Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

Prevention and Rehabilitation for Older People with Long Term Care Needs

German National Report

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Berlin | November 2009

European Centre for Social Welfare Policy and Research (AT) • Ecole d'études sociales et pédagogiques (CH) • University of Southern Denmark (DK) • National Institute for Health and Welfare (FI) • Institut de Recherche et Documentation en Economie de la Santé – IRDES (FR) • Institut für Soziale Infrastruktur (DE) • Wissenschaftszentrum Berlin für Sozialforschung – WZB (DE) • CMT Prooptiki ltd. (EL) • University of Valencia – ERI Polibienestar (ES) • Studio Come S.r.l. (IT) • Stichting Vilans (NL) • Institute for Labour and Family Research (SK) • Institute of Public Health (SI) • Forum for Knowledge and Common Development (SE) • University of Kent – CHSS (UK) • University of Birmingham – HSMC (UK)

SEVENTH FRAMEWORK PROGRAMME

Funded by the European Commission
under the Seventh Framework Programme
Grant agreement no. 223037

Contents

1 Background

Concepts of 'upstream' approaches in LTC aimed at keeping older people healthier and more independent for longer, have gained attention in current German LTC policy debates. The main goal of LTC insurance, to prevent residential care as long as possible and facilitate life in private homes ("home care instead of residential care"), can be understood as a preventive approach. In addition, nursing concepts such as 'activating care', with positive effects in terms of prevention and rehabilitation, are now widely recognised as state of the art. Against the backdrop of a solidly developed foundation (basic coverage of needs by long term care insurance, general access) the existing preventive and rehabilitative potential in the field of seniors' health still needs to be developed. This report provides an overview on the status quo of prevention and rehabilitation in long term care within the German health and social care system. Current problems and solutions were collected and evaluated by literature analysis and with the strong support of the German National Expert Panel, which helped to formulate the relevant questions and topics, select good practice examples and structure the material (literature, concepts) in a sensible manner.[1]

1.1 Demographic starting point

In Germany, as in many Western countries, new challenges for the development of long term care systems arise because of an ageing population caused by low birth rates, restrictive immigration quotas, increased life expectancy and the baby boom generation reaching old age. According to the Federal Statistical Office, the percentage of the population aged 65 plus (16.9 million or 20% in 2008) will increase to 21.9 million (34%) in 2060. The share of people aged 80 and older (4 million or 24% of the 65 plus group in 2008) will increase with a peak in 2050 of 10.0 million to about 9.0 million (41% of the 65 plus population) in 2060 (Statistisches Bundesamt, 2006). The life expectancy of 65-year-old women (men) will increase from 20.4 years (17.1) in 2006/8 to at least 25.5 (22.3) in 2060.

Since the prevalence of chronic diseases rises with age, there is an absolute increase in chronic diseases in the ageing population. The National Health Survey (Bundes-Gesundheitssurvey) 1998 gives representative results for the population living at home until the age of 79: 87% of men and 92% of women reported at least one chronic disease (of a subset of 43 interviewed), although the majority reported no life-threatening, severe disease (Lampert & Ziese, 2005; Wiesner, 2003). Similarly, the Berlin Ageing Study, which included older people at home as well as those living in care homes showed one third of the 70-year-olds and almost 50% of the 85-year-olds to have at least five internal, neurological, orthopedic and/or psychological conditions (Bundesministerium für Familie, 2002; Lampert & Ziese, 2005).

[1] The German NEP on prevention and rehabilitation in LTC met on 10 July 2009 and 25 June 2010 and performed further reviewing and advisory work by mail exchange, list of the participants in Annex 1. The work was dedicated to collecting as much information as possible and discussing critical developments in this area. It produced important contributions on the current state of the art in Germany, the respective regulatory situation (with critical remarks concerning political developments in this area), examples of good practice and information on continuing problems and gaps in the system.

Parallel to this trend, statistics on multimorbidity also show rising prevalences: Within the population under examination, the Alterssurvey (2002) reported 12% of 55-69 age group and 24% of the 70-85 group to have five or more diagnosed diseases (Wurm & Tesch-Römer, 2006). Simultaneously, a trend of compression of morbidity is found in subsequent cohorts of older German women and men: the proportion of healthy life expectancy is increasing, lifetime disability decreasing (Kroll et al., 2008). However, this will probably not compensate the increase in care needs resulting from demographic change.

Since the risk of needing care increases dramatically for the over-80s – rising from 3.9 per cent in the 60 to 80 age group to 28.3 per cent in the 80 plus group (Bundesministerium für Gesundheit 2008) – a significant increase of frail older people with care needs is predicted. The number of members of the statutory long-term care requiring care is forecast to increase from 1.97 million in 2006 to 3.09 million in 2030 (Bundesministerium für Gesundheit 2008). These numbers include neither those persons who fail to apply for long-term care insurance services (unmet needs) nor those who are assessed as ineligible for care services (degree of need assessed as below threshold). At present around 80 per cent of all frail older people are looked after by at least one family member (informal care providers). Moreover, in 55 per cent of all households with a frail older person informal care is the only form of care available (Schneekloth & Leven, 2003); (Arntz et al., 2007).

Both aspects – expected morbidity/mortality and expected care needs – exhibit significant social inequalities. Men and women show increasing life expectancy and healthy life expectancy with increasing income (the difference in life expectancy at birth between the lowest and highest of five income groups is 10.9 years for men, 8.4 for women; the difference in healthy life expectancy at birth between the lowest and highest of five income groups is 14.3 years for men, 9.8 for women (Lampert et al., 2007).

Accordingly, the data shows that people applying for services for the first time in the Private Long Term Care Insurance (comprising the more affluent insured population) are six years older than the comparable group in the Social Long Term Care Insurance (Behrens, 2008). Moreover, there are indications that socially disadvantaged individuals, especially those from ethnic minority communities, are less likely to be positively assessed for services funded by the care insurance (Okken et al., 2008).

An additional factor for increasing care needs is the growth in single households; the rise of dementia patients living alone will represent a special a future challenge for municipalities.

1.2 Organisation and delivery of national long term care – governance and financing aspects

Under a broad definition of long term care – to help older people with care and support needs to continue to live a chosen lifestyle and to have as good a life as possible – long term care delivery in Germany includes services provided by the long term care system itself, services provided by the health care system and social and informal care efforts. The differentiation into several systems stems from the regulation of funding and delivery of these services by different insurance schemes.

a) *Social long-term care insurance:* The long-term care insurance scheme was introduced by the German government in 1996. In several respects it is organized similarly to other social insurance systems in Germany (pension, unemployment and health insurance). Coverage by the long-term care insurance is limited regarding actual care needs and is understood as complementary (partial coverage). It aims to support informal care but not to replace it. If beneficiaries with low income cannot afford additional private spending for services, they can apply for a public long-term care assistance allowance on a welfare base (Hilfe zur Pflege, Bundessozialhilfegesetz, SHGB (SGB XII)), which is designed to compensate the gaps in the social long term care insurance. These benefits are means-tested against the family income.

Long term care can be applied for by the patient and/or his or her family, or outsiders such as the GP or a social worker (access not necessarily via medical service/acute illness). Eligibility for services depends on the level of care needs as assessed and certified by the Medical Review Board of the Statutory Health Insurance Funds; fixed amounts are granted in three categories. The final financial decision is made by the long term care insurance. Patients can then choose between benefits in kind or cash benefits ("care attendance allowance") or a combination of both. Benefits from the long-term care insurance can be received as payments for the informal carer. In-kind services include personal care services as well as housekeeping and medical supplies.

b) *Social health insurance:* Other important services for older people with care needs, such as medical and therapeutical interventions, and some kinds of nursing care (e.g. short term care up to 6 months) are covered by the SHI and mostly delivered as a benefit in kind. In contrast to the long term care insurance, the health insurance system aims to be fully comprehensive, except from strictly defined and limited copayments.

Health and long term care insurance are linked to one another: The responsible long-term care insurance funds (Pflegekassen) are affiliated to the corresponding health insurance funds (Krankenkassen). Contributions to both insurances are in principle paid in equal shares by employers and employees with contributions representing a percentage of gross income up to the social security contribution ceiling.2 For employees below a certain income threshold, membership in the social insurance schemes is obligatory. In all other cases (including the self-employed, etc.) private health and long term care insurance may be chosen instead. This system leads the social health and long term care insurance covering about 90% of the German population.

c) *Pension insurance system:* The PIS forms an additional financing system for the care needs of older people since it accounts for some rehabilitative interventions (see below).

Like other industrialized countries, the interaction between the different insurance systems and care sectors is shaped by a relatively strong focus on acute medical care and sophisticated downstream interventions. Unlike procedures in other countries, free access to specialists is guaranteed for the majority of the population while the role of general practitioners as gatekeepers is rather weak. In a "cure instead of care" culture, preventative and rehabilitative concepts have been underdeveloped for a long time – and have only recently begun gaining attention in German health policy. However, these

2 In recent years some elements of the insurance have been shifted to be paid only by employees. Additionally with the implementation of the Long-term care insurance one bank holiday was skipped to limit the additional expenses of employers.

approaches are mostly applied to the healthier and younger parts of the population – frail older people with pre-existing care needs not yet seem to be a relevant target group.

Since the Health Care Reform of 2007 older people with corresponding needs have been entitled to geriatric rehabilitation. Rehabilitation at home for older people is funded by the social health insurance, but the implementation of such approaches is very fragmented (List et al., 2009) (cf. also http://interlinks.euro.centre.org, 5.5.c).

Community LT care is delivered by a multiplicity of competing private and non-profit care service providers, that function (primarily) as private enterprises. There is virtually no regulation by local authorities or bottom-up coordination of catchment areas, making local coordination difficult in a competitive environment. This happened because the implementation of long-term care insurance prioritised private provision and consumers' choice and weakened existing social care structures provided by the big German charities. In the following period, the developing structure of mainly small-scale providers and the scarcity of funding caused an underdevelopment of specialisation and high-quality services (SVR, 2009), leading to a bias towards traditional care and a neglect of prevention and rehabilitation.

Institutional care, too, is provided by a mixture of private and non-profit providers in a competitive environment, and service planning and development is subject to little in the way of local, regional or state regulation. Thus local authorities have nearly no influence on whether and where care homes are built, sometimes they do not even know about the existence of such building projects. Against this background, intermediate care services especially are still underdeveloped. There are some services in the realm of respite care, which are increasingly funded by the long term care insurance. They are, however, often badly communicated and underused; while crisis intervention approaches and intermediate care services to support hospital discharge or prevent unnecessary hospital admissions – all of which would bear preventive and rehabilitative potential – are very scarce.

To sum up the strengths and weaknesses of the system:

Strengths:

- The existing long term care insurance scheme is complemented by public long term care assistance (SHGB): Care for older people is a publicly financed social service.
- The institutionalisation of the social long term care insurance in the 1990s has significantly decreased the percentage of older people who become dependent on welfare benefits because of their care needs.
- The choice between cash benefits or benefits in kind allows flexible solutions for patients and family carers.

Limitations/challenges for long term care delivery

- Coordination problems between care sectors: The German care system faces large integration problems, especially between medical, social and informal care. Characteristic problems affect:
    - Unclear patient pathways: Care standards (e.g. for dementia) are often undefined and contested among different actors (e.g. caused by heterogeneous qualification levels:

specialist nursing care and general home care are sometimes following different care concepts; referrals to medical specialists (psychiatric, neurological) are not handled in form of standardised algorithms but depend on individual training and valuation).

- Intransparent choice: Patients and families do not receive systematic information and advice about care options, e.g. home care. Existing information centres are often not involved in discharge management. Often hospital staff is not well informed about home care and prefer to recommend institutional care settings.
- Community care for long term care needs is often fragmented, with a multiplicity of competing, often small providers and underdeveloped coordinating structures (SVR, 2009). This leads to a huge case management burden for relatives: Patients' chances e.g. to stay at home or to get access to rehabilitative services, depend predominantly on relatives actively arguing for them – and being willing and able to complement professional care with their informal commitment. A lack of social networks is thus a risk factor for earlier admission into a care home and comparably poor quality of care. Not only within community care, well-developed and evaluated concepts of 'case management' are an example for existing solutions, which have not been extensively implemented yet.
- The fragmented provision of long term care in the community is connected with its shortfalls: Services provided in general follow mainstream patterns, and specific care needs – in an increasingly diverse older population – are often not met (SVR, 2009).
- Underdeveloped culture of interprofessional/interorganisational cooperation: The extent of information exchange often depends on the personal commitment of the professionals/ agencies involved. However, quality standards are increasingly implemented, at least for information transfer.
- So far, health care reforms seeking to promote integrated care have been restricted mainly to the medical realm; the integration of health and social care is still underdeveloped (SVR, 2007).
- Approaches to intermediate care (incl. crisis intervention) are in an initial stage; in combination with few rehabilitation services the risk of premature admissions to care homes is high.
- Medical care in care homes (physical and mental health) is often suboptimal, which also leads to unnecessary hospital admissions.
- Geriatric services are underdeveloped; moreover their institutional contexts and regulations vary strongly between the states (List et al., 2009).

- Financing for social care is scarce. This contributes to a lack of activating and preventive care.
- Inadequate needs assessment criteria: In principle, every member of the statutory health insurance is entitled to receive long term care services for their approved level of care needs. However, assessment criteria are biased to somatic problems and associated disabilities. Patients with primarily mental health problems (e.g. dementia) are thus discriminated. The recent Long-term Care Further Development Act (2008) therefore implemented extra benefits for persons with severely restricted daily living skills living at home or in care homes. Further changes are being discussed (see below, current political context, 1.4)
- Interface between somatic medicine and psychiatry: Especially gerontopsychiatric patients with challenging behaviour AND severe somatic diseases are at risk of underprovision and avoidable negative outcomes. General hospitals are rarely adequately equipped for this target group (special

wards, specialised staff). Conversely, psychiatry wards often do not have enough somatic competence at their disposal to treat patients on site.

Within this context, differences in patients' and families' financial resources do in fact matter: Higher income helps to compensate inadequate home care services with additional services like night care, etc.

1.3 Cultural context: Attitudes to ageing, older people and their care needs

- The traditionally paternalistic conduct of professionals towards older people is changing slowly to a partnership model. The agreed principle of "informed consent" ensures that patients (and family) will be informed about diagnosis and treatment on a routine basis. Nevertheless, care practices are still quite a long way from patients' participation and involvement in planning and goal-setting in health and social care (at an individual as well as at a system level). Patients and relatives are not involved on a regular basis in decision-making. Especially within the hospital setting (acute crisis intervention) physicians and, in a broader sense, hospital staff decide whether home care or a nursing home is appropriate.
- In addition, various dominant stereotypes in the societal and political discussion – active ageing, civil engagement and older people as a potential for society – lead to the bulk of preventative activities aiming at the younger and healthier older people, with the danger of discrimination of frail older people with limited mobility (Pichler, 2007; van Dyk, 2007), where especially persons with low socioeconomic status face care disadvantages. This effect is enhanced by disincentives in health care financing; and moreover, societal support for civil engagement and voluntary work – which can enhance social participation and therefore health chances - is middle-class-oriented and thus insufficiently targeted to disadvantaged groups of older people.
- "Activating care" as the leading approach for long term care is widely agreed upon, i.e. promoting and supporting patients' own abilities and resources in daily activities. By now the approach is well known and widespread in professional care services. However, its implementation is often impeded by working conditions (lack of time, low-skilled staff) and the strict regulation of service provision (care Taylorism).
- Long term care services are insufficiently diversity-oriented (SVR, 2009); there are very few services (with regard to prevention, rehabilitation, long term care in general) targeted to special groups of disadvantaged older people (the poor, ethnic minority communities, etc). This goes along with a long-term care provision system based primarily on private enterprise – oriented at strong competitive incentives.
- Long term care and the nursing profession in Germany are influenced by a still rather doctor-led system: professionalisation and scientific recognition of nursing and therapy (ergotherapy, physiotherapy, logopedics) are less developed compared to Anglo-Saxon and Scandinavian countries. This also impacts on the self-representation of these professions: Their claim to have a say in shaping the (long term care) system is still rather reticent and modest (Pundt, 2006).
- The principle of free choice of medical services and physician is deeply rooted in the attitudes of the German population to their health care system. Long-term care organisation is influenced by this principle e.g. in debates about gatekeeping and case management. Ideas about limiting individual choice to allow for more continuous care guidance are controversial. Moves to supply medical

services in care homes by permanently employed or contracted GPs also receives criticism, because the freedom of choice of physicians is highly valued.

1.4 Brief description of current political context

In general, the public profile of long term care is currently high. The attention is linked to concerns about the affordability and sustainability of care in an ageing society, but also to a societal and political value shift regarding quality of care and dignity of older people and the understanding that great efforts are required to adhere to these values. The latest legislation has been the Long-term Care Further Development Act (2008) (cf. Ministry of Health http://www.bmg.bund.de/cln_091 /nn_1169696/EN/Pflege/pflege__node.html?__nnn=true). It introduced the following changes:

- Better support for family carers: "People working for employers with at least 15 staff members now have the right to take up to six months unpaid leave from work in order to care for a relative. The return to their employer is guaranteed." And: "If care needs arise unexpectedly, working relatives can take up to ten days leave from work at short notice to ensure care provision or to organise appropriate care during this time."
- Extra financial benefits for people with dementia (see above);
- Enhanced financial support for respite care;
- Implementation of community-based long term care support centres for case management, advice and coordination of long term care services;
- Support by a case manager as a statutory right (central point of access, counselling and advice, coordination of the entire spectrum of care);
- Under-supply of medical services for care home residents addressed by new legal options for providers to contract physicians (either contracting or employment);
- A procedure for the regulated development of expert nursing guidelines for specific nursing problems (e.g. decubitus prevention, wound treatment) implemented to become obligatory guides for care practice.
- For the first time (in Germany) quality reports about home care services and care homes, generated by the Medical Review Board in unannounced visits (once per year from 2011), to be made accessible to clients and the public in an aggregated form. Although seen as insufficient, this extends the so far sparse transparency.

Reconceptualisation of the rules of care assessment is currently high on the policy agenda: A modified approach to assessment is oriented at ressources for independence and compensation for functional disabilities. It is based on eight areas of functional activities, competencies, or other areas of daily life.3 By this Germany should meet international standards in nursing sciences (Bundesministerium für Gesundheit, 2009). The new model should especially address the inadequate consideration of mental health problems (especially dementia).

3 These are: mobility, cognition and communication, behaviour and mental problems, self-care, coping capacity, maintenance of daily living and social relations, social inclusion and participation, management of financial and administrative matters (Bundesministerium für Gesundheit, 2009).

Aside from recent and ongoing regulatory changes, long-term care issues are also receiving increasing attention within the field of training. Geriatrics have been certified as a new qualification for physicians and other professions (however, training is not yet provided adequately by all national medical associations, which are responsible for organizing medical training). In this respect, academic representation of geriatric medicine is still underdeveloped. Chairs of geriatric medicine for example, which could ensure knowledge development and transfer in education and research, are not yet represented in all medical faculties (Lüttje, 2005).

The quality regulations in the 2008 reform can be seen as a reaction to increasing, sometimes lurid media reports about severe and unacceptable problems in care homes. There is, however, a sharp debate about whether the defined form of publication of quality reports on care homes and home care services – just aggregated results with single good and bad marks compensating each other – can in fact ensure sufficient transparency for users to enhance their choice of services and/or empower their position vis-a-vis service providers. Therefore further improvements of legal regulations are asked for.

Prevention and rehabilitation do not yet receive much explicit attention within long term care. However, the expansion of geriatric rehabilitation in the package covered by the social health insurance and the focus on activating care create opportunities for further development and reflect growing interest in revising the picture of long term care as a “dead end”. There is a focus on prevention in the public and political debates, but with a clear focus on healthy older people and thereby contributing to a sharp separation between the “third” and the “fourth age”.

2 Current national mainstream prevention and rehabilitation practice in long-term care – achievements and gaps

The following chapters present mainstream (and good practice) examples in four different care settings: Community care is defined here as the informal and formal care delivered at a persons’ home. Intermediate care involves services providing institutional part-time care (day/night), or short term/respite care for a limited period of time; this includes crisis interventions. Acute care refers to acute admissions in general hospitals for persons with long term care needs. Finally, of course, the care home setting is addressed.

2.1 Living in the community (care at home)

Description of services:

Routine care arrangements in the community setting encompass informal and formal care, mainly delivered by relatives, self-help groups, GPs and medical specialists, and specialised long term care services.

Relatives often play a central role directing care processes for patients. Families' engagement remains crucial to organizing and assuring good service quality, continuity and adequate services for the patient. Informal care is regularly required, since community care allowances do not cover all needs (which again increases time pressure for care workers and a tendency to low-skilled staff).

As part of organized informal care, self-help groups have been established, offering support, lay information, and information about local infrastructures for informal and formal care. One of the most developed associations is the Alzheimer Society Germany, which offers information and psychological support for patients and care givers.

Role of GP: Most older people are seen regularly by a GP, who they might already have been consulting for some years and who might know their medical history. Over 90% of older people consult a GP at least once a year (Keyser & Sandholzer, 2008). Nevertheless, GPs in general have a rather weak gatekeeping function. GPs often have some sort of case management function – especially if the patient is bedridden and home visits are necessary – but their exact range of responsibilities is highly dependent on their individual qualification and commitment, and varies between them. The same holds true for GPs' awareness of preventative and rehabilitative potentials in older people in general, particularly in those with long term care needs.

Medical specialists are regularly included in the care of older people as part of the social health insurance coverage – by means of practice-based and outpatient consultations as well as acute and elective hospital admissions.

Nursing services: Temporary nursing and domiciliary care (for needs linked to an actual health problem) can be prescribed by physicians (mostly GPs) and are covered by sickness funds for six months.

Long-term care services (home care, domiciliary care) are delivered by local private or non-profit home care services, where nurses, and – decreasingly – social workers as well as – increasingly – assistant nurses are employed. The needs assessment for long-term home care is done by the Medical Review Board of the Statutory Health Insurance Funds. Housekeeping services are regularly included in the long term care insurance coverage – and often delivered by the same service providers.

Currently *local community-oriented support centres* are being implemented on the basis of the Long-term Care Further Development Act (2008). They are to focus on case management for long term care of older people people and on advice for people with care needs. Already implemented across the burroughs in Berlin and in some of the other states, such centres are supposed to offer independent information on local formal and informal health and social services infrastructure (free of charge). Case management in the Berlin centres consists of repeated consultations, including comprehensive information transfer, psychosocial support and advice and help regarding administrative and financial matters, etc. To what extent these new centres will provide independent information and case management is doubtful, since many of them are affiliated to the long-term care insurance institutions – rather than to "neutral" agencies.

Local community initiatives for social support and social networks of older people (often church-based, but also by other voluntary actors) exist in rural and urban environments.

Typical Problems:

Although prevention and rehabilitation for the person with care needs and prevention for the family carer are essential for realising patients' potentials and relieving the burden on carers (and thus keeping care arrangements sustainable), these elements are hardly institutionalised; e.g. an assessment specifically for carers, as known in England, has yet to be discussed in Germany. Preventative (activating) care approaches are, as already mentioned, hindered by lack of time and money, as well as lack of qualification and sometimes a negative attitude on the side of the care workers. Therefore family carers are left with an important advocacy role.

A lack of counseling for beneficiaries of the LTC insurance hinders the establishment of preventative and rehabilitative approaches in home care. Beneficiaries of cash services do not receive regular support or counseling for establishing coordinated and high quality care arrangements at home.

Typical *interface problems* affect cooperation between informal carers and professionals (information barriers) and between the different sectors of health and social care: e.g. between social care professionals and housing associations.

These gaps and coordination difficulties lead to a lack of user-orientation. Services are criticised for having a mainstream orientation and not acting flexibly enough to consider users perspectives. Subgroups with special needs – often subject to social taboos - are thereby at high risk of being underserved, with gaps in services e.g. for support of the growing group of dementia patients living alone or for incontinence counselling.

Concerning *specialist medical care*, frail older people with restricted mobility are often underserved, as home visits by specialists are rare, even in care homes, due to reimbursement problems (Hallauer et al., 2005). Avoidable hospital admissions and worsening of existing diseases demonstrate gaps in specialist care and preventive /rehabilitative approaches in long term care. Additionally, although specialist geriatric medicine is currently being established (see above), a shortage of qualified physicians is reported, especially for the ambulatory sector.

The same is true about *social care*: Ideally, care workers should be trained in working with geriatric patients (e.g. dementia care) or supported by specialist staff. However, given the trend towards deprofessionalization in care agencies because of financing constraints such services are often not provided. Patients and family carers frequently complain about the burden of having many helpers in the household at the same time, because services are often not well coordinated.

Complementary services such as counselling, guidance for family carers, volunteer befriending schemes, meals on wheels, mobility support services, etc. are often not offered. This is because these services are not covered by the national long term care insurance scheme, but are to be regulated by state-level long term care legislation (Schaeffer et al., 2008).

Local community initiatives for social support and social networks of older people mostly dedicate their services to healthy older people. So far awareness is not wide-spread that care needs bring about a risk of financial and social impoverishment and isolation. For example, mobility support could help a person

to continue their personal lifestyle and maintain social inclusion and participation and therefore has an important preventive and rehabilitative impact on older people with long term care needs and functional disabilities.

Overall, there are great regional differences in care quality. Persons with care needs in urban regions have significantly more services at their disposal, whereas in rural areas problems of undersupply arise (partly compensated by stronger social networks).

In terms of service planning, the lack of steering capacities at local level (e.g. local authorities, municipality) is seen as a reason for gaps and deficits. Local initiatives e.g. for round tables of regional LTC actors and the analysis of local care structures are not yet far developed; possible initiators such as municipalities often remain hesitant.

2.2 Intermediate care settings (intensive home interventions, day care, short-term in-patient care)

Description of services:

In-kind support services: Increasingly, respite services are offered to relieve family members e.g. for routine or occasional home visits, mobility training, household, etc. Additionally, short-term institutional care services (e.g. day centres, night clinics) are available. However, these services are not available everywhere and often require private co-payment. As already mentioned, geriatric rehabilitation at home has been covered by the social health insurance since 2007. So far, however, the service has only been implemented in a few regions.

Typical problems:

Overall, intermediate care services are still underdeveloped. Where they exist, however, they are often poorly communicated and underused. Crisis intervention approaches and intermediate care services to support hospital discharge or prevent unnecessary hospital admissions – all of which would offer preventive and rehabilitative rewards – are very scarce.

Against the background of these service gaps, the absence of informal carers especially increases the risk of a patient being transferred to a nursing home.

2.3 Acute care / Hospital setting

Description of services:

Hospital care in the context of long term care is delivered mostly in general hospitals/wards. Only a minority of older people is treated in specialised geriatric settings. Geriatric knowledge is increasingly valued, leading to a rising number of geriatric units – and to an involvement of geriatric specialists in general hospital care. Preventative/rehabilitative tasks for the hospital setting, such as appropriate drug safety (avoiding polypharmacy), hygiene issues (avoiding nosocomial infections) and fall prevention are

discussed within the expert community and tested in pilot projects (see below), but are not implemented extensively.

Typical problems - Gaps and problems in this setting include:

- Unsystematic discharge management: Hospital nurses or social workers organise initial domiciliary care at home, or transfer to a short-term residential care unit or nursing home. These staff members often lack comprehensive information about existing community care options; rather, they tend to prioritise an institutional view of care, neglecting the potentials of community care. Community carers criticise high numbers of discharged patients unnecessarily transferred to care homes.
- A risk of poor care for patients with mental health problems and challenging behaviour (cognitive impairments) in acute care settings. Hospital wards – e.g. in internal medicine, surgery, etc. – are seldom well prepared for those patients (by specialised, trained staff, and suitably prepared areas). Therefore they tend to be discharged early and /or transferred to psychiatric wards or care homes – with a risk of receiving a lower quality of acute care.
- The DRG reimbursement system – recently implemented – brings along incentives for earlier discharge – with a risk of rehabilitative approaches being underused in the hospital setting. This trend has to be compensated by downstream actors like domiciliary care providers, GPs or care home providers – for which these providers are insufficiently equipped.

2.4 Care homes (residential and nursing care facilities)

Description of services:

There is a lively discussion about and political support for alternatives to traditional care homes such as assisted living approaches and small scale group settings e.g. for people with dementia. These approaches are probably not yet developed to their full potential, and in some respects lack regulation and quality assurance. Currently long term care policies foster strategies to support ambulatory care as long as possible: A shift towards a majority of older people being cared for at home is a national policy goal, based on ideas of quality of care and independence as well as for economic reasons. Nevertheless, care homes still play a relevant role in the landscape of care of older people. Innovative projects for assisted living and sheltered housing for dementia patients are being tested, especially in bigger cities.

Typical problems - The characteristic gaps and problems discussed in this setting include:

- Quality problems occurring because of a lack of specialisation. Especially for the growing group of dementia patients there are not enough adequate care units with skilled staff. Also, nursing home staff is not always adequately trained for dementia care.
- Medical care in nursing homes is mostly delivered by visiting GPs or – too seldom – specialists. Because of financial disincentives there is a risk of undersupply (see above).
- Admission to a nursing home might be determined by financial resources, where a lack of private financial means restricts choice. Economically disadvantaged older people are at higher risk of being admitted to a care home early, since domiciliary care often requires private co-payment.

- Quality problems arise in residential care, because – like in the community care sector – under-funding of long term care (insufficient insurance coverage at the individual and societal level) contributes to inadequate qualification of staff (incl. high staff turnover), lack of time for patients etc.

3 The good practice discourse and good practice models related to care settings

Current trends for good practice in long term care in Germany are reflected in recent legislation. As in other countries, the main strategies focus on community care and rehabilitation.

The following description of current discussions on preventative and rehabilitative strategies in long term care is structured according to the care settings outlined above. Models that are explicitly designed to function across settings are listed in a separate chapter (3.5), as are models/interventions that are non-specific in terms of setting (3.6). Where possible, good practice models are differentiated according to their intervention focus (behavioural, medical, social, environmental, etc.); some of them combine several of these.

3.1 Living in the community (care at home)

- *Medical interventions* such as screening (annual free check up at the GP) or vaccinations (influenza) are well-established approaches in community care and available everywhere to all members of the social health insurance.
- A dominant cluster of good practice models in the community setting is characterised by their focus on *visiting clients' homes* with the goal of better reaching clients for medical, social, nursing or environmental prevention/rehabilitation interventions.

The internationally discussed approach of preventative home visits also receives broad attention within the German expert community. These have not yet been implemented across the board, but are being tested and developed within several pilot projects. Often they involve cooperation between specialised geriatric units, GPs and nursing services (e.g. Albertinenhaus Hamburg: (Dapp, 2008; Dapp et al., 2005, 2006, 2007). In the context of long term care the benefit of these interventions for frail older people with pre-existing care needs is subject to criticism: Preventative home visits seem to foster *lifestyle modifications for more healthy subgroups* ("upstream intervention"). Sometimes, clients with existing care needs covered by long term care insurance (SGB XI) are explicitly excluded from these programmes.

New approaches for home visits by nursing staff or physician assistants specifically for chronically ill patients ("Gemeindeschwester Agnes", (Terschüren et al., 2007); VERAH, HELVER) aim to encourage new forms of interprofessional cooperation (enhanced responsibility for nurses, etc.) and to better reach and monitor older people with care needs living at home (drug management, cardiovascular parameters, etc.).

Aside from a medical focus, other approaches try to foster clients' abilities to remain at home by *more general rehabilitative methods* (physiotherapy, adaption of environment). Successful models in

Germany include ambulatory geriatric rehabilitation programmes, which offer support in a day care setting accompanied by home visits (Plate and Meinck 2005) and mobile rehabilitation, which offers rehabilitative support in the client's home, e.g. after an acute hospital stay (Schmidt-Ohlemann, 2004; Schweizer, 2004; Schweizer et al., 2006), (see also: http://interlinks.euro.centre.org/model/example/DomiciliaryRehabilitation_MoRe).

Finally, *socially oriented home visits* (prevention of loneliness, social exclusion) have a long tradition on the one hand, e.g. in volunteer and professional pastoral care – but, on the other hand, are redeveloped in current policies to improve and strengthen civil engagement (e.g. visiting and care services following §45, Long-term Care Further Development Act (2008). National labour market policies contribute significantly in this field: long term unemployed people are obliged to do some kind of work in order to continue receiving unemployment benefits; they are expected to fill in gaps in the long term care sector by covering different kinds of social care and support (home visits, mobility training, housekeeping assistance, etc). This development is contested because of heterogeneous motivation and qualification of mostly unskilled individuals.

Further innovations include *counselling and training for care givers*, that are being pilot-tested and implemented increasingly, though not yet existing areawide.

As in other countries, *fall prevention* attracts much attention (assessment, intervention, osteoporosis treatment, (Hauer et al., 2006).

Case management as a gerontological concept for integrated care delivery is widely discussed. With the Long-term Care Further Development Act (2008), long term care beneficiaries are entitled to support provided by a case manager (Ewers & Schaeffer, 2005). Qualified case management ensuring comprehensive and systematic counselling about rehabilitative and preventative care options (e.g. to encourage clients to return home after an acute hospital admission instead of being transferred to a care home) and advocacy are not available everywhere, but the number of local initiatives is growing (e.g. Berliner Koordinierungsstellen rund ums Alter).

Finally[4], there are some broader approaches aiming at social integration by community-based approaches. Good practice models in this group aim to improve environmental factors, e.g. urban planning, to enhance mobility of older people (FRAME – Freizeitmobilität älterer Menschen, BMBF 2001–2004: (Kasper, 2008); to promote networks of local volunteers (Netzwerk Märkisches Viertel: Ehrenamtliche Vernetzung lokaler Akteure, Gesundheitsförderung durch Kooperation und Ressourcenstärkung: (Heusinger et al., 2008; Wolter, 2007)) or seek to link informal and professional actors for long term care in a community-based approach (see example below).

4 The collection of good practice examples as drafted here makes no claim to be complete. Additionally to be mentioned are e.g. new initiatives focussing on older persons with dementia (Alzheimer Society e.g. aims to facilitate training material for police, fire departments, bank employees, retail sale etc); further projects/concepts include the development of community-oriented geriatric service centres within existing hospitals, community-based assisted living arrangements or neighbourhood initiatives for cross-generational living.

Example: Miteinander wohnen (living together), Lichtenberg/Berlin

Type, scope: Living together is a voluntary initiative with public funding for multiple subprojects that change over time. It is situated in a small high-rise development with mainly one-room flats in East Berlin with about 4,000 residents, including a high percentage of older people. In addition, there is a care home administrated by and linked to the initiative, and organised links to the geriatric pathway. In this sense this is also an across-settings approach (3.5). Moreover this initiative involves creating publicly funded (low-paid) jobs.

Background and aims: Founded shortly after reunification by a former teacher in her 60s, the initiative aims to support older people in maintaining their independence and living at home. The overall goal is to facilitate living at home until end of life without being lonely and under-cared.

Content and method: Multiple small initiatives focus on social networking, joint activities (mental, physical, social) and include exercise and many other health-relevant topics. For older people with care needs and mobility restrictions there are befriending and support services, laundry service, help with benefits and allowances, mobility support and supported excursions. Participants have to pay a small monthly fee (25 €). Home care is separate and paid via the care allowance.

Target groups: Older inhabitants living in the quarter, mostly native German. The socio-economic situation is modest, but not extremely poor. Ethnic German immigrants from Eastern Europe living in the neighbourhood are not reached – perhaps due to competition with another welfare service.

Results, evidence: Participation is high; more than 90% of participants to date live at home until death. Because of the complexity of the approach hard data regarding morbidity and mortality are not available.

Current state: Ongoing. The initiative is continuingly searching for new ideas and especially new funding opportunities.

Contact and further information: http://www.miteinanderwohnen.de/index.html

3.2 Intermediate care settings (intensive home interventions, day care, short-term in-patient care)

As mentioned above, preventive and rehabilitative approaches in intermediate care are rather underdeveloped. Good-practice examples are harder to find than in other settings, e.g. in community care.

Although several intermediate care services are provided (short term care, day care, assisted living etc.), they are often criticised for lacking adequate concepts especially for rehabilitation. Besides that, clients and professionals are insufficiently informed about entitlement to intermediate care, which leads to underutilisation.

Nevertheless, good practice initiatives exist at different levels: At the regulatory level, the latest reform of the long term care insurance scheme extended entitlement to respite care (professional care for those periods of time when the regular family care person is absent or otherwise unable to attend to care needs).

Additionally, among local initiatives there are some pilot projects which provide rehabilitative intermediate care to prepare clients for their return back home (see text box below).

Other general preventive and rehabilitative approaches like cognitive training, etc., which are often not linked to a specific care setting (see 3.6), might also be applied in intermediate care.

Example: Rehabilitative short-term respite care (Caritas Bremen)

Type, scope: The rehabilitative approach of Caritas Bremen is implemented by a short term respite care unit (15 places) in the Northern German city of Bremen, which has about 500,000 inhabitants. The program aims to support people returning home, with the help of a bridging person.

Background and aims: The project is one of the few initiatives ensuing from the latest health care reform that pilot tests new contracting options for integrated care for the target group of frail older people. The main innovation is the provision of a defined pathway for patients. A problematic side-effect generated by this vertical integration might be providers' interest in keeping patients within the reach of their own services (hospital, respite care unit, home care service) and thereby restricting their choice.

Content and method: The care unit is located in a care home, close to the departments of physiotherapy, logopedics, occupational therapy. After the program, home care for up to 7 days after discharge is included.

Target groups: An innovative integrated care contract with two health insurance funds allows provision of an extended rehabilitative training to mobilise older people, e.g. after an acute hospital admission, to regain autonomy and cope better with disabilities. The program aims exclusively at older people insured by the participating insurers, with care needs exceeding those met by home care and part time care (day care) services.

Results, evidence: Quality management is in place, though not published. Evidence not published.

Current state: Ongoing sustainability of the project might depend on economic success of integrated care contract for the involved insurance funds

Contact and further information: http://www.caritas-bremen.de/51408.html

3.3 Acute care in the hospital setting

Good practice examples for prevention and rehabilitation within the hospital setting mainly address the well-known problems of fragmented pathways and interface management for patients, and the

management of patients with mental disorders (especially dementia patients) with acute somatic care needs during their stay in a general hospital.

Pathway improvement has been pilot tested and published, for instance within stroke management. (Becker et al., 2006) present a concept for early assessment of rehabilitative potentials to optimise the referral of patients to downstream intervention units (e.g. rehabilitation clinics).

Further innovations of patients' pathways include discharge management (e.g. quicker and more transparent information flow at admission and discharge through information leaflets and summaries, Krankenhaus Bethanien, Hamburg)

Innovative dementia management strategies exist as rehabilitative programmes involving family carers (Bad Aibling), consultation and liaison services by specialised nursing and therapeutic staff (see (Kirchen-Peters, 2005), and specialised wards in general hospitals for dementia patients (Zieschang et al., 2008).

Example: Gerontopsychiatric Consultation and Liaison Service Kaufbeuren

Type, scope: A pilot project launched in 2000 and funded by the Federal Ministry of Health implemented a new interdisciplinary team (medical specialist, two psychiatric nurses, occupational therapist, secretary) to cooperate with the local general hospital in a rural region in Southern Germany.

Background and aims: The twofold aim is to assist patients during their hospital stay and support hospital staff.

Content and method: Patient care includes counselling, diagnostic and therapeutic advice, support for coping with the situation on the ward, consultation for family carers, organising discharge and home care. For staff there is skills training and case-oriented information exchange on all professional levels (medical, nursing, etc.). Additionally, the team provides crisis intervention and de-escalation strategies for patients (e.g. postoperative delirium), and for staff in situations of excessive demands.

Target groups: The programme aims to support frail older people with mental disorders (e.g. dementia) who have to be admitted to a general hospital because of a major somatic condition. Increasingly, the team identifies new cases independently of referrals by hospital staff.

Results, evidence: The service is utilised by about 600 patients every year, not including follow-up contacts. This represents 10% of hospital patients older than 65 years. Initially, challenging behaviour was the most frequent motive for consulting the service. Dementia patients seem to benefit most. The implementation process was dicussed as a process of complex organisational development. The project received a WHO award for its innovative potential in 2001.

Current state: Ongoing, after the pilot phase the programme became part of the regular services.

Contact and further information: http://www.klinikum-kf-oal.de/kf/abteilungen/funktion/liaison/liason.htm, (Kirchen-Peters, 2008)

3.4 Care homes (Residential and nursing care facilities)

Within the care home setting in Germany innovative preventive and rehabilitative approaches mostly focus on activating programmes aiming at enhancing the activity and autonomy of inhabitants. There are several projects in place offering cognitive, physical and psychomotoric training programs or singly or in combination, especially for frail older people (SimA-P, http://www.sima-akademie.de , Selbstständig im Alter; (Ackermann, 2007; Oswald et al., 2007; Rupprecht et al., 2004).

The well-known problem of undersupply of medical services in German care homes is addressed by several projects testing new contracting options for physicians in care homes (see example). The conceptual change from a "free choice" model with several general practitioners serving in a care home involves introducing a "care home physician" responsible for all residents in a home.

As mentioned above, new services are developed to offer appropriate care settings especially to patients with cognitive impairments (dementia). Shared and sheltered housing for dementia patients with continuous community care assistance are currently established; however, since legal regulation has not yet caught up with this development, quality of care is heterogeneous. Although this kind of care facility is developing from pilot project to general implementation, scientific evidence for improved dementia care is scarce (Hallensleben & Jaskulewicz, 2005). This conceptually new type of service can be seen as a hybrid form between institutional and community care.

Example: Berlin project for primary medical care for severely ill care home residents

Type, scope: In this project, several (not all) regional health insurance organisations, the Berlin Hospital Association (BKG), the Association of Private Hospitals and Care Homes Berlin-Brandenburg (VPKBB) and the local Association of Statutory Health Insurance Physicians (Kassenärztliche Vereinigung Berlin) concluded a framework agreement to ensure better medical care in residential homes by expanding contracting options. 38 local care homes are involved.

Background and aims: In 1998 several regional health insurance organisations, BKG, VPKBB and the local association of statutory health insurance physicians in Berlin concluded a framework agreement introducing accountable "care home doctors" in several care homes in Berlin. The initiative was a response to a historical change, as the types of care homes that had existed since the 1970s in the former West Berlin, which had worked with employed doctors, had to be transformed to conform to the new legislation (and financing arrangements) of the care insurance system introduced in 1994. Several care homes in the region voluntarily took part in the project. The project aimed at ensuring availability and quality of medical services within residential care.

Content and method: Care homes have extended options to contract ambulatory physicians or employ medical staff. The physicians provide 24-hour services, 7 days a week. Weekly rounds and multiprofessional case conferences are obligatory. Physicians have to take part in quality control groups and skills trainings.

Target groups: The project aims to improve medical care for residents of care homes, especially to lower the rate of avoidable hospital admissions.

Results, evidence: The rate of hospital admissions in participating care homes was 2.3 to 2.6 times less than in other care homes (1998–2003). Expenditures for ambulatory medical care and medical supplies were higher. Costs for transportation, stationary care and drugs were lower. Overall, significant cost savings were stated.

Current state: Ongoing, important motivation for the Long-term Care Further Development Act (2008) to provide new legal options for institutions to contact physicians.

Contact and further information: http://www.berliner-projekt.de/ , (Kotek, 2006)

3.5 Across settings

Interventions that are targeted to link several or all of the aforementioned settings and thereby create new care networks in the interest of better pathways for patients through the whole system can be seen at the most complex level of good practice. Ideally these initiatives are oriented locally and act as community-based projects involving care organisations and key persons. This also implies concentrating and coordinating existing community initiatives.

This type of project is considered difficult to implement and even more difficult to measure in terms of outcome parameters.

Nevertheless, good practice models aiming explicitly at prevention and rehabilitation do exist (see two examples below). The first one, Gerinet Brandenburg, served also as a model region to pilot-test mobile rehabilitation, which was included in the package funded by the social health insurance (in 2007).

The other example – support centres for older people and family carers in Berlin – is one of several similar centres established by most of the federal states (IAV-Stellen Baden-Württemberg, ABC-Stellen Brandenburg, etc.).

Example: Gerinet – geriatric network in rural environment

Type, scope: Implemented 'umbrella-network' (at state level, Brandenburg, Eastern Germany) of 12 regional networks for geriatric care, including hospitals with geriatric wards, GP practices, care services, therapists. The initiative came mainly from hospital-based geriatricians.

Background and aims: Severe problems regarding older people's care (fragmentation, overmedication etc) were stated. Aims are to improve quality of care for older people at regional level across professional and organisational boundaries including prevention and rehabilitation and to allow older people to live at home or to return to home as long/ as soon as possible.

Content and method: Improved coordination between professions and organisations (jointly developed pathways), and enhanced geriatric competencies of generalists (certified trainings for all involved professions). Developing and implementing comprehensive quality standards and innovative care approaches like rehabilitation at home.

Target groups: Vulnerable older people, no extra programmes for specific target groups.

Results, evidence: Interim results are partly functioning networks and better qualified professionals. No evidence at patient outcome level. Criticism: underdeveloped specialisation (dementia, palliative care)

Current state: ongoing and in further development

Contact and further information: http://www.geriatrie-brandenburg.de/lokale_netzwerke.html

Example: Support centres for older people and family carers Berlin-Tempelhof

Type, scope: The local community-oriented initiatives ("Koordinierungsstellen rund ums Alter") were initiated in 1999 by the federal government and the Federal Association of Social Welfare Providers as a response to demographic changes and increasing demands for advice in the area of long term care.

Background and aims: The concept involves a combination of counselling and case management services with the development of a care network in inner city quarters. Social workers are supported by volunteers and informal carers.

Content and method: The centres are dedicated to helping older people with care needs to stay at home as long as they wish (supporting autonomy), to facilitating a return home after a hospital admission and to providing systematic information about regional service options for home care and rehabilitation. In addition, the centres have a remit to initiate and build up a local network of existing organisations of long term care.

Target groups: Services are accessible and free of charge to all older people and their relatives in the respective region. There is a special focus on intervention in critical care situations (crisis in home care arrangements, acute hospital admission), to prevent avoidable care home admissions.

Results, evidence: Most of the centres are well established in their regions and in many cases they successfully facilitate better cooperation between service providers. However, there is little evidence in terms of measured patients' outcomes (difficult or impossible to measure).

Current state: Ongoing; the centres have been an important pilot project for the recommendation of the Long-term Care Further Development Act (2008) to establish community-based LTC support centres for case management, advice and coordination of LTC services.

Contact and further information: http://www. koordinierungsstellen-rundumsalter.de/

3.6 Services not linked to specific settings

We classify a number of approaches as non-specific, since the respective authors either did not tailor them to a specific care setting or they seem to be applicable or transferable to several or all of them.

One group of lifestyle interventions focuses on nutrition (assessing and reducing malnutrition, e.g. Mini Nutritional Assessment; (Bauer et al., 2008), involving staff training for prevention of undernourishment, another on cognitive or physical training (Freiberger & Becker, 2006; Freiberger et al., 2006; Frye et al., 2007).

Other approaches are of relevance for all mentioned care settings and have to be specified for them, e.g. tackling an inappropriate multiplicity of drug prescriptions (Vass & Hendriksen, 2005), fall prevention concepts (Anders et al., 2008), geriatric assessments for professional carers and innovative ideas for the delivery of medical supplies.

Additionally, approaches to better services for specific target groups are currently being discussed (e.g. gender-specific, migration-specific approaches: (Lademann, 2006); (Kuhlmey, 2006).

4 Special topics

4.1 Social inequality: Equal access, age, gender and diversity issues

As mentioned above, significant social inequalities regarding health chances (morbidity, functional disability, mortality) are confirmed for Germany as for other European countries.

Both men and women show higher life expectancy and healthy life expectancy with increasing income (the difference in life expectancy at birth in the lowest of five income groups compared to the highest is 10.9 years for men, 8.4 for women; the difference in healthy life expectancy at birth in the lowest of five income groups compared to the highest is 14.3 years for men, 9.8 for women) (Lampert et al., 2007). This shows that social inequalities are greater for healthy life expectancy – which is most relevant for long term care – than for life expectancy in general. There are some indications that those with higher SES gain more from the compression of morbidity (Kroll et al., 2008).

Data on care needs show a corresponding picture: people applying for services in the private long term care insurance (the more affluent insured population) for the first time are 6 years older than the corresponding group in the social long term care insurance (Behrens, 2008).

Long term care delivery seems to add to the inequalities: Long term care services are insufficiently diversity-oriented (SVR, 2009). There are very few services – prevention, rehabilitation, long term care in general – targeted to special groups of disadvantaged older people who are most in need (the poor, ethnic minorities, etc.) and who are known to have difficulties accessing mainstream services. Moreover, there are indications that socially disadvantaged individuals, especially those from ethnic minority communities, are less likely to be positively assessed for long term care services funded by the

social long term care insurance (Okken et al., 2008). This gives reason to assume that vulnerable groups have particular difficulty accessing already scarce preventative and rehabilitative services.

4.2 Involvement of older people in developing prevention and rehabilitation

Within the German social insurance system (with its largely profit-led service delivery and rather weak planning competences of local authorities regarding health and social care), older people and service users are only marginally involved in the planning and development of services.

4.3 Quality assurance

So far quality assurance in prevention and rehabilitation within LTC is only partly developed and follows diverse approaches. Quality assurance in geriatric rehabilitation in Germany is reported to be actually based on seven different approaches, case-based as well as institution-based. Recommendations aim at standardisation of procedures (Lübke & Meinck, 2008).

Regarding quality assurance in LTC in general, current developments were described in section 1.4. Legislation on quality assurance instruments, however, address issues of prevention and rehabilitation only marginally, and predominantly in medical aspects of nursing care (e.g. decubitus prevention). There are detailed guidelines for fall prevention. Other areas of prevention are addressed mainly as information to be given to patients and family carers (e.g. nutrition). Maintaining or promoting mobility, independence or social inclusion and participation are adressed at best indirectly. (https://www.gkv-spitzenverband.de/upload/QPR_Anlage_1_30062009_7606.pdf (quality assurance instrument for home care); https://www.gkv-spitzenverband.de/upload/QPR_Anlage_2_30062009_7607.pdf (quality assurance instrument for care homes))

4.4 Informal carers' needs and contributions

This theme is developed extensively in INTERLINKS Report of Work Package 5 "Informal Care in the Long Term Care System", http://interlinks.euro.centre.org/sites/default/files/WP5_Germany_final_11.pdf)

5 Conclusion

Long-term care in Germany has an established financial and delivery base in the form of the long term care insurance implemented in 1996, and the increasing numbers of long term care providers for home care and care homes since then. The long-term care insurance guarantees basic (partial) coverage of care needs, with three levels of care depending on the assessment of the Medical Review Board, to which all older people people have access in principle. Activating care with positive effects in the sense of prevention and rehabilitation is widely recognised as state of the art.

However against this backdrop of a solidly developed base there are serious weaknesses which have to be overcome in order to prepare the system for the demographic changes, by providing good quality care exploiting existing preventive and rehabilitative potentials for the health of older people.

Future developments should be directed as follows:

- Scarcity of resources has to be tackled since it impacts negatively on qualification of staff and time for care. Further restriction of resources has to be avoided; innovative and client-centered approaches need to be promoted and enabled in mainstream services.
- Unmet needs, as built in the structure of the long term care insurance, need to be monitored especially in groups who cannot buy services privately but are not eligible for additional social assistance allowance.
- Consideration of and orientation on prevention and rehabilitation potentials should be promoted in mainstream long term care services, while paternalistic and de-activating approaches should be further discouraged.
- Services should be developed explicitly for prevention and rehabilitation for older people and especially those with long term care needs; services should be provided and made accessible to all older people in long term care processes.
- Specific services/interventions should be targeted to client groups of older people with specific needs (diversity aspects).
- The knowledge generated from the multiplicity of local good practice pilot projects should be used to shape mainstream services; good practice approaches need to be made sustainable.
- For better planning, development and delivery of comprehensive services, incentives for cooperation have to be implemented to counterbalancing the existing competitive incentives for insurers and providers. Integrated care pathways encompassing cure and care, prevention and rehabilitation, tailored to different and changing care needs of clients, need innovative governance efforts.

6 Literature

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Annex 1: NEP members

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Name	Organisation
Dr. **Bartmann**, Peter	Diakonisches Werk der EKD e. V. (outreach ministry of the Protestant Church of Germany), Federal Association, Berlin
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Dr. **Döhner**, Hanneli	Department of Medical Sociology, University Medical Center Hamburg-Eppendorf
Fuhrmann, Ingrid	German Alzheimer's Society, Carers, Berlin
Hammerling, Rainer	Carers' Organisation, Berlin
Dr. **Heusinger**, Josefine	Institute for Gerontological Research, Berlin
Jansen, Sabine	German Alzheimer's Society, Coordination office of the Federal Association, Berlin
Mauel, Herbert	German Association of Private Providers of Social Services, Berlin
Dr. **Naumann**, Frank	Head of department, Working Group on Geriatrics Brandenburg Protestant Hospital "Gottesfriede", Woltersdorf
Rausch, Ariane	Social Association VdK Berlin-Brandenburg, Berlin
Dr. Richter, Antje	Association for Health and Academy of Social Medicine Lower Saxony, Hannover
Schmidt, Doris	German Red Cross, Berlin
Weritz-Hanf, Petra	Federal Ministry of Family Affairs, Senior Citizens, Women and Health, Unit 306: Health in Old Age, Berlin