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"GOOD NEIGHBOUR" PROJECT
EUROPEAN REPORT ON THE STATUS OF SOCIAL EXCLUSION OF ELDERLY PEOPLE LIVING ALONE IN FIVE EUROPEAN CITIES
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VI. CONCLUSIONS ..............................................................................................................
The “Good Neighbour” project is a European project promoted by the City of Barcelona. Four other European cities participate in the project: Birmingham, Lyon, Milan and Rotterdam. It is being carried out within the framework of the summons “Preparatory measures to fight against and prevent social exclusion (line B3-4105)” of the EC Directorate General for Employment and Social Affairs. It aims to define a new model of support for the elderly who live by themselves and are at risk of social exclusion, based on the sympathetic attitudes and commitment of their neighbours in each city.

A description of the project, including the objectives, actions, terms and participants, is attached to this document to help when reading this report.

This document is based on information obtained from reports prepared by the five cities that participate in the project on the status of social exclusion of the elderly, in particular those who live by themselves. This document comes within the framework of one of the objectives of the project, which consists of the analysis and identification of the necessary guidelines and of the situation of social exclusion experienced by lonely, elderly people in large European cities.

The information corresponding to each city is basically qualitative and was obtained from interviews of experts on the care of the elderly and from existing reports in the cities concerning the situation of the elderly. Therefore, the affirmations and conclusions given in this report are not intended to produce a global X-ray of the situation of the elderly in Europe, and not even a fully representative picture of the situation in the participating cities.

This report aims to be an instrument for the project itself, insofar as it makes it possible to analyse and compare the situation of the elderly in the five cities, in order to outline and define a model of intervention based on action in the environment that is closest to the person living alone: the neighbourhood.

Information had to be provided by the five participating cities in order to prepare the report, and a number of common aspects were therefore defined to serve as a basis for each city's analysis. These aspects were:
a) Understanding of social exclusion  
b) Demographic trends in each country  
c) Sociodemographic indicators of the population over 65 (demography, resources, health, housing, etc)  
d) Aid and support services provided by the public authorities in each city  
e) Situation of the elderly living alone  
f) The differences between elderly women who live by themselves and elderly men who live by themselves  
g) The challenges faced by each city to tackle the social exclusion of the elderly

All these aspects were investigated, analysed, systematised and compared, and are summarized within the different chapters of this report.
I. INTRODUCTION

A) The ageing of the European population

During the last few decades, the sustained increase in life expectancy and the evident reduction in the birth rate has brought about the gradual ageing of the European population, as in other parts of the world.

In the early eighties, and specifically in 1982, when the first International Action Plan on Ageing was approved in Vienna, this phenomenon was believed to be restricted to developed countries. Nonetheless, current demographic trends show that, in the near future, the ageing process and negative population growth will also affect some parts of the developing world.

Among the developed countries, the populations of Europe and Japan are ageing the fastest. In 2000, 61 million people aged 65 or over lived in the EU in comparison with just 34 million in 1960. Today this segment represents 16% of the total population. If we take into account the dependency ratio of the elderly, we find there are 24 people over 65 for every 100 people within the working age bracket (15-64 years). This percentage is expected to reach 27% by 2010.¹

Another relevant fact is the marked increase of people over 80. Although this segment of the population barely entails 3% of the total, this percentage will reach 10% by 2050 in at least 11 of the 15 current EU Member States.

Moreover, the eastern European countries are also undergoing significant demographic ageing. All of these countries except Poland will experience negative population growth before 2010.

Within this process of ageing population, the differences between men and women are evident: women's life expectancy exceeds that of men by six years and 70% of people over 75 who live by themselves are women. These differences, along with others related to the inequalities that exist between the sexes, should be taken into account when designing policies for the elderly.
Another trend that is relevant in the analysis of the situation of the elderly in Europe is the steady reduction in the size of modern homes and the transformation of family patterns. The growing divorce rate and declining birth rate have changed the traditional family pattern and reduced the number of homes occupied by two adults with children in their care. It has also entailed a rise in the number of homes with just one adult caring for just one child. The percentage of people living alone is also growing. These changes in family patterns and models, brought about by factors such as the integration of women on the job market, affect the situation of the elderly as well as their care.

The increased life expectancy is the result of social and economic development linked to scientific advances, and also to a series of public policies that have significantly quashed many of the causes of death in the elderly. Nonetheless, this consequence of progress presents a series of challenges to society in general, and also affects the way public policies are designed and implemented.

**B) The political approach of the European Union towards ageing**

The phenomenon of population ageing presents a series of challenges for public policies at all levels. In this respect, on 18 April 2002 the European Commission presented a report to the European Council and Parliament on ageing, on the occasion of the 2nd World Assembly on Ageing that was organised in Madrid in April 2002.

The European Union’s strategy to confront the challenges posed by ageing takes into account the repercussions of this phenomenon on the economy, employment and social affairs, and centres its overall strategy on policies and practices that promote active ageing.

The concept of active ageing is based on the development of practices that promote:

- Ongoing learning
- Extension of a person’s active life
- Promotion of later, gradual retirement

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- Promotion of active retirement and of activities that promote the capacities and health of the elderly.

In summary, it aims to take the greatest advantage of these people’s possibilities, regardless of their age, directing policies to all stages of life and not just to the eldest.

The global challenges identified by the European Union in relation to the ageing phenomenon are as follows:

1. To confront the economic effects of the ageing process: pressure on public finances, labour market, economic growth, etc.

The ageing phenomenon has a twofold effect on the economy: on the one hand, the increased demand for public pensions, health attention and long-term care exerts pressure on public finances, with the increased expenditure this entails; on the other hand, an ageing population implies a reduced labour force, along with the repercussions this may have on economic growth.

In relation to this last point, some factors that could compensate the initial negative impact of ageing with respect to the reduced labour force are as follows:

- Higher participation and employment rates in Europe. Above all, it is necessary to apply policies to guarantee equality between men and women in the workplace and to reconcile work with family life.
- The adoption of a new direction that promotes a sustained capacity to work and the employability of older workers through measures such as training, health, safety, adjustment to the workplace and the definition of tasks, fine-tuning of technologies that facilitate work and restructuring of working hours.
- Extension of active policies for the employment of the older working population, thereby raising the effective retirement age, for men and women, and reducing current practices that offer incentives for early retirement.
2. To guarantee suitable, feasible and adjustable pensions

In 1999 most Member States assigned the major part of their social-protection expenditure to retirement and survivors' benefits (the EU average is 46%\(^3\)). On the EU level, benefits granted to these two categories increased by 25% per capita in real terms during the period 1990-1999. This increase is due above all to the demographic evolution and, to a certain degree, to retirement policies (in particular, early retirement).

The ageing of the population entails a burden for the pension systems and the Commission believes that measures should be adopted to ensure the feasibility of the pension systems. Furthermore, pensions should be adjusted to cover people in unregulated jobs. Pensions must offer the same incentives to men and women, leaving aside the traditional model of the man as the main breadwinner.

Nonetheless, in addition to the ageing process, other aspects such as the structure of the labour market or the guidelines for retirement affect the pension system. And, paradoxically, while life expectancy has increased, retirement age has been lowered. Since 1950, life expectancy in the EU has risen by approximately 10 years and the retirement age has been lowered by the same number of years.

According to these appreciations, the characteristics of the labour markets, the disappearance of the model of the worker for whom the pension systems were designed and the changes in family structures - mainly resulting from increased divorce rates and lower fertility rates - directly affect public policies designed to improve the state of the elderly and to prevent the social exclusion of this community.

3. To guarantee access to healthcare services and to long-term quality care, ensuring the financial viability of the services

The main challenge to be dealt with when designing social policies concerning health services and long-term care consists of ensuring the suitable quality coverage of services provided. As we underscored earlier, the difference in men's and women's life expectancy as well as the traditional

\(^3\) *The Social State in the European Union 2002*. European Commission and Eurostat
models of care require that greater attention is paid to the issue of equality between sexes. Women still continue to bear a greater part of the burden with regard to care.

On the other hand, the variations in demand for social expenditure are not just determined by demographic variations. For example, in relation to medical attention and long-term healthcare, the level of formal protection depends on many variables such as health, marriage patterns, family members and the characteristics and specific circumstances of each person’s life. The fact that families are smaller, as mentioned above, reduces their capacity to look after their dependants.

In this sense we underscore the need to be able to guarantee certain levels of well-being throughout a person’s lifetime. The promotion of measures that improve social participation, attention, personal realisation and the dignity of the elderly is an essential factor when guaranteeing a healthy old age for men and women.

C) Social exclusion in the European context and the situation of the elderly

The concept of social exclusion is a complex, heterogeneous concept on which it is not easy to reach a global consensus. In this respect, the relationship between social exclusion and the shortage of material resources is difficult to determine: it is understood that poverty is one of the relevant factors that can aggravate the risk of social exclusion, though it is not the only one.

Insufficient income is just one of the dimensions of social exclusion. In order to evaluate and analyse this phenomenon fully, we have to consider other important aspects such as the access to employment, education, housing and healthcare, the degree of satisfaction of people’s basic needs and the capacity to participate fully in society.

In the Joint Report on Social Inclusion by the Council and the European Commission, which was delivered to the EU Council at Laeken on 14 December 2001, the concept of social exclusion (in line with poverty in its broadest sense) is understood as a situation in which people cannot participate fully in economic, social and civil life or where their income or resources (personal, family, social and cultural) are so insufficient that they cannot enjoy the level and quality of life that is considered as acceptable by the society in which they live. In these situations, people are
frequently unable to exercise their basic rights to the full.

It is the first time that the European Union approves a political document on poverty and social exclusion. This document synthesises and analyses the first stages of the National Action Plans on Social Inclusion (July 2001 – July 2003), which were presented by the Member States in early 2001.

The non-monetary indicators reveal that in the EU as a whole, a significant number of people are living in unfavourable conditions in terms of finance, basic needs, consumer durable goods, housing, health, social contacts and general level of satisfaction. One of every six people in the EU (17%) suffers multiple shortages in two of the following areas, or in all of them: finance, basic needs and housing.

Possibly a substantial number of people whose income exceeds the relative poverty threshold cannot satisfy at least one of the needs deemed as basic, due to the harmful influence of factors such as their state of health, guaranteed income, the additional care needed for elderly or disabled family members, etc. On the other hand, the real standard of living of people with incomes that fall below the poverty threshold are highly conditioned by factors such as whether they are homeowners, or social benefits received in kind.

The National Action Plans on Social Inclusion identify several risk factors that significantly increase the risk of poverty and social exclusion. Unemployment, in particular long-term unemployment, is by far the most frequently mentioned factor. Other important factors are: low-quality employment, homelessness, immigration, lack of qualifications and incomplete schooling, inequalities between men and women, discrimination and racism, disabilities, separation from family, drug and alcohol abuse, and residence in an area with multiple shortages.

In particular, the risk factors that were mentioned most frequently regarding the elderly are:

- age
- health problems
- low income
- precarious housing
- loneliness, social isolation
On the other hand, several National Plans single out some structural changes that are taking place in the EU which could create new risks of poverty and social exclusion in groups that are specially vulnerable unless suitable policies are adopted.

In particular: structural changes in the labour market due to a period of rapid economic transformation and globalisation; rapid growth of the information society and information and communication technologies; steady evolution towards ethnic, cultural and religious diversity, brought about by international immigration and increased mobility within the Union; increased presence of women on the labour market; changes in family structures, etc.

The following should be underscored among the identified structural changes that affect the risk of social exclusion of the elderly:

a) Demographic changes: as mentioned previously, significant demographic changes are taking place in Europe as a consequence of longer life expectancy, entailing more elderly and very elderly people, most of whom are women.

The decreased birth rate in many countries also contributes to increase rates of dependency. This considerably affects poverty and social exclusion in several ways:

- Tax and social security systems face difficulties to finance suitable pensions for all retired people, especially those whose professional career was not sufficiently long or continuous to accumulate suitable retirement rights. This problem mostly affects women.

- Public services find it difficult to satisfy the needs of the growing elderly population, render assistance and aid, guarantee the permanent possibility of fully participating in society and to face the growing demand for health services.

b) Changes in family structures and the roles of men and women. The elderly increasingly require more care. However, families are increasingly changing due to the high divorce rates and the tendency to move away from the family as an institution. Simultaneously, women's presence on the labour market is increasing. Women traditionally cared for, and still continue to care for, dependent family members, for which they are not paid. The interaction between all of these
trends poses essential problems to reconcile labour and family life and to offer suitable and attainable care for dependent family members.

c) *Electronic integration*: The fast evolution of the information society and information and communication technologies (ICTs) is bringing about significant structural changes in society, both from the point of view of the economy and employment, as well as the relationship between people and communities. These changes provide us with immense opportunities but also entail significant risks. ICTs can create a new layer of exclusion and widen the differences between rich and poor if certain vulnerable groups, among them the elderly, that are already running a high risk of exclusion, do not have access to them.

Lastly, we should underscore that many of the challenges confronting public policies to reduce the risks of social exclusion of the elderly are being posed in the sphere of local politics. While aspects relating to the economy, pension systems and labour markets are linked more to nationwide competencies, many of the aspects that determine the daily realities of elderly people’s lives come under the local framework: social support services, living conditions, the environment of neighbourhoods, networks of relationships and participation in public life, etc.

This report on the state of social exclusion of elderly people living along in five European cities should be studied within the local framework.
II. SITUATION OF ELDERLY PEOPLE IN THE FIVE CITIES PARTICIPATING IN THE "GOOD NEIGHBOUR" PROJECT

a) Sociodemographic aspects

The participating cities in the project are not an exception to the general trend in Europe with respect to the ageing of the population, the higher proportion of women than men over 65, and the implications in relation to the risks of poverty and social exclusion.

In cities such as Milan, citizens over 65 represent close to one-third of the total population[^4], as illustrated in the following table:

<table>
<thead>
<tr>
<th>City</th>
<th>Percentage of people over 65 with respect to total population</th>
<th>Percentage of men over 65 with respect to total elderly population</th>
<th>Percentage of women over 65 with respect to total elderly population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barcelona</td>
<td>21.9%</td>
<td>38.5%</td>
<td>61.4%</td>
</tr>
<tr>
<td>Rotterdam</td>
<td>15.0%</td>
<td>38.7%</td>
<td>61.3%</td>
</tr>
<tr>
<td>Milan</td>
<td>28.5%</td>
<td>38.3%</td>
<td>61.7%</td>
</tr>
<tr>
<td>Birmingham</td>
<td>14.7%</td>
<td>41.7%</td>
<td>58.3%</td>
</tr>
<tr>
<td>Lyon</td>
<td>19.3%</td>
<td>37.92%</td>
<td>62.08%</td>
</tr>
</tbody>
</table>

The percentages of approximately 15% for Rotterdam and Birmingham are due, among other things, to the fact that these cities have received an important influx of immigrant population, which means that the percentages of people over 65 are still relatively low. This has occurred to a lesser extent in Barcelona and Milan, as we shall see later on.

The life expectancy of women is longer than that of men by an average of 6.5 years for the five cities. This figure confirms the statement made previously that women live longer than men and, if we take into account that their pensions are usually lower and that once they surpass the age of

[^4]: Source: Reports by City Governments of the corresponding cities, for 2001 in Barcelona and Rotterdam, 2000 in the case of Milan and Birmingham, and 1999 in Lyon.
78 or 80 their health problems worsen, it can be affirmed that this segment of the population is the most liable to suffer from social exclusion. In summary, the five cities confirm the general European trend, in that elderly women are the ones that undergo the greatest degree of social exclusion.

As an example, the following table compares the life expectancy of men and women in each of the cities and confirms women's longer life expectancy, with the ensuing implications concerning the risk of social exclusion.

<table>
<thead>
<tr>
<th>City</th>
<th>Life expectancy of the population</th>
<th>Life expectancy of men</th>
<th>Life expectancy of women</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barcelona</td>
<td>78.95</td>
<td>75.3</td>
<td>82.6</td>
<td>7.3</td>
</tr>
<tr>
<td>Birmingham</td>
<td>75.15</td>
<td>72.7</td>
<td>77.6</td>
<td>4.9</td>
</tr>
<tr>
<td>Lyon</td>
<td>79.25</td>
<td>75.5</td>
<td>83</td>
<td>7.5</td>
</tr>
<tr>
<td>Milan</td>
<td>78</td>
<td>74</td>
<td>82</td>
<td>8</td>
</tr>
<tr>
<td>Rotterdam</td>
<td>82.05</td>
<td>79.6</td>
<td>84.5</td>
<td>4.9</td>
</tr>
</tbody>
</table>

Within Europe, it is increasingly emphasized that measures against poverty adapted to people's needs should contribute towards awareness of the different situations of men and women. However, some of these differences require an in-depth review of the stereotypes on which the social system is based, e.g. insufficient pensions paid to women who live by themselves after a short or non-existent working life.

In relation to the origin of the population over 65, we find significant differences if we compare the data on the five cities.

Holland and Great Britain have traditionally been receivers of immigration, especially from their former colonies and, during the past two decades, from third countries. There are consequently high percentages of immigrants within the population over 65.
In the case of Rotterdam, 3% of the total population are elderly immigrants, and this figure is expected to rise to 12% by 2011, based on the present immigrant population in the city. These immigrants come particularly from Surinam (in the first place), Turkey, Cape Verde, Morocco, the Antilles and some northern Mediterranean countries (Spain, Portugal, Italy, etc.).

In Birmingham, 18% of the immigrant population are over 65 and their countries of origin are chiefly India, Pakistan and the West Indies.

The cases of Barcelona and Milan are practically the opposite, in that 99% of the elderly population were born in the country, although these cities have witnessed significant indices of internal immigration. For example, 45% of elderly people in Barcelona were born outside Catalonia and 70% of the elderly people living in Milan were born in other parts of Italy, and only 30% in Milan.

The populations of countries such as Spain and Italy have traditionally been emigrant populations. Only recently have these countries become receivers of immigration, so, in terms of both the origin of the elderly people and the demographic structure, the effects of immigration are not so evident as in Rotterdam and Birmingham.

Lyon is in an intermediate situation with respect to the other cities. It has a considerable proportion of immigrant population, although the figure is not so highly representative as in northern European cities. Immigrants over 65 represent 1.3% of the total population. These immigrants come, in practically equal proportions, from Europe (Spain, Italy and Portugal) and from the former French colonies (Algeria, Tunisia and Morocco).

Later on, we shall see that immigration is a relevant variable in three of the five cities when analysing the question of elderly people’s social exclusion.

As regards educational levels, the situation varies considerably between one city and another. For example, the percentage of elderly people in Rotterdam who are considered to be illiterate or who had less than 4 years’ basic education is less than 2% and corresponds particularly to communities of immigrant origin, whereas in Milan this percentage is as high as 30%. A similar situation arises in Birmingham and Barcelona. In Barcelona, 33% of all elderly people are illiterate and 43.7% of the population over 65 only received primary schooling (5 years). In all five cities, most of the people who had less schooling are women.
In Lyon, no representative, up-to-date figures are available with respect to elderly people's educational levels. However, a survey carried out by Demain, a non-profit association that provides care to senior citizens, indicates that 55% of the people it attends received basic schooling, although only 27% obtained a certificate of basic education. And, again, the people with the lowest educational level are women.

With regard to income, the situation also varies considerably between the five cities, not only because the minimum income associated to quality of life in each country is very different, but also in terms of the levels of retirement pensions.

Before going further into this question, we give below a table which shows the income that is considered to be minimum in each of the five cities. This is the minimum income payable to the working population and is supposedly calculated to cover people's basic requirements of food, transport, healthcare, etc. (basic basket).

<table>
<thead>
<tr>
<th>City</th>
<th>Minimum monthly wage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barcelona</td>
<td>€442.20</td>
</tr>
<tr>
<td>Birmingham</td>
<td>€1038.4 (gross)</td>
</tr>
<tr>
<td>Lyon</td>
<td>€1154.27 (gross)</td>
</tr>
<tr>
<td>Milan</td>
<td>€600,00</td>
</tr>
<tr>
<td>Rotterdam</td>
<td>€1234 (gross)</td>
</tr>
</tbody>
</table>

The public pension system is the main source of income in all five cities. However, there is a considerable difference between one city and another in terms of elderly people's income levels compared with the minimum wage in each country.

The following table shows the minimum non-contributory pensions paid to pensioners in each of the cities.

<table>
<thead>
<tr>
<th>City</th>
<th>Minimum monthly non-contributory pension paid to elderly people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barcelona</td>
<td>€268,77</td>
</tr>
<tr>
<td>Birmingham</td>
<td>€500</td>
</tr>
</tbody>
</table>

In order to give comparative data, the monthly income for a 35-40-hour working week was taken. For this purpose, the wage/hour was calculated for the United Kingdom based on a monthly wage. For France, the calculation was based on the annual salary.
<table>
<thead>
<tr>
<th>City</th>
<th>Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lyon</td>
<td>€569.38</td>
</tr>
<tr>
<td>Milan</td>
<td>€526.00</td>
</tr>
<tr>
<td>Rotterdam</td>
<td>€1244.52</td>
</tr>
</tbody>
</table>

In Barcelona, 32.1% of elderly people have incomes below the country's minimum wage.

In Milan and Birmingham, 10% of elderly people have incomes below the minimum wage. In Milan, most elderly people (90%) have incomes between the equivalent of and double the country's minimum wage.

Data on the percentage of the population with incomes below the minimum wage in Lyon are not available.

The most favourable situation is found in Rotterdam, where everyone over 65 has a right to a minimum state pension equal to the country's minimum wage, so all elderly people are guaranteed a basic income. Furthermore, only 20% of elderly people in Rotterdam depend entirely on the minimum state pension, given that 80% supplement this income with alternative pension schemes or other types of income.

As regards housing, elderly people mostly live in the older centres of cities, where there are large numbers of aged buildings that do not provide optimum conditions in terms of accommodation, access, hygiene, health or safety.

The elderly (together with immigrant and local population groups with lower income levels) tend to live in these types of buildings. The main problems detected in the housing occupied by elderly people are as follows:

a) They are not easily accessible and are unsuitable for elderly people. The lack of lifts and the fact that they have to go up and down stairs is a factor that impedes their mobility and activity. This problem has been identified in Barcelona, Rotterdam and Milan. In Barcelona, at least 14% of the elderly population live in buildings without lifts, and this figure is brought up to 30% in Rotterdam if all houses that have to be accessed by steps or have stairs indoors are taken into account.

b) The overall poor state of housing, especially noticeable in winter, when cold and humidity places elderly people's health at risk. This is one of the main problems detected in Birmingham, together with the lack of the necessary public resources to undertake a general plan to improve the condition of housing.
c) The bad state of bathrooms and sanitary facilities in general. In Milan, modernizing and improving the bathrooms of houses occupied by elderly people (and other groups at risk of social exclusion) is considered to be a priority. In Lyon, an overall plan to improve such housing has been carried out in recent years, but, even so, there are at least 1634 people over 74 in this city in the south of France who do not have a bath or shower; and almost 600 only have a shared WC outside their home.

Emphasis should be placed on the health of elderly people, given that it is a factor that determines their quality of life and affects the risks of social exclusion. People's health, or rather, the health problems that make an appearance and become more acute with age directly affect elderly people's independence, mobility, their mental and physical skills and self-respect.

There are no great differences between the five cities insofar as the most frequent illnesses among the elderly are concerned: the main ones are chronic kidney, eyesight, respiratory and bone disorders and the loss of mental and physical faculties.

All five cities indicate that elderly people who lose their mental and/or physical faculties earlier on are the ones who have the worst quality of life and greater risk of social exclusion and are more dependent on other people or public services. They also concur on the fact that women have a better resistance to chronic disorders and live longer than men with similar illnesses. However, after the age of 75 or 80, there are more probabilities of their quality of life worsening and their having to depend on third parties for the basics of life.

Where there are fundamental differences between the five cities is in the area of support, participation, assistance and healthcare services for elderly people. For this reason a whole chapter is dedicated to describing the different types of services available in each city.
III. PUBLIC SUPPORT, ATTENTION AND CARE SERVICES FOR THE ELDERLY IN THE FIVE CITIES

Since each city has different, specific services, this chapter will describe the different types provided in each one:

3.1) Barcelona

Barcelona City Council's Municipal Plan for Elderly People is divided into 4 main sections covering a total of 18 courses of action:

a) Social participation services

Encouraging the participation of the community of elderly people has, in recent years, been one of Barcelona City Council's priorities. The structure of the municipal services is organized at different levels (city and suburbs), which make it possible to channel this community's opinions and suggestions on the issues that affect it:

- The Municipal Social Welfare Council

This Council is one of the City Hall's organs for consultation and participation and deals with all questions relating to city welfare. It consists of a Plenary Session, a Permanent Commission and task groups. A task group has existed ever since the Social Welfare Council was created to focus on the issue of elderly citizens and it draws up its recommendations and proposals every year. Approximately 30 city bodies participate regularly in this task group.

- The Advisory Council on Elderly People in Barcelona

This Council is another of the City Hall's organs for consultation and participation and deals with all questions relating to improving the welfare and quality of life of the elderly in Barcelona. This Council is structured at different levels and approximately 200 city bodies that represent or are connected with the elderly participate in it.

The Advisory Council on Elderly People, together with the City Council, has promoted three conferences for elderly people in recent years.
b) Social promotion services

The second area of action consists of a group of services and facilities whose objective is to guarantee the necessary social climate, services and facilities to enable elderly people to enjoy a high level of social integration.

- Sociocultural activities

There is a wide range of sociocultural activities for the elderly, including such varied activities as courses and workshops (drawing and painting, pottery, gardening, etc.), conferences, exhibitions, traditional fiestas, championships, dances, etc. Approximately 48,000 people took part in activities organized specially for this sector of the population in 2000.

A wide range of sports and leisure activities is also available for elderly people. The programme consists of two sessions per week, given and/or coordinated by physical-education professionals in more than 80 sports centres in the city. Approximately 4500 elderly people participated in these activities in 2000. Furthermore, all sports facilities in the city (mostly inherited from the Olympic Games) offer special discounts for elderly people with the "pink card".

- Holiday programme

The Holidays for the Elderly programme was started up in 1989 at the proposal of the Advisory Council on Elderly People by means of a cooperation agreement with IMSERSO (the Institute for Migrations and Social Services of the Spanish Ministry for Labour and Social Affairs). It grants aid to the city's elderly population with lower resources and offers them the possibility of taking a holiday. In 2000, the number of grants was 2745.

- Support to elderly people's associative movements

Barcelona City Council's support to elderly people's associative structures is available on three levels: infrastructure, technical and financial. The City Council currently provides financial aid to approximately 50 organizations of elderly people in the city.

- The "pink card"
The "pink card" is an identity card which, depending on holders' incomes, enables elderly people to travel on municipal transport free of charge or at a special low rate. In recent years, the eligibility for this card has been extended (by lowering the applicable age from 65 to 62), as have the discounts available on certain city services and facilities.

There were 244,145 holders of "pink cards" at the end of 2000.

- The casales (civic centres) for the elderly

The casales are meeting and leisure centres for elderly people. They are organized by means of a Management Board and a General Assembly made up of all members, who prepare their activity schedules. At the end of 2000, there were 43 municipal casales for the elderly, with approximately 30,000 members or people enrolled.

**c) Primary care social services**

The primary care services provide a point of immediate access to the social service system. Broadly speaking, these services have two objectives: to provide information, guidance and support, and to provide assistance in the home.

- Municipal social service centres

These facilities form part of the public social service network and constitute the point of assistance that is closest to citizens, where professionals (social workers, educators, psychologists, lawyers, etc.) provide information, advice and support. At the end of 2000, the 33 social service centres had attended a total of 14,610 elderly people.

- The permanent social assistance office (OPAS)

The OPAS service is available 24 hours a day, every day of the year, to attend to any emergencies of a social nature. It is therefore complementary to the city's social service centres. During 2000, the OPAS attended 335 elderly people.

- Home assistance
This covers a range of services (help in the home, tele-alarm, home repairs, cleaning, washing, etc.) that are provided in people's own homes to prevent or reduce the deterioration of elderly people's conditions of everyday life and to avoid having to send them to a care home or hospital. During 2000, services were provided to 6580 elderly people.

**d) Specialized care services**

These services are oriented towards specific sections of the population. They are the secondary level of attention, which, in the case of the elderly, includes three types of services: sheltered residential accommodation, day centres and care homes.

- **Sheltered residential accommodation**

These are small residences or apartments that have a number of common services (porter, dining room, cleaning, etc.) for people who need a certain amount of support in their everyday life. In this way, they can continue to be self-sufficient for as long as possible. At the end of 2000, there were 63 municipal attended residence homes.

- **Care homes**

These homes are for people with considerable functional limitations. At the end of 2000, the municipal network of homes provided accommodation for 218 people. The main services provided are focussed on healthcare.

**3.2) Birmingham**

Birmingham divides its services oriented towards the elderly into 5 sections, which each include a number of specific services and facilities.

**a) Accommodation and nursing-home services**

- Residences for the elderly with alarm systems. They can cater for 3000 people.
- Nursing homes for the elderly, with medical attention. There are 31 homes of this type in the city, catering for 4837 people.
- Sheltered residential apartments for the elderly, catering for 144 people.
- Shared accommodation, catering for 75 elderly people.
Council houses. A percentage of the city’s council houses are currently set aside for elderly people, and 16,729 people live in these houses.
b) Leisure, entertainment and relations

- Social clubs for elderly people. There are over 100 clubs of this type in the city, managed both by the local administration and NGOs.
- Day centres for the elderly. There are currently 27 day centres in the city.

c) Transport services

- Special transport pass. This pass is free and enables elderly people and people with disabilities to travel on public transport at off-peak times of the day. There are currently 405,000 people of 65 and over in Birmingham who have these passes.

d) Healthcare

- Approximately 291,423 elderly people in the city receive specialized medical attention in the city’s hospitals.

e) Home assistance

- As in other cities, help in the home is provided by people who regularly visit the elderly and cooperate or take care of certain domestic chores such as doing the shopping, cooking, small home repairs, cleaning, accompanying people when they have to attend to formalities, etc. This assistance is currently provided to 12,800 people.

3.3) Lyon

Lyon City Hall offers senior citizens the following services:

a) Shelters and nursing homes

This service focuses on two profiles of elderly people:

a) Those who do not have a suitable place to live and require care and medical attention, without actually depending total on others.

b) Those who have a chronic illness or are disabled and require permanent medical attention.
b) Home medical attention

This is similar to the home-assistance system, but specifically focuses on medical attention.

c) Home aid services

Home aid in Lyon is provided by professionals belonging to companies or local service cooperatives specializing in personal care. Help is granted to senior citizens so that they can continue living in their own homes for as long as possible.

d) Home food services

The purpose of this service is to meet one of elderly people's main requirements: their meals. The help granted bears in mind any medically-prescribed diets.

e) Financial aid to maintain, clean and repair the home

This consists of aid that is paid every month directly to elderly people who live in their own homes.

3.4) Milan

Milan's support services for the elderly are focussed on preventive measures, which, in order to be effective, involve:

- ensuring that people's homes are well equipped
- cooperation between the different service providers
- offering leisure and cultural activities
- providing sufficient information on all available resources
- guaranteeing daily medical attention for any type of illness
- analysing senior citizens’ requirements
- hospitalisation as a last resort, when there are no other alternatives
- offering appropriate permanent instruction (continually and for life)

In accordance with these priorities, the services offered to the senior citizens of Milan are as follows:

a) Preventive services
The City Council has created a network of preventive services. They are based on maintaining the interest and favourable conditions of the elderly, in an environment of a full social and cultural life, with plenty of leisure opportunities.

- **Social, cultural and recreational centres (CSRs)**

These centres offer senior citizens the opportunity of organizing cultural, recreational, sports activities, etc. They help people keep up an active role as members of the community and encourage them to make good use of their free time. A wide range of activities is carried out, reaching over 3500 people every day.

Approximately 40,000 people go to these centres every year, of whom 70% are women, mostly over 70.

- **Health resorts**

These programmes are linked to social tourism at sea or mountain resorts. They are short holidays which favour social contact, rest, breaking with routine, making new friendships and, in some cases, contribute towards people's psychic or physical rehabilitation.

The holidays last about two weeks and are available to all women over 55 and men over 60 who live in Milan. Senior citizens contribute towards the expenses in accordance with their incomes.

In 1998, around 1650 people took advantage of these holiday programmes.

- **"Over-60 card"**

The "Over-60 card" is a pass the City Council gives everyone over 60. The services covered include the following:

- discounts for cultural and recreational events
- discounts at the theatre and cinema
- banking and insurance services
- information on safety and health
- discounts at shops
- consulting on social security and tax

The services to which this card gives a right are provided by a network of private agents, shops and the City Council. The card is sent to all residents of 60 and over. At present, it is valid for 5 years.
b) Support services

These services were created to support people's basic rights throughout their life, regardless of whether they are self-sufficient or not. One of these fundamental rights refers to granting elderly people support services in the home and ensuring that they live in a pleasant, safe environment.

- **Multicentre services for senior citizens**

There are currently 25 multicentres offering services for the elderly in Milan.

They were originally created to provide daily services in the home (home assistance, cleaning, personal care, medical attention, therapy, etc.), but, as requirements increased (hospitalisation, financial advice, therapy, etc.), they were converted into receiving and management centres with networks of formal and informal services, of which home assistance is just one.

- **Integrated day centres (CDIs) – occupational-therapy laboratories**

The CDIs provide assistance to elderly people who are not self-sufficient and are attended mainly by family members. Their action is focussed on helping the elderly when the people who regularly care for them cannot do so. The centres provide transport, canteens, nursing care, laundry, personal hygiene and rest rooms. They are appropriate for people who are temporarily not self-sufficient, but who do not need to be hospitalised or receive treatment in a nursing home. They are a midway point between home assistance and nursing homes.

The purpose of the two occupational-therapy laboratories associated to the CDIs is to:

- postpone treatment in nursing homes
- allow people to stay in their own homes for as long as possible
- provide effective support to family members
- ensure that elderly people who live alone do not feel lonely

- **Financial aid for therapy and treatments**

This consists of financial aid to family members who look after an elderly relative whose illness and/or nursing requirements would make him or her eligible for entering a care home. The amount of the aid
depends on the elderly person's and the family's incomes and the estimated cost of the services required. The number of families applying for aid increased from 104 in 1996 to 335 in 1998.

- **Help Line**

The purpose of the Help Line is to cover periods of time when public services are not available (weekends, holidays, etc.). The main objective of this telephone service is to clarify any doubts on questions of health. It also provides assistance in terms of shopping and psychosocial support when people are feeling lonely. The Help Line also has a number of beds for when an elderly person needs to be looked after.

This project was started up in 1998, and 656 calls were received in August that year. The service is provided by Milan City Council personnel, social care cooperatives, conscientious objectors, volunteers, etc.

Although the service is open to everyone, 90% of the calls come from elderly people who live alone, and the great majority are women.

c) **Nursing homes**

In spite of the preventive services and social-service policies to put off senior citizens' entry into a home of this type as long as possible, the demand has not decreased. It is felt that this is because of the increase in the population over 80, an age at which healthcare and specialized attention are very necessary.

Most of the people in these homes are women with low incomes and no family support.

One of the crucial problems of these centres is their lack of beds. For example, it is estimated that about 11,031 beds are needed to cater for everyone who requires this attention.

3.5) **Rotterdam**

a) **Accommodation**

- **Sheltered residential apartments**

These apartments enable the elderly to lead a more independent life. They have common rooms for recreational activities, alarm systems and a porter or caretaker on duty all day long. The idea is that senior
citizens should look after their housework themselves, although some domestic and nursing services may be available.

The average age of people living in sheltered apartments is 75. There are currently 26,000 sheltered residential apartments in Rotterdam, with around 39,000 people living in them.

- **Homes for the elderly**

These are homes for people who need help for everyday basics (washing themselves, cooking, cleaning, tidying up, etc.). The average age is 85 and the average stay is 3½ years, death being the chief cause of vacancies. These homes currently cater for 4200 people.

- **Medical centres (nursing homes)**

These are institutions for people who need intensive medical attention that cannot be adequately covered by home assistance. The average age is also 85, and 93% of the people at these centres stay there for life, whereas 7% enter these homes to recover from an illness or accident. Overall, these nursing homes cater for 3800 people.

The difference between the homes for the elderly and the nursing homes has tended to disappear over the last 5 years. They are occupied by the same population sectors and will soon become one and the same. Furthermore, there is an increasing number of initiatives that combine the factors of all three types of accommodation for senior citizens, e.g. top-quality sheltered residential apartments in which it is also possible to receive intensive nursing care.

**b) Home attention**

This service is provided to any citizens who need it, of any age, although in practice 75% of the people who make use of it are elderly. Approximately 12,000 homes in Rotterdam receive this service every day. Home attention includes:

- Nursing care (injections, tending injuries, medicine control, etc.)
- Personal attention (helping people to dress, wash themselves, take showers, etc.)
- Domestic chores (cleaning, shopping, cooking, etc.)
- Equipment and facilities (adaptation of furniture, especially beds)
- Repairs
c) Services for social, cultural and leisure relations

- There are over 100 civic centres for the elderly throughout the city
- 36 day centres cater for 40,000 people per year

d) Special cards for the elderly

These cards can be acquired by everyone over 65 and provide discounts on cultural, leisure and sports activities and facilities, and on consumer prices in general.

The main characteristic of Rotterdam's social services for the support and care of the elderly is their extensive coverage, way above that of any of the other cities.
IV. STATUS OF SOCIAL EXCLUSION OF ELDERLY PEOPLE LIVING ALONE IN THE FIVE CITIES THAT PARTICIPATE IN THE "GOOD NEIGHBOUR" PROJECT

There is no doubt that elderly people who live alone are more liable to suffer from social exclusion, especially those over 75. According to the different reports of the five cities participating in the project, this latter group is basically made up of women. The different cities’ reports also concur on the fact that the percentage of elderly people who live alone is high, and is on the increase.

In Barcelona, 18% of the population between 65 and 75 live alone, whereas this percentage is increased to 30% for the group over 75. In Milan and Birmingham, the figures are similar: 33% and 40% respectively of the total population over 65. In Lyon, the percentage of people over 60 who live alone is almost 50%, and of all elderly people living alone, 78.31% are women and 21.69% are men. The exact percentage is unknown in Rotterdam, although the qualitative data provided by experts indicate that the levels are similar.

Obviously, not all people who live alone are in a situation of social exclusion. Social exclusion is found in those groups of people and communities that suffer, at the same time, from aspects relating to lack of income, chronic problems of health, functional problems of mobility and mental health and social isolation (having lost ties with the family, friends, neighbours, social organizations, etc.).

Social exclusion of elderly people living alone can give rise to deep feelings of anxiety, loneliness, low self-esteem and the impression that their lives have no meaning. And these feelings accentuate the exclusion of elderly people who live alone.

Some experts indicate the primordial importance of focussing on psychological aspects to combat and/or prevent the social exclusion of elderly people.

It is felt that living alone is not synonymous to suffering from social exclusion, although certain situations (such as those mentioned above: low income, health problems, etc.) are adverse factors. However, living alone is not the same as feeling lonely, and it is loneliness that has a direct bearing on and accentuates the social exclusion of the elderly; loneliness understood to be a subjective mental condition that causes anxiety, low self-esteem and the feeling of uselessness and exclusion.

Loneliness, rather than living alone, is a decisive factor in the social exclusion of elderly people, and may, in some cases, bring about and, in others, accentuate the situation:
- It can be brought about in those sectors of the population whose basic needs in terms of welfare and quality of life are covered, when the subjective condition of loneliness (anxiety, depression, low self-esteem) makes them isolate themselves from the rest of the world and fail to socialize and participate in community life.

- And loneliness may condition or accentuate the social exclusion of elderly people whose basic needs in terms of income, health, safety, etc. are not covered. In these cases, anxiety, depression, lack of self-assurance, etc. make them become passive and reduce their ability to look for help and/or resort to the services available.

In both cases, loneliness makes elderly people more vulnerable than their peers and makes them more likely to fall into situations of social exclusion insofar as:

a) their basic conditions of life, even if covered in principle, would be impaired. They would take less care of themselves, not follow health treatments properly, neglect proper eating habits, cleanliness, leisure activities, etc.

b) when their basic conditions of life are deficient and not attended to, they would passively let them get worse until the situation becomes extreme. They would not ask for the help they need.

Some experts, as in the case of Rotterdam, relate the appearance of psychological problems such as anxiety, depression and low self-esteem directly to people's ability to develop social and affective habits throughout their whole life. From this perspective, to prevent the loneliness and social exclusion suffered by some elderly people, policies should concentrate more on people's whole lives rather than just old age.

People who do not develop social and affective habits throughout their lives to procure quality social relationships beyond their family and work environments, run a greater risk of falling into a situation of social exclusion when they retire.

The best way to combat social exclusion from this perspective would be to boost people's relationship ties at an earlier age, given that if, at 40, a person does not have these social habits, it will be much more difficult to develop them later on. In this respect, ongoing education plays an important role in developing people's interests and skills outside their work environment throughout their lives.

Nowadays, retirement brings about an abrupt change in working people's lives, and more and more emphasis is placed on the importance of trying to make this change less abrupt to avoid the feeling of
uselessness that people often feel when they stop working outside the home, especially in our present-day society based on work and consumption.

This analysis is not intended to refer to all participating cities, given that different socioeconomic realities determine the roles played by other factors influencing social exclusion, such as insufficient income, poor social service coverage, chronic illnesses, disabilities, etc. However, it is important to stress that elderly people’s social exclusion and their loneliness are closely linked, and this link is more important than determining which is the cause of the other.

The loneliness that is associated to social exclusion is that perceived as a person's vital condition. It is the absence or the perception of the absence of satisfactory social relationships and is manifested by the cognition, emotion and conduct of a person (Page, 1991). There are 3 basic characteristics of loneliness (Peplau and Perlman, 1982):

a) It is the result of deficiencies in social relationships. These deficiencies may be quantitative (no friends or family) or qualitative (lack of affection or close relationships with other people).

b) It represents a subjective experience, which is not necessarily synonymous to social isolation, given that it is possible to be alone without feeling lonely; and, just the opposite, it is possible to feel lonely when in a group of people.

c) It is unpleasant and emotionally distressing.

4.1) Loneliness and social exclusion in the five cities

The loneliness of elderly people is directly related to social exclusion, but there are significant differences between the five cities.

In Rotterdam, where everyone over 60/65 is assured a basic pension equal to the country's minimum wage and most people have other, complementary income, the factors determining the social exclusion of elderly people living alone is not their income level or the access to goods and services that this provides, but the more psychological aspects of the individual, such as the loneliness we have mentioned before.

The data on Rotterdam indicates that elderly people who live alone (in general, the whole population over 65) are guaranteed a basic quality of life through their pensions, healthcare, help in the home, etc. This does not mean to say, however, that in some specific cases it may not be insufficient and that this fact does not have a bearing on social exclusion, but what finally determines the situation of social exclusion of
this group of the population are, as we have said before, the psychological characteristics of each individual such as, for example, the ability to recover from the spouse's death.

The heterogeneity of this group of elderly people is greatly stressed. Generalizations are avoided, while it is stressed that the interests, wishes, etc. of these people are as varied as those of other age groups in the population.

The subjective feeling of loneliness causes people to take little part in social affairs, to isolate themselves and to be unable to establish satisfactory relationships or, as mentioned above, to take up their life once more after the death of the spouse. Given that this condition of loneliness and isolation has to do with the lack of personal and social aptitudes and self-confidence developed throughout a person's life, it should be attacked over the long term, throughout all stages of a person's life, in order to enable people to develop and maintain their personal and social habits beyond the work environment. However, it is emphasized in Rotterdam that initiatives to improve the condition of elderly people in a situation of social exclusion must currently be based on personal visits to these people by highly qualified personnel, which is very costly in terms of both time and money.

Contrary to other cities such as Milan, in Rotterdam it is felt that strategies to encourage the participation of elderly people in all types of initiatives and activities have not shown satisfactory results.

In Milan, emphasis is also placed on the importance of the subjective aspect that determines how a person lives and interprets the situation of living alone. However, rather than stressing the development of social habits throughout a person's life, attention is focussed more on a person's reaction to the spouse's death, the children's emancipation, retirement, etc.; in other words, the ability to confront a new stage in one's life.

The public administration in Milan has set up a number of social, healthcare, cultural, leisure activities, etc. for the elderly population, and it is acknowledged that the people who take much more advantage of them are those who live alone, and especially those who are caused less anxiety by the fact of living alone.

Basically, the most urgent problems to be solved with regards to the elderly people who live alone in Milan are those involving situations of degenerative health, deterioration of physical or psychical faculties, lack of mobility and lack of interest or incentive to follow treatments regularly and/or participate in other activities offered by the administration, associations or NGOs. Emphasis is also placed on the problems deriving from living in the more depressed neighbourhoods or areas, involving questions of citizen security. Some
of the initiatives are therefore aimed, among other objectives, at offering more secure environments for elderly people, so that they can go out into the street without the fear of being mugged.

The quality of life in Rotterdam and Milan is among the highest in Europe. It is therefore not surprising that the cases of social exclusion detected are related more directly to loneliness than the lack of suitable conditions and resources to sustain a decent lifestyle. However, this does not mean that the philosophy of the social services and the initiatives carried out in these two cities to combat exclusion are ostensibly different.

On the other hand, in Barcelona, Lyon and Birmingham, there is more evidence of high percentages of elderly people living alone, sometimes in inadequate conditions, with low incomes, precarious homes and with health problems that are difficult to solve with the administrations’ limited budgets, in spite of the efforts made and policies followed to support the elderly in all three cities.

The cases of these three cities are different from those of Rotterdam and Milan because their budgets are lower, so the problems detected with respect to elderly people are more closely related to the quantity and quality of services rather than the more psychological, subjective aspects emphasized particularly in Rotterdam, and to a lesser degree in Milan. However, this does not signify that these cities do not take factors relating to social isolation, loneliness and citizen participation into account in their analysis of social exclusion.

In Barcelona, as has been stated earlier on, elderly people's low income is an important factor when analysing social exclusion; this is illustrated by the fact that 32.1% of elderly people have incomes below the minimum wage.

However, as stressed throughout this report, social exclusion is a more complex concept than just poverty, because of the intervention of factors other than material factors.

The report on Barcelona identifies the profile of the typical elderly person who is at risk of social exclusion, which responds to:

- a woman
- living alone
- not self-sufficient
- low income
- low degree of mobility
- little or no social or family ties
According to the census for 2000, there are 7073 people over 65 living alone in Barcelona’s old district, and 5052 of them are women.

Furthermore, the factors that determine social exclusion are interrelated and mutually conditioning: loneliness may cause depressions and psychological disorders, the lack of mobility may make hygiene and health conditions worse, the lack of resources may be a conditioning factor with respect to the poor state of the home, etc.

While acknowledging the heterogeneity of the community of elderly people, a series of needs they have in common have been identified, bearing in mind the priority profile of the typical elderly person defined above.

Broadly speaking, the requirements of elderly people at risk of social exclusion can be divided into two groups:

a) Requirements relating to support, help and care in terms of the problems that get worse as time goes by (health, mobility, income, etc.)

b) Requirements relating to acknowledgement of their status as active people and members of a community (respect, dignity, friendship, company, etc.)

Within these categories, the main requirements identified are:

- company, friendship, love, affection, etc.
- assistance and care of basics (hygiene, food, etc.)
- medical attention and healthcare
- practical help (shopping, administration of money, etc.)
- adaptation and improvements to the home
- better communication facilities in the district (better adapted to their mobility problems)
- more information and support for administrative/bureaucratic formalities
- less complicated administrative procedures (in keeping with their difficulties)
- individualized attention, adapted to their age
- inter-generational leisure activities
- awareness of their status as citizens with rights and obligations (feeling of community and/or group)
As can be seen, these requirements of elderly people at risk of social exclusion intermix those relating to lack of resources with those relating more to social and psychological aspects.

In this respect, it is relevant that in Barcelona, given its sociocultural characteristics as a Mediterranean city in the south of Europe, in some districts (especially in the old, historical centre), people still enjoy what we could call "neighbourly life", marked by more or less close relationships between neighbours in the same district (whether residents, shopkeepers, shop staff, etc.). People live in the same environment for many years, an environment that constitutes a vital space for relationship that to a certain degree gives elderly people a sensation of safety and familiarity.

However, with the urban reforms of recent years, new residents are coming to live in these districts (young people from other parts of town, immigrants who have recently arrived in the country, etc.), and this fact has transformed and changed that formerly familiar, close-knit neighbourhood and definitely affected the lives of the elderly people who have lived in the historical centre for many, many years.

Another important factor is that, unlike northern European countries, the culture of the family still persists more intensely in southern countries, which means that the care of elderly people is often left in the hands of the family (usually the daughters) rather than professional carers, as is more common in northern European countries. However, the development of these southern countries in the last few decades, and women's incorporation in the workplace, means that families are devoting less and less time to looking after their elderly family members.

Birmingham is a great industrial city with a population of over one million inhabitants, which has witnessed the collapse of many of its manufacturing industries that gave work to large numbers of unqualified workers. Many of the elderly people who live alone still suffer from the socioeconomic consequences of this situation: low income as a result of long periods of unemployment and the impossibility of saving money or taking out private pension schemes. The low income level means that a large number of elderly people cannot suitably face up to problems of health, functional mobility, housing, etc. And this situation is more acute amongst elderly immigrants who live alone.

In Birmingham, the conditioning factors and historical characteristics of the environment have a great influence on the social exclusion that some people suffer from, on the actual process of growing old and their lack of resources. However, it is also emphasized in the case of Birmingham that these conditioning factors are only a part of what causes exclusion, because exclusion can be defined as inadequate social participation, a lack of social integration, decision-making power, etc., and is also
related to other problems such as the poor quality of housing, living in depressed areas with high
delinquency, lack of good public transport, weakening of family ties, etc.

Within this context, the main problems detected in Birmingham with relation to the social exclusion of
elderly people living alone are as follows:

- poverty – dependence on relief
- inferior quality of housing
- deficient diet and malnutrition
- tendency not to look after themselves properly – high indices of smokers, alcoholics;
lack of exercise, etc. - in general, a shorter life expectancy
- fear of being victims of delinquency
- depressed districts and environments
- lack of services and transport
- lack of mobility and self-sufficiency
- lack of social ties developed during their former adult life
- non-existence of family members or lack of contact with them
- low levels of education and training, involving greater probabilities of poverty
- groups of ethnic minorities living in poor city districts who suffer from discrimination in
terms of services, or who have difficult access to them
- high rate of chronic illnesses, which increase levels of dependence
- changes in traditional family structures
- lack of support to carers, who are in a precarious situation
- lack of preventive and therapeutic services

Birmingham's profile of a typical person in a situation of social exclusion coincides with that of Barcelona,
with some qualifications.

The majority profile also corresponds to a woman, but attention should also be paid to the profile of a man
in a situation of social exclusion and his particular features, such as the fact that he may not be skilled in
looking after his home because, in the past, housework was exclusively the obligation of the women (this
in the case of his wife having died).

It is emphasized that, in Birmingham, the question of independence is very complex. A person may be
quite capable of taking his or her own decisions, doing the shopping, administering the home, etc., but,
precisely because of this high level of independence, may not have any social contacts in the
environment. In other words, practical, daily independence does not necessarily entail having the affective assurance derived from quality interpersonal relations. Just the opposite: the feeling of loneliness may become more acute, involving greater and greater levels of social isolation. On the other hand, there are also people with functional-mobility limitations who directly associate this fact to their lack of independence and exclusion. In summary, defining lack of independence as a component of social exclusion is tremendously complex, because the comprehension and practical significance of the concept is clearly determined by the self-perception of each individual person.

Another important question in Birmingham is the high proportion of elderly people of Irish origin. The Irish elderly people have been classified in a separate group from the rest because a number of problems have been identified that are specifically associated to them:

- more admissions to hospital for mental-health problems
- depressions and dementia, particularly among Irish women
- lower average life expectancy than the rest
- health problems specifically linked to long periods of work in the construction industry, under very severe conditions
- the majority of Irish elderly people living alone are men

The high level of elderly men of Irish origin living alone is due to the fact that, when they went to England to work, they only lived in temporary lodgings, moving around in accordance with the demands of their work. They went back to Ireland to see their family every now and then, but stopped doing so owing to lack of income, and so lost contact with their family members. At the same time, again owing to insufficient income, they could not establish their families in England.

This example of the Irish (which is also the case, with certain qualifications, of other population groups of Indian, Pakistani and West Indian origin, etc.) must be borne in mind when analysing the social exclusion of elderly people in Birmingham and, consequently, when designing policies to combat this exclusion.

The reality in Lyon is similar to that of the other cities, insofar as the situation of elderly people living alone is complex, involving low incomes, problems of health owing to old age, the local environment, low self-esteem and/or anxiety, and also the condition of foreigner, which accentuates the predicament of people living alone, without social or support networks.

With regard to the profile of the typical elderly person in a situation of social exclusion, it is similar to that of Barcelona: a woman, living alone, with little independence, problems of mobility, low income and few or no
family or social ties. However, Lyon has other sociodemographic characteristics that bring it closer to the situation of Birmingham and Rotterdam than to Barcelona and Milan.

Lyon has a high percentage of elderly immigrants who live alone, especially those of Algerian origin. This may be one reason for the loneliness and segregation felt by immigrants over 65 (particularly men), who say that one of their main problems is that they are rejected as "old" and "immigrants". These people have been working in France and living in Lyon for many years (more than 30) but, even so, continue to feel the local population excludes them as "foreigners". Furthermore, they have no family with them, either because their families are in their country of origin or because they never formed a family in France. This situation should be taken into account in all public policies and interventions to combat social exclusion.

This situation requires specific programmes and intervention to combat the social exclusion of this group of people, taking their special needs and characteristics into consideration.

The particularly important requirements of elderly people living alone in Lyon are support and help in the home, the responsibility of the home aid services.

There is a considerable need for social recognition, respect of their status as members of society and members of their closest environment, their neighbourhood. From the perspective of the administration, special attention should be paid to housing to reduce possibilities of exclusion. This involves designing policies to improve housing so that elderly people can live for as long as possible in the environment they lived in before they grew old, even if their ability to lead an independent life is reduced.

Another very important factor that was identified through interviews with elderly people in Lyon is their need for friendship and human warmth to establish an environment of trust and reduce their loneliness.

In Lyon, it is also emphasized that the problem of exclusion is not linked only to aspects of resources and services but, as in the case of Rotterdam, also to people's social habits and relationships established in earlier stages of life, which influence people's approach to old age and the greater or lesser psychological and emotional resources people have, which can reduce the risks of social exclusion.

Summing up the information on the main problems of elderly people who live alone and are at risk of social exclusion, it is clear that there are certain similarities, but also differences, between the different cities:
a) On the one hand, in some cities elderly people have sufficient incomes to cover basic services and suitable conditions in terms of housing and health. This is the case of Rotterdam and, to a lesser degree, Milan. In these cities, social exclusion is related to psychological factors and lack of social aptitudes.

b) On the other hand, we have Barcelona, Birmingham and Lyon, where social exclusion is determined more by the lack of sufficient income and/or the limitations of the administration to cater for the overall requirements of elderly people. In these cases, individuals' social and psychological needs are of secondary relevance.

It is therefore not surprising that, where elderly people have higher incomes, the factors identified as those that would prevent the social exclusion of elderly people living alone are focussed more on psychological aspects and personal/social abilities to face up to adverse situations; and on the possibility of establishing and maintaining intense, long-lasting personal affective ties.

However, if a person has a monthly income that hardly covers the cost of food, lives on a fourth floor without a lift in a depressed district with high delinquency, has serious health problems, is dependent on social aid, with no leisure centres or places where he or she can meet other elderly people, etc., etc., the risk of social exclusion is clearly high, regardless of that person's social gifts.
V. CHALLENGES FACED BY THE FIVE CITIES TO FIGHT AGAINST THE SOCIAL EXCLUSION OF THE ELDERLY

From the foregoing information, it can be deduced that the challenges faced by each of the cities to combat the social exclusion of the elderly hinge on preventing and/or improving the key factors identified as causing social exclusion, especially of elderly people living alone, i.e.:

a) Psychological and personality aspects, to provide people with the necessary social skills to enable them to face up to adversities and take care of and/or generate important affective ties with others, or to encourage social relationships and citizen participation.

b) Aspects of welfare and overall basic quality of life of the elderly (housing, income, healthcare, leisure, culture, etc.), which should be improved or optimised through the action of municipal services or the different networks of social players in each city.

The priorities given to the above points will differ in accordance with the realities of each city, in direct relation to the challenges posed by the five cities with respect to elderly people in general.
5.1) Challenges to prevent social exclusion of the elderly

Each city has set out its challenges in accordance with the specific realities of each situation:

a) Rotterdam

In Rotterdam, it is acknowledged that, given the main cultural trend in Western Europe and other developed countries in recent decades towards increased individualism and social fragmentation, social cohesion can no longer be developed through natural factors but must be organized and managed more and more. The main challenge for Rotterdam is to develop, organize and carry out policies that generate new means for creating social connections, personal ties, quality relationships between elderly people living alone and with the rest of society, thereby fostering their integration within the environment.

This is very difficult because elderly people's attitudes, opinions and hopes are heterogeneous, varied and complex, the same as any other population group. Socializing policies cannot be based on the "average" elderly person, but must approach the diversity of hopes and needs. The greatest obstacle that social-cohesion policies come up against is the need to respect people's individuality as much as possible.

Rotterdam also needs to incorporate differentiating analyses and specific intervention focusing on diversity, because 40% of its population is immigrant (from different countries of origin) and will be the elderly, many without families, of the 2050s.

Another important challenge for the city is a significant consequence of the high volume, quality, quantity and diversity of the support services for the elderly and a direct result of its policies: the complexity (or super-specialization) of the services provided. Attention to the elderly should be simplified, with efficient collaboration between the social players, so that action can be taken to solve meaningful, real needs. This involves learning to listen to and channel the real wishes of elderly people and basing policies for the elderly on their own decisions rather than the wide range of services offered.

In brief, policies that grant decision-making powers to the people who are directly affected, in this case the city's elderly population. Rotterdam is currently moving towards a change in its present dynamics, which favour financing the institutions that offer services, towards endorsing people's ability to pick and choose from the variety of services offered.
b) Birmingham

A significant number of elderly people in Birmingham live in extreme poverty, and the city is ranked fifth in Great Britain's National Index of Local Poverty. Life expectancy is lower than the national average in some areas of the city where income is lowest. There are high rates of unemployment and social isolation.

In 2020, there will be 12 million people over 65 in the whole of Great Britain, and at least one-third of them may be at risk of social exclusion.

Serious lacunas have been found in the administration's services to the elderly, particularly to black elderly people, for whom the services were inexistent.

Within this framework, the challenges set out for the city are to overcome the following problems affecting the elderly, particularly people living alone, and which are even more acute in the cases of black elderly people and/or those belonging to ethnic minorities living in socioeconomically depressed neighbourhoods.

- high indices of chronic illnesses.
- lack of support/aid for carers. They need more resources to be able to carry out their work. Most carers are older people, with an average age of 60. They suffer from stress, poverty and social isolation, which leads to physical and psychological disorders.
- need for curative and therapeutic services for the most vulnerable elderly people.
- need to avoid hospitalisation, which can lead to relapses and the need for long-term care. Hospitalisation should be avoided so long as people can continue to live in their own homes.
- need to promote the culture of independence.
- high indices of illnesses derived from smoking, cancer, cardiovascular and respiratory disorders; also high indices of coronary disorders, infarction, etc.
- high numbers of elderly people with mental diseases. Services have insufficient resources, are badly coordinated, and there are few advisory services for family members to inform them how to look after these people. Many people with mental diseases have not been diagnosed definitively or their situation is considered to be unavoidable.
- low life expectancy in the more depressed areas of the city. In the most poverty-stricken areas, 50% of the population is black or belongs to an ethnic minority, and the level of people with asthma is 78% higher than the average for the whole city.
- very old hospitals with inadequate facilities and infrastructure.
The black and ethnic-minority communities of elderly people, who usually live in depressed areas, suffer most acutely from these problems. In fact, the population of elderly people is currently being polarized to two extremes: people with high purchasing power, and very poor people (blacks and ethnic minorities).

The main challenge is to generate policies that prevent this polarization and will efficiently solve the chief problems faced.

c) Milan

The challenges faced by Milan are grouped into 5 courses of action:

1) Information campaigns and preventive courses for a healthy life

The city's policies are directed towards granting more say to elderly people, so that they can control their own lives, based on appropriate information and education. The intention is to get away from the idea of an assisted person and closer to the idea of an individual who is capable of looking after him/herself and taking decisions affecting his/her life. Appropriate courses should be given (with simple, useful methodologies) regarding eating habits, one's own body, physical education, preventive medicine, etc.

2) Generation of new models of support or help for elderly people

Milan has been carrying out different types of action for several years to promote elderly people's independence and self-sufficiency. During the past two years, Milan City Council, together with other organizations, has been carrying out a project consisting of the introduction of a new professional figure: that of the "social porter/concierge", whereby help and support are given to elderly people living in large city buildings, in which the quality of life is usually pretty low.

The objective is to detect and meet elderly people's needs by involving providers of public and private services, parishes, the district's volunteer associations, municipal police force, etc. This new professional figure has brought about a decentralization of services, with the aim of becoming aware, in a short period of time, of people's requirements by means of individualized intervention.

3) Increased direct financial aid for elderly people

The objective of this course of action is to provide elderly people with greater purchasing power to foster their capacity to buy and choose products. It is intended, once more, to get away from the idea of an
assisted person by giving elderly people vouchers or cheques, which will enable them to choose goods and services and buy at different shops.

4) Council houses

Improve and increase the number of council houses and sheltered residential accommodations, in order to prolong people's independence as long as possible, in housing that links them to a neighbourhood and community

5) Improve healthcare by increasing the number of admissions for rehabilitation

It cannot be denied that one of the main difficulties of senior citizens is their need to face up to chronic illnesses or disorders requiring prolonged rehabilitation. The need to improve and optimise therapeutic attention is therefore evident, which means that the number of beds available in hospitals and specialized clinics needs to be increased.

d) Barcelona

The challenges faced by Barcelona with respect to elderly people are divided into three broad groups:

1) Promote measures that will help to make Barcelona “a city also for senior citizens” in three strategic areas:

   a) Promote information circuits and improve elderly people's access to the city's services
   b) Foster social cohesion and the participation of the city's elderly population
   c) Encourage elderly people to make greater use of the city

2) Increase, improve and/or reorganize the current social services available for elderly people, in two areas:

   a) Promote the proximity of services, so that elderly people can receive attention in their own environments
   b) Increase the network of facilities for the care of elderly people, and spread them out more evenly throughout the city

3) Guarantee better coordination and improve the quality of services for the elderly in Barcelona, on two fronts:
a) Guarantee overall planning and better coordination between the city's services for elderly people
b) Improve the quality of services for the elderly in Barcelona

e) Lyon

The challenges faced by Lyon are divided into 5 work areas:

1) Promote the creation of new accommodation for elderly people and improve the existing accommodation

As mentioned, one of the main problems in Lyon is the inferior quality of a large number of buildings in terms of the lack or poor state of sanitary installations and bathrooms in general. There is furthermore the need to give intensive care to elderly people, specially those who have lost physical faculties or mobility and those who suffer from chronic illnesses. Priority should therefore be given to creating new accommodation for elderly people and, in general, improving and suitably equipping the accommodation already existing.

2) Creation of a service to supply food and meals to the home

Supporting elderly people in their most basic needs, such as food, is essential in order to encourage their independence and enable them to stay in their own homes for as long as possible. The City Council consequently wants to create a service to supply meals to the home that has a wider coverage than the current service, and particularly to ensure that it provides food that is in keeping with their medically prescribed diets.

3) Promote mobility about the city to enhance their social life

The third challenge faced by Lyon is to help elderly people get to know the city and to make use of it safely, with suitable means of transport. The different options that fulfil this aim and can be assumed within the administration's budget should therefore be studied.

4) Support in legal and bureaucratic formalities

Legal, bureaucratic and administrative formalities are often a serious problem for elderly people owing to their mobility difficulties and the complications of bureaucracy in France. It is intended to simplify the
formalities that elderly people have to comply with, through personalized attention and assistance at home.

5) Improve elderly people's personal safety and security

It is necessary to ensure that the city's elderly people live in safe conditions in their home and are secure in their neighbourhoods. The challenge has therefore been taken up to define courses of action to make their homes inhabitable, comfortable and safe; and to make the districts places of neighbourhood and citizen security. This is one of the main reasons why Lyon City Council decided to participate actively in the "Good Neighbour" project, given that it aims to create a new model that gives a leading role to the neighbourhoods and the people who live in them to combat the social exclusion of elderly people.
VI. CONCLUSIONS

1) In all five cities, the profile of a typical elderly person susceptible to social exclusion is similar. This profile responds to an elderly woman, who lives alone, lacks independence, has problems of mobility and has very few or no family or social ties of any type. Furthermore, it should be emphasized that, in cities where immigrant elderly people live, and those belonging to ethnic minorities, these communities are at greater risk of social exclusion and require programmes and initiatives that take their particular circumstances into account.

2) There are substantial differences between the status of welfare in the different European countries, and this is reflected in the development of policies and degree of coverage of the social services supporting the communities with greater risks of social exclusion, as is the case of the elderly. It should be stressed that the differences in the money earmarked in municipal budgets for programmes to combat social exclusion are not only related to the country’s economy, but also to the political priorities of the bodies governing the cities. However, common to all the cities, regardless of the number of services they have, is the need to study in depth the development of different, innovative services, fully adapted to the circumstances of changing realities in demographic and social terms. In this respect, all the cities need to make an effort to develop further and better adapt their support services for elderly people.

3) Some of the courses of action that are common to all cities are oriented towards developing further assistance in the home, so that elderly people can live longer in their own homes and maintain higher levels of independence. Furthermore, the admission of elderly people in geriatric homes tends to be put off for as long as possible and intermediate accommodation formulas are looked for, depending on people’s degree of self-sufficiency, such as the sheltered apartments with services that enable people to enjoy greater independence. On the whole, the ultimate objective of maintaining greater levels of independence and welfare is pursued through the personalization and diversification of the services offered, adapted to the situation of each individual person.

4) The asymmetry in the degree of development of the social services in the different cities means that the local authorities identify different priorities in terms of the procedures to be followed to combat social exclusion, and even identify different causes for this exclusion. Generally speaking, it is agreed that social exclusion is a complex, heterogeneous concept that covers a number of different aspects, some more related to the lack of material resources and services, and others to psychological and subjective aspects. The cities where there are more services, with greater coverage, tend to place more emphasis on psychological factors, whereas cities where even minimum resources and broad social services cannot be guaranteed place the emphasis on meeting these basic requirements as a decisive step towards fighting
social exclusion. In spite of these differences, it is agreed that resources and services are only part of the fight against social exclusion, and - all cities agree on this - other psychological and emotional aspects should also be taken into account, especially those relating to loneliness, respect, citizen participation, etc.

5) It is precisely within this framework of more subjective needs where the "Good Neighbour" project comes into play, differentiating the scope of the project from the services that should be covered by the public administrations. The project has an influence on strengthening attitudes of solidarity and community life in a society that is characterized by growing individualism.

6) The model of "Good Neighbour" intervention is based on strengthening attitudes of solidarity, cooperation and exchange within the framework of existing neighbourhood networks, which are a reality in some cities such as Barcelona, where the model is being implemented for the first time. However, these informal networks, which provide elderly people with a community environment and a sense of belonging and thereby reduce the factors leading to social exclusion, are on the decline. These networks are more common in rural areas than in large, modern, cosmopolitan cities. Nevertheless, they can be recovered, particularly in neighbourhoods where a substantial informal network of relationships between neighbours still exists; or where they existed until a short time ago but, for a variety of reasons, gradually disappeared. Some of these reasons can be found, among other factors, in the urban reforms of neighbourhoods in cities' historical centres and the arrival of new residents in the neighbourhood (young people, immigrants, etc.).

7) Cities' social, urban and cultural realities are different, so social-intervention projects such as the "Good Neighbour" project may be implemented in one way in one city, but could probably not be implemented in exactly the same way in others without certain variations. One same city may even have very different districts and neighbourhoods, and what works in one place may not work in another. The relationships between neighbours depend to a great extent on the social, town-planning and historical characteristics of a neighbourhood, so a project such as our "Good Neighbour" project would need to be adapted to the social realities of each area in which it is intended to implement it.