencies involved in deprivation, and on which to base programme development and policy. It is important for administrations to move beyond rudimentary conceptualisations of deprivation, such as simply looking at income thresholds: while income levels are obviously of no small importance, it is generally accepted that deprivation as a concept brings together various factors (e.g. inter-generational issues, access issues, and so on). This report would like to strongly encourage administrations to update their understanding of deprivation with the current practice of their peers, and prioritise the issues of deprivation and exclusion to the degree these issues deserve.

### Impact analysis and policy projection:

The administrations contacted generally had difficulty in assessing the impact of their programmes, and what the situation would be if these programmes were not in place. Although, once an issue was explored, they could invariably begin to identify the effect of a given practice or programme, there rarely seemed to be a clear idea of **what the situation would be** without that practice/programme i.e. there was little evidence of – a succinct comparative before and after view of the impact caused. This is not to question the actual impact of these programmes, but the level of analysis and evaluation involved.

Action needs to be based on evaluation, the results and implications of which are **understood by all those working** in a given programme. The question 'how does the programme alter the situation?' (or similar questions) should be expected: it should not come as a novelty.

**Policy and programme development** needs to be based on projections of the impact, compared to what the predicted situation would be otherwise. Rather than justifying a policy or practice because of received wisdom (e.g. by simply copying best practice elsewhere), it should be a conscious choice based on a consideration of alternative scenarios.

Moreover, while forecasting the impacts of either taking or not taking a course of action can admittedly be difficult in many instances, such forecasts can be an **extremely powerful tool for soliciting resources and policy lobbying**.

### City involvement in National Action Plans for Social Inclusion (NAPs):

Likewise, investigation into the role of cities in the National Action Plans for Social Inclusion produced somewhat ambivalent findings. Reference to the NAPs by local authorities or stakeholders, in designing or implementing policy, is erratic at best, and often entirely absent. Significantly, where more attention was given to the NAP as a tool, city government had been involved in developing the NAP in the first place i.e. there was 'buy-in'.

This is important, as much, if not most, of the impact and practical implementation of the NAPs inevitably happens at the local level (e.g. outpatient care for the elderly is quintessentially a policy executed on a local level, as are policies aiming to integrate newcomers in their communities). Any successful implementation needs the involvement of local administrations and service-providers; and involvement in implementation is conditioned by involvement in design.

Moreover, aside from ensuring successful implementation, city involvement in the NAPs is a requirement for well-designed Plans: social inclusion policies cannot reasonably hope to be effective or accurately focused without the benefit of the kind of understanding and experience that can only be gained on the ground i.e. at a local level.

### Activation strategies:

One of the key ideas which, like the move to more outpatient and community care, – is found to be driving health and social policy strategy for dealing with demographic change throughout Europe is this: if, in an ageing society, **more people are successfully included in the labour market** and have longer working lives, then income **redistribution** from the working to the elderly **can be manageable**.

Such strategies raise important questions for Krakow, as **Poland** is lagging behind in terms of **inclusion rates**.

Likewise, the current **economic downturn** raises questions, particularly in countries facing an end to an extensive economic boom cycle (e.g. UK, Ireland and Spain), about the sustainability of current and recent strategies that rely heavily on labour market inclusion.

**Integrated approach:**

Complementing a labour activation-based strategy is the hope that better **coordination** and **economies of scale** (such as Vienna's system of 'Health Platforms'), by leading to greater efficiency, will extend resources further: this should allow for fewer services to be cut (thus ensuring 'rationalisation' over 'rationing'), and/or a reduction in the tax burden.

Much of the best practice identified thus involves greater coordination, and the combining of services and interventions (e.g. Vienna's day care centres for the elderly, designed to meet a range of health and social service needs and provide users with a single integrated platform). This allows cities to stretch resources farther, but also to provide services in a more complete or holistic way.

With healthcare services across Europe increasingly delivered by a **mix of public, not-for-profit and for-profit organisations or individuals**, the ability to work increasingly and more effectively with NGOs and other partners emerges as a growing challenge to putting into practice a **coordinated approach** (e.g. note Krakow's emphasis on structured work with volunteer organisations).

**Organisational change:**

**Restructuring**, and the combining of roles and functions that were previously separate, runs against the current of any existing organisational structures, organigrammes and customs, and thus necessarily generates a certain **friction**, even at the best of times. However, most of the administrations contacted **did not recognise** having any such difficulties themselves, unlikely though this seems.

In terms of reworking administrative and political structures, local **context weighs so heavily** that **generalised conclusions are difficult** between one case and the next. Nevertheless, in all cases studied, it emerged that real and **sufficient authority and resources** must accompany any such restructuring, if it is to be taken seriously and have an impact (e.g. Rotterdam's City Marine reporting directly to the Mayor, and Stockholm's appointment of a Vice-Mayor for Elderly Affairs).

**Conclusions:**

With regard to adapting to significant demographic shifts, the critical element that this study wishes to focus readers' minds on is **proactiveness**. Context varies so much across Europe that generalised 'one size fits all' type proposals are just insufficient. However, being proactive is one decisive distinction to be made between more successful and less successful cities.

Questions to ask include: Is the administration's approach **proactive**? Does it hold the initiative with regards changing needs? Or is it waiting until the actual circumstances on the ground, and/or the example of other cities, oblige it to act?

Furthermore, if there is a robust strategic vision, is that vision properly shared? Throughout the course of this study, when contacting practitioners on the ground, in a diverse range of localities, they were often unable to identify their local strategic vision; where such a vision does exist, this surely defeats the purpose of having it: strategic visions need to be shared.

This study, given its limited scope and resources relative to the breadth of the issues being considered, hesitates to make any sweeping generalisations. However, the study does raise questions, which will hopefully **promote further debate**, about a possible **fracture** in Europe, in terms of the proactiveness of city administrations in the face of growing demographic pressures.

What does it mean to be proactive? For one thing, a proactive administration acts preventatively; and of course any effective policy of prevention implies looking forward, with an understanding of both current changes and the direction of future change. A proactive administration therefore has to have a vision and it has to communicate that vision; and to do so it has to engage its stakeholders, including other institutional agencies as well as its own service delivery staff. Above all, a proactive administration has to innovate and initiate.

If being proactive involves planning, and, above all, acting for the future, then it is patently a problem that planning and future projections are always limited in terms of reliability and are imperfect at best (e.g. the timing of economic cycles). However, forward planning, as long as it is continually updated and is adapted proactively to meet forthcoming challenges, will clearly be more effective in safeguarding the wellbeing of citizens, than any reactive approach. This is hopefully a statement of the obvious, and of course no local European administration is arguing in favour of its own ineffectiveness: the reality is there are relative degrees of proactiveness, with mixed situations and varying 'shades of grey'.

## Annex 1\_Case Studies

As always, when looking from a European level, any analysis and comparison is subject to **limitations due to different circumstances** in each country or city: e.g. different competencies at different levels of government; different economic circumstances; and different cultural, political and historical backgrounds.

Nevertheless, the **same demographic trends** are clearly found across Europe, as are the impacts of these trends on cities. Sometimes even seemingly very different circumstances are in fact linked demographic phenomena, at a European level (e.g. Polish emigration/British immigration).

In all cases, local government is the front line administration for dealing with the majority of the impacts stemming from these phenomena, and, in partnership with other organisations, will, and must, play a key role in any effective solutions.

### I\_ 'Counselling on the Corner' and Counselling Centres for Nursing and Care at Home – Vienna

Key elements: Social services, ageing and migrant backgrounds, local community focus and counselling

#### Context:

From the mid-1990s on, awareness has grown in Vienna with regards to the particular situation of **older people with migration backgrounds**. A key departure point was a social scientific study, which demonstrated the extent to which **social services were targeted at the majority population**, and showed **low knowledge** of and low claims to these services, **among the older population with migration backgrounds** (cf. Reinprecht/Dogan/Tietze 1998).

During 1997-9, a multi-disciplinary project, on socio-cultural integration and the improvement of the social infrastructure for older citizens, in a densely populated region of Vienna (within the ERDF programme 'URBAN Wien Gürtel Plus'), **combined community work, counselling, personal accompanying services and empirical social research**. A low-threshold community centre was set up in this region, which worked in close cooperation with one of the Counselling Centres for Nursing and Care at Home. Following this project, **mother-tongue** counsellors were employed in all counselling centres for nursing and care at home, for all the major population groups with migration backgrounds.

As part of a subsequent project, **young persons with the corresponding migration backgrounds and professional social knowledge** achieved qualifications as mother-tongue counsellors.

The city's basic services for persons with nursing and care needs are organized by the Vienna Social Fund, on behalf of the municipality, and in conjunction with various NGOs: services are organised through eight counselling centres (termed Counselling Centres for Nursing and Care at Home) distributed throughout the city. These centres have been in existence since the early 1990s and replaced the traditional outpatient nursing and care facilities launched in the 1970s.

The programme is further contextualised by a few key social and political issues:

- **Legal claims to services have expanded**, under the Vienna Social Assistance Law (stemming from a 2003 EU Council Directive on long-term resident status for third country nationals).
- **Nursing requirements** are increasingly perceived as a social issue and are connected to questions of **ageing, migration** backgrounds, as well as **gender** and **intercultural** issues. Accordingly the **demand for culture-sensitive nursing** is growing. Since the introduction of mother-tongue counselling for senior citizens about ten years ago, nursing issues, in relation to persons with migration backgrounds, and legal and financial concerns, are increasingly receiving more attention.
- In the context of family nursing care, the question of **relief for women** carers is an issue clearly on the rise, both among persons with migration backgrounds and otherwise.
- The **health of many migrants is considerably poorer** than that of the general population, not least **due to work** undertaken (e.g. in construction and cleaning).
- 30 % of older persons with migration backgrounds in the 'Counselling on the Corner' neighbourhood live in **substandard housing**
- In Vienna, the nursing allowance is granted to third-country (i.e. non-EU) nationals who have a visa and whose main residence is in the City of Vienna, without a waiting period.

#### The Programme:

'Counselling on the Corner' is **oriented towards the local community**, and stems from the needs of an increasingly diverse population. For example, for strong **oral tradition** groups, the personal presence and accessibility of social workers and counsellors in the neighbourhood is significant: during encounters on the street the question asked is not 'Is 'Counselling on the Corner' open?', but, is **Ms. XYZ** on the Corner?. Importantly, even with limited staff, it is possible to work within group traditions, such as the status of older women in Roma communities, through co-operation with respected **personalities in the communities**.

'Counselling on the Corner' is visited by **70 to 80 persons** a week, of whom about **40 are new clients**; and some two thirds of the visitors have migration backgrounds. The facility belongs to a much larger general Counselling Centre for Nursing and Care at Home, which was visited by 899 men and 2,367 women in 2007 (totals for all such centres in Vienna were 6,988 men and 18,019 women in 2007).

The Counselling Centres for Nursing and Care at Home are responsible for **case management** (i.e. information and counselling for persons with nursing needs and their relatives; joint identification of nursing requirements with clients and professionals; calculation of costs; people to accompany clients to offices and local authorities, and so forth), **specialized counselling** (e.g. crisis intervention, or incontinence counselling), **group activities** (e.g. discussion groups or specialised gymnastics), and **community-oriented activities** (networking, PR).

Specific concerns addressed to the multilingual counselling team typically refer to the inability to work, invalidity pensions, and various health-related issues. Family reunification is a rising issue, as clients **bring ageing parents**, with nursing requirements, from their countries of origin to Vienna: this raises issues of residence, maintenance, co-operation with pension insurance companies, and applications for nursing allowance.

One of the major objectives of the programme is the reduction of **xenophobia** and the promotion of intercultural communication in everyday life. However, it is **not a two-tier or separated system**: staff of Austrian origin work with clients with migration backgrounds and professionals with migration backgrounds work with Austrian clients.

Nonetheless, mother-tongue senior citizens' counselling makes the **topics** treated in the centres **more diverse**. The target group is becoming on average **younger**. Initially, users were, almost exclusively, members of the general population who were over 80-years-old, and their relatives: they turned to the centres to claim specific, largely standardized, domestic care and nursing services. In contrast, now, the centres are increasingly visited by persons in their 60s and 70s, with questions about social security and health.

**Increasingly, intercultural counselling competence** is required in various specialist subjects e.g. in the differences between the Austrian pension system and those in the countries of origin; or in the role played by courts in enforcing entitlements. The issue of health also necessitates intercultural competence, in addition to an understanding of material poverty and discrimination.

The development of culture-sensitive programmes and methods in community-oriented nursing and care is ongoing. With the **increasing age of the migrant population**, the challenges facing intercultural counsellors will grow.

**Benefits and Limitations:**

In terms of care quality, the programme coherently combines a variety of services, while meeting specific individual needs and promoting social inclusion and participation.

Moreover, counselling centres like 'Counselling on the Corner' reduce stereotypes and prejudices, promoting more receptive attitudes and culture-sensitive outlooks.

With regards to increasing competencies, the centres are building a growing awareness of these intercultural issues, particularly in terms of creating access to services and establishing contact with persons and groups of persons with differing cultural backgrounds. The teams in their entirety have experienced an ongoing development of their intercultural and diversity competence, originating with the experience of mother-tongue counselling.

However, the development of such intercultural competencies does involve a rather specific caveat: people must not be **pigeonholed** in terms of culture, either due to real or surmised cultural affiliations. Rather, full account should be taken of their basic human rights to **self-determination** and fairness, concerning access to the social system.

*For more information, contact: Christine Petioky, Vienna Social Fund, Department of International Networks and Incentives, christine.petioky@fsw.at*

**II\_F.E.M. Sued – an Intercultural Women's Health Centre – Vienna**

Key elements: Intercultural women-oriented health counselling, gender mainstreaming, immigration and access to health services and information

**Context:**

The genesis of the programme involved a series of international events and declarations, all directly linked to a chain of local Viennese initiatives. First, an international 1991 symposium entitled 'Women, Health & Urban Policies' was organised in Vienna; from this came FEM, a WHO model project for Austria's first women's health centre. Then 1994 saw a WHO conference 'Women's Health Counts', in the city, which produced the 'Vienna Statement on Investing in Women's Health': this demanded women-friendly health promotion that is empowering and encourages all women to lead self-determined lives.

In line with such principles, the 'Vienna Women's Health Programme' was established in 1998 by the Vienna City Council (it was developed by a commission of representatives from relevant fields of medicine, psychology and social affairs as well as NGOs and politicians from all parties); this was to ensure that women's needs and problems would not be neglected in a **predominantly male-oriented health system**. As part of the same resolution, a Vienna Commissioner for Women's Health was established, to implement the programme. The programme aims to improve medical, psychological and social services for women, and to increase awareness of women's health and a holistic approach to health care for Vienna's female population.

In compliance with the principle of equality, the Vienna Women's Health Programme places particular importance on **socially disadvantaged women and female migrants**. Migrant women's health is a matter of public health: their low socio-economic status, their limited knowledge of the majority language, and their experiences of discrimination, have reduced their health competence and caused them difficulties in **accessing relevant health information and services**. Migrant women should be "empowered" to take healthy decisions in their daily lives.

**The Programme:**

F.E.M. Sued is a contact point for women, parents and girls, focusing on the needs of migrant women and socially disadvantaged women, and was one of the first steps towards implementing the Vienna Women's Health Programme. Since 1999, it has been located in the southern part of Vienna, in a hospital in the 10th district of Vienna, in Favoriten: this is a traditional workers' district with low average levels of income, education and social status. 16.5 % of Favoriten's inhabitants are immigrants without Austrian citizenship, mostly with a low socio-economic status, which usually **correlates with a poorer state of health**. (In total, one third of Vienna's total population has a migrant background, with or without Austrian citizenship.)

F.E.M. Sued's activities developed out of a **needs assessment** conducted in Vienna's 10th district, showing the district needed a women's health centre (among those interviewed, 88% of Turkish women, 80% of German native speakers, and 77% of women from former Yugoslavia were interested in having such a centre nearby).

In the Women's Health Centre, **psychologists, psychotherapists, physicians, midwives and social workers** are involved in **counselling** women and girls of all ages. The **multilingual** team works in close co-operation with the staff of the Kaiser Franz Joseph Hospital. There, women can get psychological, medical and social advice in seven languages, in addition to attending affordable health promotion courses, workshops and other such services. There is also a **telephone hotline** women can call to obtain counselling by psychologists.

The centre seeks to: support health-conscious lifestyles for women; encourage women's own to improve their own psychological and physical welfare; and strengthen the awareness of female health needs.

One of the centre's main tasks is to break down **barriers** impeding access to the healthcare sector, and to promote initiatives for socially disadvantaged women and migrants. The aim is to increase the competence of these clients by improving access to information and thus strengthening their sense of self-determination.

Accordingly, to meet the needs of the high proportion of migrants living in the 10th district, F.E.M. Sued offers information and counselling services in the area's main migrant languages: largely Turkish, Serbian, Croatian, and Bosnian, with Arab, French and Lingala added in 2007, when a health counselling service was set up especially for African women. In total, **nearly half** of all client contacts are in languages other than German.

The F.E.M. women's health centre functions as a kind of interface between hospitals and institutions in the healthcare sector: the centre co-operates closely with the **Vienna Commissioner for Women's Health** to implement health promotion for socially disadvantaged and migrant women. Effectively, the centre sees itself as an advocate of women using healthcare services, aiming to develop models with a special emphasis on women's issues, based upon the Ottawa Charter for Health Promotion. These recommendations are most effectively implemented by a **holistic bio-psycho-social** concept of health and illness. The goal is to empower women to lead healthy, satisfactory and happy lives, that meet their needs, and to enhance women's self-esteem and self-confidence.

Concretely, the centre has carried out a number of projects, such as:

- **'To Your Heart's Content'**: a multidisciplinary and intercultural intervention programme for health promotion and the prevention of cardiovascular diseases in adult women, with an awareness and media campaign, in addition to courses, phone-counselling and screening interviews. Importantly, the project, in developing innovative strategies to reach socially disadvantaged women with a high risk potential for cardiovascular diseases, created an attractive, effective and **exportable service** in an intercultural environment.

80 % of respondents managed to adopt healthier eating patterns and to integrate more exercise into their daily lives. About 10,000 contacts with women were achieved.

- **'Medical check-up'**: a programme aiming to **increase the use of health check-ups by Turkish women, using** a Turkish speaking female social worker and Turkish speaking facilitators with a medical background. (This is similar to the Barcelona Hospital del Mar case also included in this report). As a result, in the first year, **81 % of the participants went for a health check-up for the first time in their lives.**
- **Workplace health promotion**: using a participative approach, native language health circles were designed to give unskilled women workers with low German language skills, a voice i.e. the ability to **articulate their needs** and feelings better and gain access, by considering gender, diversity and migrant perspectives (e.g. adapting standardised questionnaires).
- **Health lectures in nine languages**: F.E.M. Sued organizes lectures about health issues in migrants' centres, mosques, churches, women's shelters etc., reaching 10,723 listeners in 2007.

#### **Benefits and Limitations:**

The **acceptance** and **utilisation** rate of F.E.M. Sued is **high**, both with users and medical health staff: this shows that the service is in keeping with the current needs of migrant women. Effectively, the centre has become a key provider of services that focus on migrant women's health and illness, combining health promotion and treatment of disease under one roof.

The approach requires ongoing **research** focusing on women's health issues, so as to be able to implement women-specific health promotion programmes. **Continuous evaluation** activities are used to maintain service quality.

Of particular interest to peers are the exportable models for service platforms and interventions which F.E.M. Sued seems to offer. The service could function as a competence centre regarding female migrants, having, moreover, a vocation to raise awareness about migrant's health issues.

In fact, the intercultural approach of F.E.M. Sued has indeed served as a role model to Vienna's first **men's health centre**: M.E.N., launched in the Kaiser Franz Joseph Hospital in 2003. M.E.N works in very close co-operation with F.E.M. Sued, focusing on men with and without migration backgrounds.

*For more information, contact: Alexandra Grasl, Vienna Womens' Health Programme, F.E.M. Sued, Kaiser Franz Joseph Hospital, Kundratstraße 3, 1100 Vienna, Website: [http://www.fem.at/FEM\\_Sued/femsued.htm](http://www.fem.at/FEM_Sued/femsued.htm)*

### III\_Southampton City Council, Strategy for Carers 2008 – 2010

Key elements: Care for carers: holidays and rest breaks, support – context of growing outpatient and home care needs

#### Context:

In Southampton, some 18,000 people identify themselves as caring for a sick, frail or disabled friend or relative. Moreover, there is an extensive body of national policy, legislation and local strategic documents, going back nearly 30 years, supporting the principle of caring for carers. This support involves helping carers have **holidays** or rest from their roles; identifying such carers as **partners**, and involving them in service planning and implementation; improving carers' **knowledge** of services and how to access them; and providing carers with **assessment** services. Importantly, legislation has enabled **local** authorities to **provide direct payments** or **services** to carers, in support of their caring role and of their own health and well-being concerns. Some of these services are provided **free** to the caregiver and care receiver for a limited time (up to six weeks).

Other approaches that are being used involve: adapting services to the particular needs of the young or members of minority ethnic groups; Powers of Attorney (so that other authorized persons are empowered to make necessary health and welfare decisions); promoting carers' right to request **flexible working hours**; and their access to work, training and leisure activities. **Broadly, the guiding principle is to help carers maintain their personal identify and control over their own lives.**

#### The Programme:

Southampton City Council currently provides 985 carers with breaks from care and other support services to help them in their caring role; and the present two-year plan (2008-10) sets out to provide 'care for carers' and identify ways in which support services for carers can develop. In keeping with broader trends found across Europe, which emphasise working with partners in the community, the Council carries out this support for carers in close cooperation with partner agencies, particularly carers' own organisations (including various minority group organisations: black, Asian etc.). The strategy aims to address the specific needs of different types of carers and people receiving care (such as **long term** conditions, **learning disabilities**, **mental** health or **substance** misuse problems, **young** carers).

The 2008-10 plan has identified a series of objectives:

- **Identifying** carers and stakeholders, and **learning** from them about specific carers' needs (e.g. ethnic minorities, the learning disabled), about what services are appropriate and how they can be improved and tailored.
- Raising **awareness** of carers' issues: through the media, organising events and working with health, childcare and social care professionals.
- Offering good quality **assessments** to all eligible carers, and advising stakeholders on their options for carrying out assessments and building competence.
- **Providing support**, to facilitate effectiveness and offer respite (breaks): this includes **greater uptake** and suitability of services, a range of community outreach activities, training, coordinating with other agencies and promoting **flexible employment** policies for carers.
- Developing **funding** from both public sector allocations and charitable support.

#### Benefits and Limitations:

The benefits of the programme are defined in terms of achieving the goals set out in previous planning cycles and the positive feedback from carers. Achievements are identified in such things as: increased availability of care support services and supporting human resources, more extensive types of services, service uptake, event attendance, fulfilling various community outreach and partnership objectives, less bullying of young carers in schools, development and dissemination of information sharing tools and increased numbers of carer assessments being carried out.

In terms of limitations, the programme has used resources to carry out various one-off activities for young carers, but these have come to be questioned in terms of their sustainability. This report, for its part, would emphasise that, while such programmes that aim to 'care for carers' are needed, and the demand they respond to will only grow, they provide limited solutions (i.e. they alleviate a situation, without altogether eliminating it). Thus, respite and other such support measures make sense as tools, to be coordinated with broader care delivery solutions and resource deployment strategies.

*For more information contact: Christopher Hawker, [christopher.hawker@southampton.gov.uk](mailto:christopher.hawker@southampton.gov.uk)*

#### IV\_Hospital del Mar, Barcelona – Intercultural Mediation and Training

Key elements: Hospital intercultural mediation and training programme, adapting to new immigration, innovation by front-line staff

##### Context:

The relatively recent and intense influx of immigration in Barcelona, as throughout Spain, has significantly changed the profile of healthcare users. Due to its location in Barcelona, the Hospital del Mar – provides services to zones of the city (Ciutat Vella, San Marti) with among the highest rates of immigrant populations, particularly those on low incomes. The hospital is therefore in something of a 'frontline' position in dealing with new and unfolding challenges, brought about by a changing population base and a hitherto unknown heterogeneity (ethnicity, language, religion). Consequently, in 2000, Barcelona's Hospital del Mar began providing **intercultural training** to the hospital's staff, and in 2003 began a programme of **intercultural mediation** for users<sup>3</sup>.

**Immigrant numbers:** The hospital numbers some 150 nationalities among its users, the main groups being: Arab, Pakistani, some Eastern Europeans (Romania particularly), and now more and more Chinese.

**Usage (2006 figures):** foreign users account for 29.2% of Emergency users, 16.3% of inpatients, 11.6% of outpatients, total average: 12.8% foreign users.

##### The Programme:

The **staff-training** curriculum rolls out in the following phases:

- General introduction to intercultural issues
- Impact of culture on health
- Cases by culture group
- Commonalities by religious group
- Commonalities by national/geographic group

The training presumes that three key concepts, religion, culture and health, are **linked**, and that **culture and health are inseparable**.

The mediation programme:

- Affects all services, wards and administrations, involving and combining translation and mediation.
- Is run through the Patient Service Department, whose manager oversees the programme.
- Involves no positive discrimination: no separate services, no women doctors deliberately assigned to women etc., or any altering in how things would otherwise function.
- Structures its approach around 3 interwoven factors: language, cultural difference and social environment (i.e. which means those people around the user who are influencing or affecting them: i.e. family and community).

Selection:

- A local NGO, 'Salut i Família', provides the mediators and makes the first selection.
- The hospital then approves a final selection of personnel and provides further training, focused on healthcare and the specificities of the hospital.
- Mediators are chosen by need: depending on the main communities present amongst users of the hospital and the degree of need among these communities.
  - i.e. some communities have more problems with language than others, some are more familiar with the Spanish system etc (for instance Moroccans, whose country of origin is geographically closer and who have a longer history of migration to Spain, have less need compared with migrants from Pakistan).
- Accordingly, the hospital currently has 2 Pakistani mediators, 2 Arab, 1 Chinese and 1 Romanian.
- A mediator must be from the relevant country or culture, and must have lived in Spain long-term: being familiar with the Spanish system and culture, understanding Western ideas of health, and speaking the host country language.
- Priority is given to mediators with some sort of **background or familiarity with healthcare** (similarly to FEM Sued's approach in the 'Medical check-up' project) in the country of origin (e.g. a nurse, etc.), and, in any case, the candidate must be comfortable in healthcare environments (e.g. one mediator, though highly experienced, turned out to faint at the sight of blood and was thus ill suited to working in the hospital setting).

Functions of mediators:

- Inform staff re: relevant cultural factors e.g. in some cases, the user will not take a decision immediately and on his or her (usually 'her') own, but will first need to consult family.
- Inform patients re: medical matters.
- Help staff and users communicate, and help with misunderstandings e.g. during Ramadan some Muslim patients do not want to take medicine because they want to fast, so the mediator tries to reassure them that religion allows the ill not to fast; and if the user still insists, the doctor tries an alternative, such as prescribing antibiotics every 12 hours, not every 3 hours etc.
- Help with written information.
- Educate users e.g. when to use Emergency, and when not to; when and how to get an appointment; how to get a health card etc.

In terms of **Human Resources**, the hospital contracts about 500 hours per month, from 6 mediators who work morning shifts (the busiest time slot); the cost is approximately 80,000€ a year, paid to the NGO (Salut i Família), which then pays the mediators (this arrangement is necessary due to regulations limiting a public hospital's ability to hire directly). Additionally, the coordinator of Attention to Users gives roughly ¼ of her time to managing the programme.

The physical resources required are quite simple: an office is provided for the mediators, equipped with 2 computers.

**Benefits and Limitations:**

The practice benefits **3 groups** of people:

- Healthcare workers.
- The users/migrants: among other considerations, they have less anxiety about their health treatment (compared with feeling surrounded by the entirely unknown and the different.)
- Other service users: as a result of mediation, visit times are shorter; with communication being easier and quicker, visits are more efficient and others have to wait less.

Broadly, everything runs more smoothly and overall service quality is better. Moreover, staff report having never had problems with migrant group related violence.

A 2005 **staff survey** shows positive results for the programme, finding that the healthcare professionals who are affected accept the need for the programme and are convinced of its value. (What criticism there has been, has mostly centred on the limited hours available i.e. they want more of the service.) Of the staff surveyed, 95.6% knew of the service and 24.2% used it regularly; 82% think it is necessary; 91.9% think it has helped communication between patients and professionals; 77.6% think it has allowed difficult situations to be resolved, and 82.3% think it improves healthcare quality. These are very important findings, as without staff buy-in, such a programme would not succeed.

When management was asked to identify what elements of the programmes' implementation were key to making it work well, the following was emphasised:

- Ensure complete support from the hospital's management.
- **Always** conduct a field **study first**, on numbers and patterns of use. An initial study is key: it was found that **initial perceptions were often incorrect** when correlated with hard data e.g. initially, there was a perception that much of the migrant user presence was in gynaecology (60% of users as migrants; 41% being on a low income), because the consequences were more dramatic (i.e. migrant women in labour and unable to communicate etc.). However, migrant user presence had in fact become much more widespread than people initially believed.
- Base the programme on the specific care facility's needs i.e. not on more general needs such as statistics of the city as a whole, etc.
- Continuously monitor needs e.g. the Hospital del Mar is now registering a growing Chinese user base.
- Where healthcare is universal, as in Spain, avoid the need for mediators to ask migrant users for their residency papers and similar documents. (Though this is perhaps not strictly a requirement for applying similar programmes elsewhere, this does seem to make the work of those involved easier, as they have one less thing to deal with, and users are less anxious about any possible negative consequences.)
- Focus on the **day to day level** i.e. this is entirely a pragmatic approach, designed for the here and now: to meet immediate practical needs that healthcare staff and users face together, in this hospital, not some broader policy tool.

In terms of **limitations** and problems, participants describe egocentrism (i.e. an attitude of 'we're right'), on either side, as the main cause of any problems in such a process of intercultural mediation.

Other factors to be aware of are:

- The dynamic is **easier** when dealing **one on one**, and harder when others are present or involved (family, groups).
- Immigrants who **speak the same language** (i.e. Latin Americans) slip through this mediation process, as it is currently established, as there is a tendency to **underestimate** the impact of cultural differences.
- Intercultural mediation is **not** a tool for **general integration** (it is not meant to be), nor a broader policy framework.
- Mediation rarely convinces the other entirely; rather, it achieves a **limited** degree of mutual adaptation, as needed for the more functional and **immediate purposes of healthcare**.

This is a tool developed by practitioners in the field, on a local level, and with an entirely pragmatic approach. It is potentially of interest to their peers as a source of insight to the practicalities of implementing similar initiatives in a similar health service context.

**V\_Stockholm Elderly Division, Services Committee and Vice-Mayor**

Key elements: Creation of administrative divisions specialised in elderly issues, headed by a Vice-Mayor for Elderly Issues

**Context:**

In 2002, in Stockholm, within the executive office of the Municipality, elderly issues were separated from general social issues and policy (i.e. they were given autonomy within social affairs). Then, after Stockholm's **2006** municipal elections, the administrative organisation was restructured to create three interconnected administrative bodies with a specialised focus on elderly issues: the **Elderly Division**, the **Elderly Services Committee** and the **Elderly Services Administration**. The Elderly Division is headed by a **Vice-Mayor for Elderly Issues**, who oversees the Elderly Services Committee of the District Council and Elderly Services, and gives it political weight.

This was a political decision, as the political actors involved agreed there was real and growing need to **improve the situation for elderly people** and **attitudes towards them**, as well as the **administration's political and technical focus on elderly matters**.

Additionally, Stockholm has an **Ombudsman for the elderly**, who gives support in issues concerning municipal care services and assists the elderly to resolve grievances.

City of Stockholm 795,163 inhabitants	
65 or older	~14.2 %, or 115,000 persons
receiving Elderly care from the Municipality	~27 000 persons
living in special housing	8%
Receiving home help services	15%
having daily help with cooking, shopping, dressing etc	~ two out of ten elderly
living in some sort of housing for the elderly	~ one out of ten elderly

Sources: Stockholm Elderly Division, [www.stockholm.se](http://www.stockholm.se) <http://www.eurocities.eu>

Each **district council is responsible for elderly care delivery**, private and public, in its geographical area, and owns and manages homes and facilities for the elderly (the Elderly Division itself has no housing units or facilities under its direct control). The City is divided into 14 local district councils, answering directly to the City Council, which is the top decision making body of the City of Stockholm.

The Elderly Services Committee and the Elderly Services Administration were established 1 January 2007 by the City Council, which was seeking to push more public and political focus onto Elderly Care issues and achieve a general recognition of their growing importance. The tasks of the Committee concern all older persons, not only those entitled to care.

#### The Political and Administrative Programme

The Elderly Division, headed by the Vice-Mayor:

- Keeps **cohesion** and an overall vision of elderly services across the 14 districts and supplies a political vision of elderly policy.
- Provides **information for policy** and for **answering political questions** from the council concerning the elderly.
- Outlines the broad **strategies** to be applied by the districts and provides **a policy reference framework** within which they work e.g. starting on 1 July 2008, a new policy, overseen and conceived by the division, that guarantees **consumer choice** in housing for the elderly, will be applied by all the districts. The division does not direct the districts in this, but rather **sets the policy framework**, which districts then apply.

The Elderly Services Committee is responsible for:

- Overall **political** matters for the municipal segment of elderly care in the city.
- **Coordinating** and developing issues concerning all elderly care in the city.
- **Policy-making**, and drawing up guidelines for activity.
- **Coordinating the planning** of special accommodation and homes for the elderly.
- Cooperating **with Stockholm County Council**, which has political responsibility for elderly medical care.
- Collaborating with **voluntary associations** and deciding on contributions to those associations (currently it distributes some €804,000 to 27 NGOs).
- Delivering general education in basic community care services, providing continuation courses and organising further development for managers, nurses and other groups employed by the city.
- Running the city's Elderly and Disability 24-hour Duty Service, for elderly and disabled people with emergency medical alarms in their home.
- The Elderly Services Committee is, together with the Stockholm County Council, joint owner of the Ageing Research Centre.

Included in the Elderly Services Committee are:

- The **Ombudsman for the Elderly**, who acts impartially and supports older people in matters involving care
- Three **Eldercare Inspectors**, who carry out systematic studies on the quality of eldercare and survey the district councils' eldercare, both municipal and private.

Two issues are prioritized in current budget plans:

- Reinforcing the importance of **equivalence** and comparability between the 14 district councils' assessments, by appointing a special office to deal with this question.
- Emphasising **freedom of choice** for the elderly, as an important goal: since 2002, older persons have been entitled to choose their Home Help service provider from **private companies** contracted by the City or from public health services. From 1 July 2008, the City of Stockholm also offers similar freedom of choice in specialist care accommodation.

As throughout the EU, Stockholm's Elderly Care Service policy seeks to enable older people to remain at home, and to receive the required services and care there. Those unable to do so are helped to obtain another more suitable residence. To enable a person to continue living independently for as long as possible, a range of services and accommodation are provided, such as:

- Serviced buildings (flats, occupied on a tenancy basis, with various services and facilities for older people included)
- Retirement homes
- Group residences
- Nursing homes
- Home Help services
- Technical aid services (for the handicapped, hearing impaired, etc.)
- Day centres
- Leisure activities
- Meals-on-wheels
- Emergency alarms and/or patrols
- Support to care-giving relatives.

Those **over 75** can receive:

- **"Fixing services"**, cost-free, for a maximum of six hours a year: the city **helps out** with things that might be more difficult for those over 75 to undertake e.g. hanging up curtains, changing light bulbs, carrying items etc., thereby reducing the risk of injury, and increasing safety and quality of life.
- **Preventive home visits**, informing those over 75 about the kind of care the city offers and evaluating whether the person has an unsatisfied need for care. The need for support and services can, through these visits, be discovered at an early stage, thereby increasing safety, reducing individual suffering and reducing the cost to society.

#### Benefits and Limitations:

Local administration workers and representatives explain that:

- Issues concerning the elderly have received a **greater emphasis** since the Elderly Division, the Elderly Services Committee and the Elderly Services Administration were established.
- It has proven **more efficient** to have one Committee/Administrative division that deals with all questions (guidelines, policies, coordination etc.) concerning Elderly issues.
- This approach is more workable in practical terms: it would be **too big** and unwieldy for the whole of social services to be combined into a single administrative division.
- The administration can employ **experts** in the subject area and therefore benefits from a specialised interest and expert knowledge.
- **Cooperation** between the Elderly Division and The Elderly Services Administration is functioning well.
- Elderly persons who **are not in need of elderly care have received greater attention** since the distinctive division was created.

To achieve the administrative restructuring and bring Elderly issues into a separate division, this initiative required a shared understanding and support for change amongst the necessary political decision-makers, with a **willingness** to assign the resources and give greater public attention to the issues of older people.

So far, those involved in providing services for older people cannot (i.e. when asked for this research report) back up their claims as to the benefits of the programme with any **empirical** data. However, this may be, at least in some part, due to the more **politically** oriented objective of reorganising the municipal administration and the assignment of a vice-mayor to head the division, or it may be because the initiative is still somewhat **young**.

In terms of challenges to the sustainability of the approach, the obvious vulnerability is that it came out of the results of one election; it could therefore become the casualty of **another election** and of subsequent reshuffling of portfolios. While all programmes are affected by political change, this specific instance would seem particularly connected to political tides. Conversely, the attachment of a political figure, the **vice-mayor**, does give elderly issues some political weight, which is a strong advantage. Both possibilities would seem to be two sides of the same coin.

## Annex 2\_References & websites

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Much information for this report was acquired through the supply of internal documents, emails and direct interviews. Specific public sources are listed below. For any enquiries or further clarification, please contact the author: Ian Goldring

[iangoldring@gmail.com](mailto:iangoldring@gmail.com)

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For more information see:

[http://ec.europa.eu/employment\\_social/progress/index\\_en.html](http://ec.europa.eu/employment_social/progress/index_en.html)



1, Square de Meeûs  
B -1000 Brussels  
tel +32-2-552.0888  
fax +32-2-552.0889  
www.eurocities.eu  
info@eurocities.eu

