

# Wellbeing and Healthy Choices for Older Adults and their Carers

## Intellectual Output 1

### Needs for implementing healthy choices for older adults and their carers: the stakeholder view

#### 01. A2 International Literature Review

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## Introduction

The following international literature review will provide a comprehensive overview of the current situation in all partner countries - Austria, Bulgaria, Germany, Greece, Ireland and Israel. The aim of this document is

- to assess the needs of the target group for the planned e-learning platform that will provide caregivers with information on how to implement physical activity and healthy eating counselling as part of daily care;
- to justify the planned project outcomes by showing the benefits of physical activity and healthy eating for the target groups;
- to provide best practice programmes that will ensure a high quality and appropriateness of the content.

The following international literature review contains information concerning needs and trends of healthy aging in the EU (chapter 1), a summary of the benefits for physical activity and healthy eating for both, elderly people in need of care and the formal/informal carer (chapter 2), and best practice programmes for elderly people in need of care as well as formal and informal carer in the partner countries and internationally (chapter 3). A conclusion will be drawn in chapter 4.

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# 1 Needs and trends of healthy aging in the EU and on the manner of living across partner countries

In this first section, the reader finds information concerning the status quo of care (chapter 1.1), existing supports for people in need of care as well as for carer (chapter 1.2) and country specific requirements in relation to the provision of formal care (chapter 1.3) in the partner countries Austria, Bulgaria, Germany, Greece, Ireland and Israel. The results are summarized in a table covering the most relevant information to allow a better comparison between the countries (chapter 1.4).

## 1.1 Status quo of formal/informal care and elderly people in need of care

The following chapter includes information, facts and figures about the status quo of care in each partner country as well as explanations of types of care available in each country.

### 1.1.1 Austria

**The status quo:** (Statistik Austria, 2014a,b, 2015c)

In 2014, Austria had 8 543 932 inhabitants. The part of people over 65 years amounts 18.4%. This is equivalent to 1 572 083 people. About 13% of men and 8% of women aged over 65 years are still in employment. 6% of people over 60 years have some limitations and 3% have major limitations during walking. 1.8% of people in this age group cannot walk without assistants. (Registerbasierte Statistiken Erwerbstätigkeit, 2015)

**Types of care:** (Statistik Austria, 2014, 2015)

In Austria, elderly people have different possibilities of care: an old people's home (rest home), a day care facility, an assistant living or a nursing home.

- **Care allowance:** In Austria there is a classification system for care allowance. It is divided into seven levels, depending on the monthly amount of hours the person needs to be cared for. In 2014 about 455 000 people received this care allowance. Most of them are classified in level two (130 067 persons). Level one needs more than 65 hours of care per month, the second level over 95 hours per month and in level three more than 120 hours of care are required per month. Level one, two and three represent the target group for the project WHOLE. (Sozialbericht, 2013-2014)
- **24 hours care:** In Austria, an average of 16 600 people require a 24 hours care per month. As long as this is carried out by untrained people and the activity relates to small support, they also fall into the target group of the project WHOLE. It is expected, that due to the rising costs of places in old people's homes, the number of 24 hours care people will rise dramatically. Furthermore, there is a financial support from the government for the 24 hours care. (Pflegevorsorge für ältere Menschen – Sozialbericht 2014)

Currently the focus in Austria on education and professional programs for geriatric is on dementia disease.

### 1.1.2 Bulgaria

**The status quo:** (National Statistical Institute,

[http://www.nsi.bg/sites/default/files/files/pressreleases/Population2014\\_2Y19BGI.pdf](http://www.nsi.bg/sites/default/files/files/pressreleases/Population2014_2Y19BGI.pdf))

**Number of population:** 7 202 198 to 31<sup>st</sup> of December 2014

**Average life expectancy** around 74 years; for men 70.6 years, for women 77.6 years

**Number of persons aged 65+:** 1 440 329 = 20% from the whole population in the country

From them: women 23.2% and men 16.6% (Difference due to the higher mortality among men and as a consequence - lower average life expectancy for them).

#### **Average age of the population 43.2**

According to data published by Eurostat, Bulgaria is one of the European countries with deepest demographic crisis. These negative demographic trends will lead to significant difficulties in terms of financial sustainability of health and social care systems.

#### **Types of care:**

##### **FORMAL CARE**

- The **System for long-term care and social services** in Bulgaria ([www.mlsp.government.bg](http://www.mlsp.government.bg)) has expanded considerably in recent years as a result of an action for deinstitutionalization and providing more community-based family home services from the state. Long-term care for older people in Bulgaria is governed by two separate systems - the health system and social security system.
- **The Social Assistance Agency provides care services in specialized institutions:** homes for old people, homes for adults with physical disabilities, homes for adults with sensorial disabilities, homes for the elderly with dementia, homes for adults with mental disorders.
- **Community services:** centres for social rehabilitation and integration of adults, day care centres for old people, day care centres for adults with disabilities.
- **Professions in the field of elderly care**
  - **Specialist medical care** – can work in hospitals, dispensaries, rehabilitation centres etc. <http://mk.mu-sofia.bg/node/68>
  - **Geriatric specialist** – can work in elderly homes, geriatric departments of hospitals, institutions for elderly care etc. <http://www.unisz.bg/content/%D1%81%D0%BF%D0%B5%D1%86%D0%B8%D0%B0%D0%BB%D0%BD%D0%BE%D1%81%D1%82%D0%B8-1>
  - Professions like “Health assistant”, “Nurse”, “Social assistant” in the area of vocational education - <http://www.navet.government.bg/>

##### **INFORMAL CARE**

Traditionally and because of economic reasons as informal carers for older people in Bulgaria are dealing their relatives - children and grandchildren. In recent years as a result of the open European market, many young people are working abroad. The rest of the country older population began to feel a great need for professional care in their daily lives. Caring for the sick or older person living alone in Bulgaria is as luxurious as it is a question of informal contacts.

As we mentioned above, long-term care for older people in Bulgaria is governed by two separate systems - the health system and social security system. These systems have not built mechanisms for coordination in support of people, which further stops access to the needed services.

#### **1.1.3 Germany**

##### **Types of care and definition:**

In Germany, health care is based on a decentralized and self-governing system run by a number of different players. The German health care system is divided into three main areas: outpatient care, inpatient care (the hospital sector), and rehabilitation facilities. The institutions responsible for running the health care system include the associations and representatives of various providers and professions, health insurers, regulatory bodies and the Federal Ministry of Health.

In Germany, a person in need of care is a person that receives services according to the Sozialgesetzbuch (SGB XI). Services are provided, if a person is not able to fulfil the common daily performances - expected for at least six months - due to physical, cognitive or mental diseases or

disabilities. The decision whether a person is in need of care and how severe the limitation is (care level [3 levels]), is taken by the care insurance<sup>1</sup>. The following care possibilities are supported in Germany:

- family members (informal care/home care): persons in need of care that only receive care allowance
- family members and/or non-residential care services: persons in need of care that are supported by a non-residential (outpatient/ambulatory) care service, mostly with additional support from family members
- nursing homes: persons in need of care that receive fulltime care or partial care (day- or night-time care)

(Statistische Ämter des Bundes und der Länder, 2010, p. 22)

The amount of service depends on the severity level of the limitations (Bundesministerium für Gesundheit, 2016; Statistische Ämter des Bundes und der Länder, 2010, p. 22):

- significantly in need of care (care level I [up to 468 Euro per month])
- heavily in need of care (care level II [up to 1144 Euro per month])
- severely in need of care (care level III [up to 1612 Euro per month])
- Older adults with significant limitations in their everyday expertise (e.g. people with dementia-related limitations in their cognitive functioning, mental disability or mental illness) that are also in need of care but do not fulfil the criteria for care level I, are considered in another care level (0)<sup>2</sup> and therewith receive support up to 225 Euro per month and are allowed to make use of the care service.

The services provided by the care insurance can be (Pflege-Informationsservice Online, n.y.):

- care allowances (for home care; lower than benefits in kind)
- benefits in kind (if care is provided by non-residential care or with support of home care)
- combination of both (if the benefits in kind are not fully used because of additional home care, a care allowance is paid proportionally)

Non-residential care services provide care by qualified caregivers that takes place in the houses of the older adults/persons in need of care and include domestic and nursing care (Statistisches Bundesamt, 2016).

According to the Federal Ministry of Health (Bundesministerium für Gesundheit, 2016), the non-residential care providers support the older adults/persons in need of care in different areas:

- basic care (e.g. personal hygiene, nutrition, mobility and positioning)
- home nursing (e.g. drug administration, dressing changes, injections)

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<sup>1</sup> One of the main principles of the health care system in Germany is the compulsory insurance: People generally must have statutory health insurance (gesetzliche Krankenversicherung - GKV) – provided that their gross earnings are under a fixed threshold (Versicherungspflichtgrenze). Anyone who earns more can choose to have private insurance (private Krankenversicherung - PKV). In 1995 the care insurance was introduced additionally. It covers part of the costs for nursing care and assistance if these services are needed. The providers became a combination of health and care insurances. Usually these are the first contacts if someone needs support (Informed Health, 2015). People are free to choose among the statutory health and care insurance companies. All of the statutory insurers basically offer the same comprehensive catalogue of standard medical benefits. But some insurers also cover the costs of additional things like travel vaccinations or sports and exercise programs. Others offer repayments or bonus programs if one, for example, take part in a prevention course or have the recommended vaccinations done.

<sup>2</sup> Persons with care level 0 do not account yet for statistics (e.g. not for the prognosis: Statistische Ämter des Bundes und der Länder, 2010, p. 27). In statistics that are more current, they are at least mentioned (only for information) (e.g. Statistisches Bundesamt, 2015).

- consultation for questions concerning care (e.g. organization of transport service, provision of contacts for food delivery)
- domestic care (e.g. cooking, house-chores, shopping)
- care service since 2013 (e.g. strolling, reading aloud)

**The status quo older adults in need of care (record date 31.12.2013):**

Table 1: Persons in need of care **2013** classified according to different services (number and quota) (Statistisches Bundesamt, 2015, p. 5)

Persons in need of care 2013 total 2.6 M (65% female)		
Homecare 1.86 M (71%) (61% female)		Nursing home 764 000 (29%) (73% female)
Homecare 1.25 M (47%)	Homecare with support or single supply of non-residential care 616 000 (23.5%)	
	Provided by 12 700 non-residential care providers with 320 000 caregivers	Provided by 13 000 nursing homes with 685 000 caregivers
Additionally 108 740 older adults in need of care due to significant limitations in their everyday expertise (care level 0)		

- people in need of care in nursing homes are older (50% are 85+) than in homecare (31% are 85+)
- people in need of care in the homecare setting have more often care level I and II while older adults with care level III are more cared for in nursing homes (Statistisches Bundesamt, 2015)

Table 2: Persons in need of care **2013** classified to different services (detailed) (Statistisches Bundesamt, 2015, p. 9)

Tab 1.1 Pflegebedürftige nach Art der Versorgung zum Jahresende 2013

	Pflegebedürftige			Pflegestufe			Bisher ohne Zuordnung	nachrichtlich ohne Pflegestufe mit erheblich eingeschränkter Alltagskompetenz	Anteil an Pflegebedürftigen insgesamt	Jeweiliger Anteil der Pflegestufe III	Jeweiliger Anteil der Pflegebedürftigen mit erheblich eingeschränkter Alltagskompetenz
	insgesamt	Veränderungen zu 2011	darunter weiblich	I	II	III <sup>1</sup>					
	Anzahl	%		Anzahl							
Pflegebedürftige zu Hause versorgt .....	1 861 775	5,9	61,3	1 174 179	534 014	153 582	-	97 157	70,9	8,2	25,1
davon:											
allein durch Angehörige <sup>2</sup> .....	1 245 929	5,4	58,4	822 282	334 026	88 821	-	65 638	47,4	7,1	23,7
zusammen mit/durch ambulante Pflegedienste .....	615 846	6,9	67,2	351 897	199 188	64 761	-	31 519	23,5	10,5	27,8
Pflegebedürftige vollstationär in Heimen .....	764 431	2,9	72,7	291 193	302 636	157 164	13 438	11 583	29,1	20,6	59,1
<b>Insgesamt</b> .....	<b>2 626 206</b>	<b>5,0</b>	<b>64,6</b>	<b>1 465 372</b>	<b>836 650</b>	<b>310 746</b>	<b>13 438</b>	<b>108 740</b>	<b>100</b>	<b>11,8</b>	<b>35,0</b>
Ausgewählte Veränderungen zu 2011 in % .....				7,0	2,3	2,0	58,1				

1 Einschl. Härtefälle.

2 Entspricht den Empfängerinnen und Empfängern von ausschließlich Pflegegeld nach § 37 Abs. 1 SGB XI. Empfänger/-innen von Kombinationsleistungen nach § 38 Satz 1 SGB XI sind dagegen in den ambulanten Pflegediensten enthalten.

Table 3: Older adults in need of care **2013** classified according to age (numbers and quota) (Gesundheitsberichterstattung des Bundes, 2015)

Age	Number of persons in need of care	Quota of care in % Both sexes	Quota of care in % male	Quota of care in % female
< 75 years	803 803	1.1	1.1	1.1
75 to < 85 years	863 733	13.9	11.9	15.5
85 to < 90 years	538 799	38.2	29.6	42.1
≥ 90 years	419 871	63.9	51.1	42.1
<b>TOTAL</b>	<b>2 626 206</b> (from 80 767 463 inhabitants)	<b>3.3</b>	<b>2.3</b>	<b>4.1</b>

- Life expectancy: Women 82.8 years, men 77.72 years
- Persons 65+ (2014) 17.05 Mio  
(Statista, n.y.)

**The status quo formal care by non-residential care (record date 15.12.2013):**

- 64% of all non-residential care provider in private sponsorship
- 35% of all non-residential care provider in non-profit sponsorship
- 1% of all non-residential care provider in public sponsorship
- on average, one non-residential care provider cares for 48 persons in need of care
- one non-residential care provider in private sponsorship cares for 37 persons in need of care
- one non-residential care provider in non-profit sponsorship cares for 68 persons in need of care
- one non-residential care provider in public sponsorship cares for 56 persons in need of care  
(Statistisches Bundesamt, 2015, p. 10; 12)

 Table 4: Caregivers in non-residential care **2013** classified according to work agreement (Statistisches Bundesamt, 2015, p. 13)

Employment	Proportion of the total staff in %
Full-time	26.8
Part time > 50%	35.5
Part time ≤ 50% but not marginally employed	13.8
Part time marginally employed	20.4
Apprentices	3.1
Voluntary social year	0.2
Trainee	0.1

 Table 5: Caregivers in non-residential care **2013** classified according to main field of activity (Statistisches Bundesamt, 2015, p. 13)

Field of activity	Proportion of the total staff in %
Care manager	5.3
Basic care	68.5
Care service	3.3
Domestic care	11.8
Management	4.8
Other (e.g. home nursing)	6.3

Table 6: Age distribution of caregivers in non-residential care **2013** (Statistisches Bundesamt, 2015, p. 14)

Age	Proportion of the total staff in %
< 20	0.9
20-30	14.9
30-40	20.2
40-50	28.1
50-60	28.0
60-65	5.5
>65	2.4

Further facts **2013** (Statistisches Bundesamt, 2015):

- 87% of all non-residential caregivers are female
- Education of non-residential caregivers (in total 60% with an appropriate education):
  - Paediatric nurses (3%)
  - Health care professionals/nurses (28%)
  - Geriatric nurses (26%)
- in comparison to 2011, the provision of care by non-residential care providers increased by 7%

#### **The status quo informal care 2002:**

Deufert (2013) summarises results from different studies in her article. A short summary of her findings shows:

- Women provide the biggest part of homecare even if the number of male caregivers in the homecare-setting is rising
- In 2002, women provided 73% of all homecare (the proportion of female caregivers worldwide is 68% at that point)
- While most of the female caregivers in homecare provide their care in the age of 50 to 55 years for their parents, most male caregivers care for their partners in the age of 80 and above.

 Table 7: Relationship of informal caregivers to peoples in need of care **2002** (Deufert, 2013, p. 521)

Family member	Proportion in %
Spouse / partner	28
Daughter	26
Mother	12
Son	10
Daughter-in-law	6
Grandchildren	2
Father	1

#### **Prognosis:**

Based on a prognosis published by the Federal Statistical Office and the statistical Offices of the Länder in 2010, the amount of older adults of 60 years and above will further increase up to 40% of the total German population by 2050. With increasing age, the probability for need of care increases. Not only that the amount of people of 60 years and older increases, but also the age structure changes due to the demographical change. This means that in the age group 60 years and older another trend exists towards an increase in the number of people 80 years and above while the number of people between 60 and 80 years will decrease. Therewith the amount of people with a risk of becoming a person in need of care increases [status-quo scenario]. On the other hand, it may be possible that older adults do not only live longer but also are longer healthy due to better medical care, better nutrition and

increased wealth. Then also the risk of care may decrease [decreasing quota of care scenario]. (Statistische Ämter des Bundes und der Länder, 2010, p. 5; 29).

Both scenarios (prognosis based on the status-quo and prognosis based on decreasing quota of care) are depicted in figure 1. It is shown, that in the status-quo scenario (dark-blue line), the amount of people in need of care may double by the year 2050. This is an increase of 100%. Also the decreasing quota of care scenario (light-blue line) prognoses an increase of the total amount of people in need of care, however, the increase is “only” 67%.

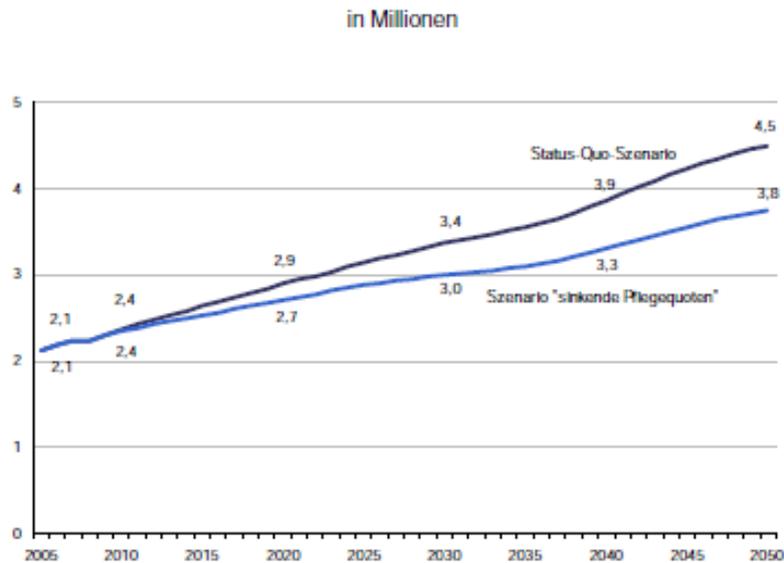


Figure 1: People in need of care (total) in Germany between 2005 and 2050 – comparison between status-quo scenario (dark-blue line) and decreasing quota of care scenario (light-blue line) (Statistische Ämter des Bundes und der Länder, 2010, p. 30)

Another trend seems to develop towards a professional care instead of home care as the social mobility and the employment of women raises. This is a problem as daughters beside spouses provide a main part of the home care (Statistische Ämter des Bundes und der Länder, 2010, p. 22f).

#### 1.1.4 Greece

##### **The status quo:**

The estimated “life expectancy at birth in Greece is almost 81 years, one year higher than the OECD average of 80 years. Life expectancy for women is 84 years, compared with 79 for men” (OECD, n.y.). In 2010 in Greece the percentage of elderly people (aged 65+), was 19% and it is expected to reach 30% by 2060 (<http://www.gerontology.gr/ενημερωθείτε/δημογραφικά-στοιχεία>).

“Those aged 65 years and over constitute 19% of the population (895 384 men and 1 142 867 women) and those aged 80 years and over constitute 4.1% (2007 estimates). (...) the vast majority of older people in need of support from others in their everyday lives rely on the availability of the family, relatives or friends for help, following the Mediterranean model” (Kagiolaris, Mastrogiannakis and Triantafillou, 2010, p. 6).

“Nowadays, professional caregivers in Greece do represent the minority of caregivers in the care system. Social security compensates the patients for the cost of professional carers only for in-hospital services covering only 30% of the total cost (this procedure is extremely long). Informal caregivers include mainly relatives, but also close friends and neighbours. It is important to note, that [since 1990] migrants occupy a central place in the market of formal and informal caregivers. Indeed, in Greece, families have taken benefit of massive female migration during 80's. (...) The majority of them are not formally qualified” (Take Care project, 2014, p. 48).

In Greece, the percentage of personal caregivers who provide care inside of the household is 75.9%. When the age of the informal care provider is 50+, the informal care provider is by 69% the husband/spouse of the care recipient and by 26% his/her children, while for care providers aged 65+ the husband/spouse rises to 85% (Riedel & Kraus, 2011, p. 9; 11).

“According to the Eurofamcare report (2003-2009), the educational level of carers is relatively low in Greece: 37.4% of interviewed caregivers had a low level of education; 40.6% an intermediate (typically those who had finished High School / Lykeio) and 22.1% had a high level of education (university, technical schools etc.). (...) 47.2% of family-informal caregivers were also in paid work. Educational and informational needs of informal caregivers in Greece are high. For example, in Greek literature in-hospital informal caregivers need more information about care techniques, treatments, nutrition, insurance funds etc.” (Take Care project, 2014, p. 48). “The mean total scores for health education needs was  $53.4 \pm 5.7$  (range: 50 to 57) for nurses and  $57.1 \pm 6.9$  (range: 52 to 63) for the in-hospital informal caregivers” (Lavdaniti et al., 2011, p. 3f).

### **Types of care:**

#### **FORMAL CARE - Public**

“**Help-at-Home service** is provided nationwide at the local municipality level, by multi-disciplinary care teams (social worker, nurse, family assistant/s), within the client’s home. The teams work autonomously and across organisations, in cooperation with other health and social care structures. The service was developed in order to help older people with LTC [long-term care] needs to stay at home with a good quality of life and initially focused on meeting the needs of socially isolated older people of low income and without family support. The programme was subsequently extended to allow family carers to work outside the home; it also aimed at the creation of new jobs in the care sector, especially for women in rural areas.

The service provides post-discharge, preventive and rehabilitative care, reduces unnecessary visits to hospital and other health care facilities and replaces or supplements informal family support.

(...)

Help-at-Home enables older people with LTC needs, to stay at home with a good quality of life and initially focused on meeting the needs of socially isolated older people of low income and without family support. By providing day-time care and supervision of older people at home, the service frees family carers to enter the labour market.

(...)

Help-at-Home was initiated by the Greek Ministry of Health and Social Solidarity and further developed by the Ministry of Labour and Social Protection for three main reasons:

- To provide care to disabled and bedridden mainly older people, enabling them to stay in their own homes for as long as possible
- To release the family members, mainly women, from the role of the informal carer in order to enter the labour force
- To create new jobs in the labour market, mainly for women (social workers, nurses, family assistants), in line with the Lisbon agenda.

(...) Help-at-Home addresses the gaps in care between the health sector and the other available alternatives for older people with long-term care needs (see impact below).

The Help-at-Home programme supports partially independent disabled and older people and those with mobility dysfunctions and special problems; priority is given to those who live alone, or do not have the full support of their family, or their income does not permit them to pay for similar services to enable them to live at home with a reasonable quality of life. The programme provides counselling and psychological support, nursing care, family assistance and companionship” (Kagialaris, n.y.).

**"Aid at Domicile of Pensioners" programme:** it aims at elderly people receiving “invalidity or survivor's pension provided by all primary insurance organisations coming under the Ministry of Labour, Social

Security and Welfare (IKA-ETAM, OAEE, OGA, ETAA, ETAP-MME, NAT, etc.) (...) as well as [for] uninsured senior citizens (...) who temporarily or permanently deal with health problems or disability. [Beneficiaries] must live on [their] own or with a spouse or another person who meets the remaining requirements for inclusion in the programme.

The state of [the elderlies] health must render it impossible for [them] to take care of [themselves] or cover [their] daily needs. The programme does not cover pensioners who stay at public, private or voluntary residential care institutions, or at nursing facilities covered by the National Health System (ESY) or private clinics.

- Day Care Centres for the Elderly: day care facilities for elderly individuals who cannot fully care for themselves (due to mobility problems, dementia, etc.) and whose families are unable to care for them because they work or because they face serious social and economic or health problems.
- Open Protection Centres for the Elderly: these Centres are intended for residents living in the area of the Centre who are over 60 years of age, regardless of their financial and social situation” (European Commission, n.y.).

### **FORMAL CARE - Private**

“This sector consists of private organizations and licensed individuals offering a variety of health and care related services for a negotiable fee, either through private hospitals, clinics, Residential care Units for Older People (MFI) and employment agencies for home carers, or through private offices, and nominally monitored by a public body, e.g. the Nomarchia (prefecture). They function on market-based principals (for-profit) and their operational costs are covered by the clients. The personnel should have at least a minimum of trained professional personnel (e.g. for MFI, trained nurse and social worker), as well as usually untrained care staff. Their evolution and expansion is flexible enough to adapt to new needs and market demands for services. Moreover, they have the potential to offer incentives for achieving better quality of service and to operate using the latest management methods, although financial constraints may limit these potentially good practices” (Kagiari et al., 2010, p. 10).

**Residential care homes (MFI):** “There is official data only on legally registered MFIs, which number 120 units from both the public, but mainly private sectors, and with a capacity of up to 10.000 beds. Additionally, many units are registered as hotels so as not to fulfil the official requirements for such institutions and there is no data available for them. The costs of residential care vary from 600 €/month or more for unregistered facilities and from 900 to 3500 €/month (vat [value added tax] 9% included) for legally registered care homes, which are partially covered only by 2 of the smaller social insurance funds (health professionals and engineers)” (Kagiari et al., 2010, p. 11).

**Private not-for-profit organizations:** “This sector includes services and programmes run by NGO’s, charity and philanthropic organisations, churches and their branches and privately funded foundations. They are private bodies, which work on a not-for-profit basis and where the voluntary element is usually quite high. They vary in size and in action while their activities may extend to the international level e.g. Hellenic Red Cross, Doctors without Frontiers etc. They are monitored and regulated by public bodies to assure both the legality and quality of services they provide and staff is composed of both paid employees in cooperation with volunteers. In Greece, as in many other countries, they cover the inadequacies of the welfare system and they are partners of the state in the provision of some social services. These organizations can be particularly flexible, giving ‘voice’ to socially excluded groups and defending their rights e.g. Alzheimer Associations. Their staff and volunteers are usually people with a deep knowledge of the problems in the field and can quickly develop new social programmes in response to changing needs. This ‘3rd sector’ is said to be developing rapidly in the Western World by providing sometimes unique services in the field of social care and policy”. (Kagiari et al., 2010, p. 12).

Descriptions of actions:

The **Help-at-Home programme** “involves specialised, well-organised, multi-disciplinary teams of three individuals per unit, which comprise a social worker, nurse and a family assistant, with the support of a doctor or physiotherapist where necessary.

The social worker is responsible for the assessment and acceptance into the programme of the beneficiaries, evaluates the client’s situation and needs, provides advice and social support and maintains contact with competent agencies, making referrals where needed.

The programme's nurse conducts home visits in order to give preventive advice, undertake a physiological assessment, give personal care, write pharmaceutical prescriptions and escort the individual to the health centre or hospital for specific examinations. She/he also undertakes the ‘training’ of family members in basic care procedures and supports the family.

The programme's family assistant is responsible for undertaking various duties such as cooking, shopping and cleaning the individual's home. Family assistants also offer an additional service, which is probably the most important in the eyes of these individuals, namely, companionship, which illustrates the programme's social nature.

The service is provided currently free to the recipients of care and the cost is covered by national and European funds in the proportion of 75% EU funding and 25% national funding, although more permanent funding sources are being sought.

In 2010 the service consisted of about 1 050 teams running in most municipalities (i.e. over 90% of total coverage), employed 5 000 staff serving over 100 000 beneficiaries, with an annual cost of €35.76 million. 500 cars for staff for the mobile units have already been offered and 120 more are going to be provided by the Ministry of Health” (Kagialaris, n.y.).

**“Day Care Centres for the Elderly:** these centres operate on specially designed premises on a daily basis and can accommodate elderly people for a short time period during the day, offering them care services (daily hygiene and nursing), entertainment and creative activities.

**Open Protection Centres for the Elderly:** these centres provide various entertainment activities, medical care, physiotherapy, occupational therapy, social work, instructions on medical treatment and hospital care. Open Protection Centres for the Elderly operate under the auspices of municipal authorities throughout Greece” (European Commission, n.y.).

### **INFORMAL CARE**

“Informal care is common in Greece and formal care was practically non-existent until the early eighties. A unique formal certification system of caregivers is lacking in Greece” (Take Care project, 2014, p. 18).

“In Greece, the term ‘Informal care’ refers mostly to family care, or care being provided by relatives and friends in the home and by people who are not being paid for this kind of service, either by the patient or by the state or by their organization (in case of a N.G.O.).

The provision of paid but non-professional and often uninsured care by individuals such as migrant care workers, who are privately employed by older people with care needs and their families, currently constitutes an intermediate category of care whose characteristics fall between the formal and informal care sectors (...).

Informal care is estimated to cover the biggest proportion of the needs of the Greek population, although there are no official data and in general, it has to replace the weakness and inadequacies of the Greek health and social care system. This lack of formal support services, combined with greater longevity and increasing needs for care, smaller family size, geographical and social dispersion of families and women working increasingly outside the home, mean that Greek families are forced to find their own solutions to the provision of care” (Kagialaris et al., 2010, p. 4-5).

In general in Greece, “public home care services cover a modest share of the older population in the country (5.6%, close to the 4.9% in Italy, (...)). A noneligible proportion of the existing demand, however, is met by hiring migrant care workers, mostly from the Balkans and Eastern Europe (Lyberaki 2008). The cost of a live-in worker to the family ranged from €450 to €900/month in 2006 (Karamessini

2010), or between 0.72 and 1.44 of the reference income for an older person in the same year” (Bettio & Verashchagina, 2012, p. 97).

#### 1.1.5 Ireland

##### **Status quo:**

- As of 2014, Ireland had a population of 4 832 765.
- 12.4% of the population are aged 65 years or older, which is a significantly lower percentage than many other European countries.
- The elderly dependency ratio is 18.7%.
- The average life expectancy is 78.28 years for males and 82.97 years for females.
- As of 2011, the health expenditures of the Irish state constituted 9.4% of the gross domestic product [GDP] (Indexmundi, 2015).

“There will be a 54% increase in the number of people over 65 over the period 2011 to 2025. In short, in excess of 320 000 additional Irish citizens are entering the zone where sooner or later home care support services will be part of their daily lives” (EPS Consulting for Home and Community Care Ireland, 2013, p. 6).

##### **Types of care:**

- There are more than 400 private and voluntary nursing homes in Ireland, and they provide care for almost 22 000 people (Nursing Homes Ireland [NHI], n.y.).
- “Unlike in many other countries, Ireland does not have a formal home care policy. The sector remains unregulated in terms of the quality of service provision and the lack of clear eligibility and implementation guidelines (at least until 2011) has resulted in uneven provision and hence glaring inequality of access to services and serious fraud and mismanagement of resources. Funding for care services for older people remains disproportionately channelled into residential care (the Fair Deal scheme has statutory backing) rather than home care and there is no legal obligation on the Government to provide home care services” (EPS Consulting for Home and Community Care Ireland, 2013, p. 7).
- “4.5% of older people in Ireland are living in long-term residential care. [This is] 40% above the EU average (EPS Consulting for Home and Community Care Ireland, 2013, p. 13).
- “Only 11% of Irish nursing homes have dedicated dementia units”, and 63% of specialist care is provided by the private sector (Aine McMahon, 2015).
- “By 2020, the number of adults with chronic diseases will increase by around 40%, with relatively more of the conditions affecting those in the older age groups.
- “Furthermore, between 2010 and 2020 the number of adults with diabetes is expected to rise by 30%, the number with chronic obstructive pulmonary disease by 23%, the number with hypertension by 28% and the number with coronary heart disease by 31%” (Healthy Ireland, 2013, p. 9).

#### 1.1.6 Israel

In 2009, 9.8% of the Israeli population was 65 years old and over; and this rate is expected to reach 14% by 2030, the share of the population aged 75 and over, in the population over the age of 65, increased from 39.8% in 1995 to 47.7% in 2009.

In December 2010, there were 143 912 long-term care (LTCI) beneficiaries (Israel National Insurance Institute), in 2007 approximately 20% of the over 65 population was institutionalized. In 2008, there were 42 beds in institutions per 1000 elderly people.

Between 1988 and 2010, the Israeli government spent approximately \$11.5 billion (in 2010 prices) on home care services (Israel National Insurance Institute, various years). The Israeli parliament passed

the initial framework law for LTCI in 1980, authorizing the Israel National Insurance Institute (NII) to collect LTCI fees.

In April 1988 LTCI benefits were introduced for the first time, the LTCI aimed at complementing, rather than replacing, the limited system of service provision in place.

The Ministry of Welfare and Social Affairs bears the responsibility of institutional care, personal care, and home services for the semi-independent (those who have some ADL dependency), as well as for the frail elderly (those who have moderate ADL limitations). It is also responsible for day care and sheltered housing. The Ministry of Health is responsible for the severely dependent and mentally frail elderly. Personal and home services for the semi-independent, frail and severely disabled and mentally frail elderly living in the community are under the responsibility of the NII.

Family status (2012) 59% of the elderly are married, 28% widowed, 10% divorced, and 3% single. Significant differences between men and women become more marked with age. Among the 65-74 age groups, 82% of elderly men are married, compared with 58% of women. Among the 75+ age group, 71% of men are married, compared with only 29% of women. Living arrangements 46% of elderly persons who reside in the community (97% of the elderly in Israel) live in households consisting of couples without children, 23% live alone, 12% live in a household comprising a couple with children, 5% live in a household comprising a single parent and his or her children, and 14% live in other types of arrangement. The elderly who do not live in the community (approx. 3% of the elderly population) reside in long-term care institutions (homes for the aged, hospitals for the chronically ill, or various forms of nursing homes). 23% of Israel's elderly live alone. The percentage is lower than in other industrialized countries (such as in Scandinavia, where it is about 35%) and higher than in developing countries (such as in Ethiopia, India, and Morocco, where it is below 6%). The proportion of elderly who live alone increases with age (17% among people aged 65-74, and 30% among those aged 75+). The percentage is much higher among elderly women than among elderly men (32% and 12%, respectively).

(see comment under: Elderly in Israel Statistical Yearbook, 2014).

## 1.2 Existing supports for formal/informal carers and elderly people in need of care

In each country, several supports exist for carers and elderly people in need of care to support the people concerned in their daily activities and with the coping of the care-situation. These can be found in the following section.

### 1.2.1 Austria

- Conversation: One available program is for people who care their relatives. It is a free of charge conversation with a psychologist that should help them to overcome psychological stress.
- Program for farmers: A comparable program is existing for farmers, where experienced nurses visit them at home to find out the stress level and psychological burdens for relatives. They found out, that about 80% of relatives who care at home, have psychological burdens.
- Hospice and palliative care: Is for severely incurable people to allow them the best quality of life possible.
- Internet platform [www.pflegedaheim.at](http://www.pflegedaheim.at): In 2014 about 60 000 people used this platform. It is mainly a FAQ catalogue for caring relatives concerning care relevant topics (e.g. mobile care, hospice an palliative care, support groups, financial support, ...).
- Care phone: The Social Ministry offers a telephone support for people who have no internet. They answer all care relevant questions, mainly questions concerning the organization of care at home. (Österreichischer Pflegevorsorgebericht 2014, 2015)

### 1.2.2 Bulgaria

- Supports provided by the Social Assistance Agency
  - Specialized institutions:

- 81 homes for old people
- 21 homes for adults with physical disabilities
- 4 homes for adults with disabilities sestivni
- 14 homes for the elderly with dementia
- 13 homes for adults with mental disorders
- Community services:
  - 81 centres for social rehabilitation and integration of adults
  - 47 day care centres for old people
  - 74 day care centres for adults with disabilities
- Hospices - state, municipal, private
- Private organizations providing social services

(Social Assistance Agency, [http://www.asp.government.bg/ASP\\_Client/jsp/main.jsp](http://www.asp.government.bg/ASP_Client/jsp/main.jsp) and Association Alzheimer Bulgaria, [www.alzheimer-bg.org](http://www.alzheimer-bg.org))

### 1.2.3 Germany

#### **Family caregivers:**

An overview about the support for family caregivers is provided by the Verbraucherzentrale (2016):

- Care consultation in care support points. (*Nurses or social workers provide independent advice and support for elderly people in need and their carers. They are supposed to create an individual aid plan by visiting people at home and usually inform carers about free training courses*) and (since January 2016) being eligible for individual case accompaniment and care consultation by the care insurance.
- Financial support. (Additionally to the services provided by the care insurance, a person in need of care may be evaluated as severely disabled and may claim for a disabled person's pass that allows discounts in public transport and other services.)
- Support groups. (*They are organized by people having the same problems and who are sharing their experiences. In some provinces these self-support groups have built local service and contact points to coordinate the requests.*)
- Care service. (The care insurance pays for care/support that can be provided in groups or part time at home, it can also be provided by non-residential care provider.)
- Short-term care in a nursing home for up to 8 weeks per year if homecare is temporary not possible.
- Prevention care with a professional caregiver or in a nursing home for up to 6 weeks per year if the family caregivers are not able to care by themselves (vacancy, illness).
- Free nursing care courses.
- Cures. (Only supported by some care insurance companies.)
- Support for employed people in homecare: family care time. (see also Bundesministerium für Familie, Senioren, Frauen und Jugend, 2015)
- 10 days break from work in acute care situations with wage-replacement benefits. (Care support fund)
- Care time: Up to 6 months complete or partial exemption from work (for under aged persons in need) and up to 3 months for support in the last phase of life, with interest-free loan.
- Family care time: Exemption from work for up to 24 months (a minimum of 15 hours work per week have to be done), with interest-free loan.
- Particular protection against dismissal.

Additional support online:

- psychological online support for informal caregivers (<http://www.pflegen-und-leben.de/>)
- online forums (e.g. <http://www.pflegendeangehoerige.info/>)

- contact data for self-support: <http://www.patiententelefon.de/pflege-und-therapie/pflege-rehabilitation/pflegende-angehoerige>
- online adviser (e.g. <http://www.senioren-ratgeber.de/wohnen-pflege>)

Additional support paper based:

- Adviser for relief of informal caregivers (Bundesarbeitsgemeinschaft der Senioren-Organisationen e.V [BAGSO], 2012)
- Care adviser (Bundesministerium für Gesundheit, 2015b)

### **Persons in need of care:**

See financial support described above

#### 1.2.4 Greece

“According to the Greek Constitution, the family is responsible for the care of its dependent members of all ages. Where the family cannot provide such care, the state intervenes by taking special measures for groups such as the elderly or the disabled. In this sense, responsibility is delegated to both the family and to the state. However, given the legislators’ wide discretion with regard to the implementation of social rights and the Mediterranean welfare regime that is dominant in Greece, the enforcement of this provision is rare and, in essence, the family undertakes the whole responsibility. A good picture of the prevailing situation is given in a national report written within the framework of the EU-funded project *Services for supporting family carers of elderly people in Europe: Characteristics, coverage and usage* (Mestheneos, Triantafillou & Kontouka 2004). As indicated in the report, no national policies exist that directly concern family carers and they have no legal entitlement to benefits. Pension and insurance rights, as well as allowances, are not available. It is common practice for family carers to use the incapacity pensions and invalidity allowances provided by social insurance funds and welfare services to the individuals being cared for to aid them in their caring activities. Sometimes, family carers use private residential homes for short-term respite care, even though these may be of questionable quality. In addition, few service providers are aware of the needs of family carers and what forms of support can best help them. Psychosocial services are available in the community mental health centres, but they are not specifically geared to providing counselling to family carers and there is no data on their use. The lack of an official policy has resulted over the past few years in the setting up of self-help groups – such as the Alzheimer’s Association – and volunteer organizations for the support of family carers. Nevertheless, their total number is small” (European Observatory on Health Systems and Policies, n.y.).

“Changes introduced by the [NHS] included increasing the number of hospital beds from about 34 000 in 1983 to more than 52 000 today, and increasing the number of doctors to more than 54 000, with a high ratio of doctors/population (4.9/1000) compared with an average of 3/1000 in OECD countries (OECD, 2005). On the other hand, there is a staggering lack of nursing personnel with a ratio of 3.9/1000 compared to the OECD average (18 countries) of 8.2/1000 (OECD, 2000) and with major implications for the LTC sector” (Mastrogiannakis, Kagialaris & Triantafillou, 2010, p. 3f).

Nowadays, as we described above, “professional caregivers in Greece do represent the minority of caregivers in the care system. Social security compensates the patients for the cost of professional carers only for in-hospital services covering only 30% of the total cost (this procedure is extremely long). Informal caregivers include mainly relatives, but also close friends and neighbours. It is important to note, that [since 1990] migrants occupy a central place in the market of formal and informal caregivers. Indeed, in Greece, families have taken benefit of massive female migration during 80’s. (...) The majority of them are not formally qualified” (Take Care project, 2014, p. 48).

“Immigrant women working in the care sector constitute an important part of the economic and family life of many Greek men and women. (...)

There is no official data on these workers, who may register with an employment agency, but are paid directly by the older person or their family, usually without a formal contract. They are mainly untrained middle-aged women with either legal, or more frequently illegal work or residence status. The [employment] contract [(whenever exists)] does not always cover social security contributions, as most of the women who are illegal do not ask about it from fear that they may be deported” (Kagialaris et al., 2010, p. 29).

“The arrival and the work of these women constitute an important part of the informal sector not only of the Greek economy but also of the economy of the countries of the immigrant women and intermediary countries situated between their homeland and Greece (Vassilikou, 2007). Upon their arrival in Greece, the women approached certain employment agencies targeting immigrant workers, regardless of their residence status (legal or not)” (Kagialaris et al., 2010, p. 27).

“There is some political rhetoric about supporting the family, but it is clear that family carers are viewed primarily as a resource and not considered to have their own needs for support. There is no type of benefits such as cash, pension credits/rights or allowances for the carers, although supporting a dependent older relative with an income below 500 euros a month may be claimed for income tax relief. The costs of caring are not only in terms of time but also direct costs, yet few carers receive any kind of financial support or benefit, with just 2.1% reporting receiving such help (Triantafillou et al., 2006).

The only supporting services for carers, mainly in Athens or other big cities, are self-help and support and training groups designed for family carers of patients with special care needs. For example, the Hellenic Gerontological and Geriatric Society and the NGO ‘Alzheimer Athens’ organize supporting groups for carers of people with Alzheimer disease. (...) The programme ‘Help at Home’ being run by the municipalities, only covers some needs of older people - where it exists - and may be a ‘helping hand’ to people who care for older relatives; although, the service addresses mainly isolated older people, it also aims to serve those who receive help from female relatives, who may thus be released to enter the labour market” (Kagialaris et al., 2010, p. 16).

#### 1.2.5 Ireland

##### **Carers:**

There are several organisations in Ireland that focus on providing carers with personal and legal support, career training and political representation, for example Family Carers Ireland, The Carer’s Association Ireland, Care Alliance, and Self Care for Carers.

##### **Elderly people in need of care:**

There are more than 400 private and voluntary nursing homes in Ireland. These currently provide care for almost 22 000 people (NHI, n.y.).

The Health Service Executive [HSE] (n.y.a) provides free home care packages based on the individual’s specific needs, as well as the Nursing Homes Support Scheme, a scheme of financial support for people who need long-term nursing home care.

In addition to this, there are many private and non-profit organisations such as Family Carers Ireland offering home care services and domestic help for older people, as well as ‘befriending’ services aimed at elderly people who live at home and mainly require companionship and social interaction.

#### 1.2.6 Israel

In addition to the universal services such as community health services and hospitalization, for which the elderly are eligible like every other age group, Israel provides a system of special services for them. This system is divided into community-based services provided in the home of the elderly person or at various day-care facilities, and institutional long-term care services provided in.

The health funds and the Ministry of Health provide all health services included in the Basket of Health Services as mandated by law. The National Insurance Institute and the Ministry of Social Affairs and

Social Services are responsible for providing certain services, while the Ministry of Senior Citizens Affairs also coordinates projects for senior health-care.

Examples of special services in Israel:

- **Yad LaKashish:** Provides stimulating work opportunities, a warm community environment, and invaluable support services for hundreds of needy elderly from Jerusalem.
- **Family Care- Reuth-Eshel:** one of Israel's leading nonprofits in the fields of health, welfare & old age, Reuth Medical & Rehabilitation Centre is today one of the country's most advanced facilities for rehabilitation and long-term care it also provide nursing home for the elderly.
- **Eshel** - Association for Planning & Development of Services for the Aged in Israel, Eshel provides programs to encourage healthy living such as: Community classes, Fitness clubs for people over 60, Nordic walking workshops, Local and regional walks, Community centre activities in smaller municipalities.
- **TTAD:** Assistance for the Institutionalized Elderly - This organization enlists volunteers to old-age homes. The volunteers organize cultural entertainment at the homes, and acquire special equipment for these institutions and the individuals living there. They seek to improve the rights of the elderly living in institutions.
- **Shilo:** Association for Promoting Services for the Elderly in Haifa - This organization is concerned with the promotion of awareness of the place of the elderly in the community. It offers home services and community services in conjunction with the relevant professional organizations.

### 1.3 Country specific requirements in relation to the provision of formal care

To receive formal care, there are different kind of requirements in each country. These can be found in the following section. Some countries also provide information on requirements to become a formal carer.

Remark: This question was interpreted in different ways that not all answers are going in the same direction.

#### 1.3.1 Austria

##### Care allowance

The key factor for most of the support is the care allowance classification. Care allowance is a financial support that allows people to stay at home. (Sozialbericht, 2013-2014)

To get a place in a nursing home you need at least level 3.

Possibilities:

- Home care (Diplomierte Gesundheits- und Krankenschwester) (wound dressings, medicines, nursing process and is carried out by a nurse)
- Mobile nursing care (Fachsozialbetreuer) (basic care, to wash, get dressed, mobilize and is performed by a qualified social worker)
- Home Help (Heimhilfe) (little support in everyday life and is carried out by home helps)
- 24 hours care (uneducated people)

#### 1.3.2 Bulgaria

The social services in Bulgaria are decentralized, their management is entrusted to the mayors. The Social Assistance Agency (SAA) maintains a register of persons and legal entities, providing social services. Social services in Bulgaria may be financed by the Republican budget as delegated activities, municipal budgets, local activities, and as part of various projects by national and international programs, also by self-financing, where services are provided by registered private suppliers.

The NATIONAL STRATEGY FOR HEALTH AND LONG TERM CARE is existing since 2014 and is closely linked to policy and strategy documents, which relate to the development of services for long-term care for elderly and people with disabilities as

- National strategy for reducing poverty and promoting social inclusion 2020;
- An updated National Strategy for Demographic Development of the Republic of Bulgaria (2012 - 2030 );
- updated Employment Strategy of the Republic of Bulgaria 2013-2020;
- National Concept to promote active aging in Bulgaria (2012 - 2030) etc.

### 1.3.3 Germany

There are different ways to receive formal care in Germany. One way to receive formal care at home is to have a medical prescription. § 92 SGB V (Code of Social Law) and the guideline of the Federal Joint Committee (Gemeinsamer Bundesausschuss [GBA], 2014) concerning the prescription of home care regulate the details. With a medical prescription the person doesn't have to be in need of care in terms of the care insurance. The health insurance company takes the costs. Until December last year the doctor could only prescribe treatment care and then combine this with basic care. Through a change in law now they are allowed to prescribe basic care without combination (§ 37 Absatz 1a; SGB V).

This is different if the person is in need of care in terms of the care insurance. In this case SGB XI (Code of Social Law) defines the regulations and requirements. Depending on the severity of the impairment and the need of care the person receives a certain amount of money from the care insurance (§§ 36, 37 SGB XI). To get this, a person is assessed by the care insurance. More information are provided in question 1.

Non-residential care provider (e.g. DRK, Malteser) do also offer the same care for persons in need of care without care level, however, the person has to pay the service individually. The same is valid for most nursing homes.

To apply for a public nursing home however, it is necessary to be evaluated with a care level 0, otherwise a person has no claim on a place in a public nursing home (Pflegeagentur 24, 2010).

### 1.3.4 Greece

"In Greece at present, there are several ways to become a professional caregiver:

- The first way, and the longest one, is to get a nurse qualification or to get a technical degree for nurses. Technological Universities and Universities offer 4 year learning for nurses. After the bachelor degree the possibility is offered to continue their education on Master of Nursing degree.
- The second way to become a caregiver is to follow some specialized technical courses (lasting from 1 to 3 years). These are the main specialized professions (<http://epagelmata.oaed.gr/show.php>):
  - 'Home caregiver for elderly': she/he works as a sole practitioner in adults residence. Related studies are offered in public and private schools (IEK) of Health and Social Services, with duration of studies ranging from two to four semesters of study and going till level 3 +.
  - 'Carer for minors': she/he works both in hospitals and clinics, and at home for minors or in orphanages. The majority of workers in this occupation are women. Related studies are offered in public and private schools (IEK) of Health and Social Services, with duration of studies ranging from two to four semesters of study and going till level 3 +.

The last way is to obtain a certification by EOPPEP. *EOPPEP is the National Organisation for the Certification of Qualifications and Vocational Guidance*, an all-encompassing statutory body investing on better quality and more efficient and reliable lifelong learning services in Greece. EOPPEP aims at quality assurance in inputs, outputs-learning outcomes and vocational guidance & counselling services. The occupational profile of 'attendant to personal care', provided by EOPPEP, concerns only caregivers

working in public organizations such as KAPI (semi residential centres), public services such as ‘ambulant home care services’, a few NGO's and Charity organizations. These caregivers are the less qualified of all professional caregivers. In order to be registered and certified by EOPPEP one has to be a graduate of secondary education (basic general or vocational undergraduate schools) and must be trained in the field for a period lasting between 6 and 18 months” (Take Care project, 2014, p. 47).

#### 1.3.5 Ireland

Elderly people can apply for the HSE’s Nursing Homes Support Scheme in order to receive a contribution towards their nursing home costs. The scheme applies to public, private and voluntary nursing homes. To be eligible, the person must “have been living in [Ireland] for at least a year or (...) intend to live here for at least a year” (HSE, n.y.b). Before support is granted, the HSE carries out a Care Needs Assessment and a Financial Assessment (HSE, n.y.b)

People who wish to stay home rather than being admitted to a nursing home can apply for the HSE’s Home Care Package, which may include home help hours, nursing care, physiotherapy, respite care and other services. There is no means test required for this scheme, and the state covers the complete costs. The HSE does, however, carry out a Care Needs Assessment to determine the level and type of care required (HSE, n.y.c).

Various charities, non-profits and private care services also provide at home care and senior support for older people. A comprehensive list of private organisations providing care can be found on the website, Senior Care (Senior Care, n.y.).

“The Health Information and Quality Authority [HIQA] is the independent Authority which has been established to drive continuous improvement in Ireland’s health and social care services. The Authority was established as part of the Government’s overall Health Service Reform Programme” (HIQA, 2009, p. 1). “The Health Act of 2007 requires that all ‘designated centres’, including residential care settings for older people, must be inspected by and registered, whether run by the HSE, private providers or voluntary organisations. This ensures equity of treatment across the whole sector and supports the aim of delivering consistent standards of service to residents regardless of the provider of the service” (HIQA, 2009, p. 7). They have compiled National Quality Standards for Residential Care Settings for Older People in Ireland. The Standards for Health Promotion, which is the section most relevant to the aims of WHOLE, are as follows (HIQA, 2009, p. 25):

“12.1 The residential care setting has a health promotion policy devised in consultation with the residents.

12.2 The residential care setting provides opportunities for the resident to pursue healthy lifestyle choices and recreational activities.

12.3 The resident’s general physical and mental health is promoted through the provision of social contact and appropriate health promoting interventions, devised and reviewed by allied health professionals.

12.4 Opportunities are provided for indoor and outdoor exercise and physical activity, personal development, communication and other psychosocial development”

#### 1.3.6 Israel

According to the Central Bureau of Statistics (CBS), at the end of 2014, Israel had a population of 8.3 million people. The elderly population was 900 000 – 11% of the general population. One in four households in Israel included someone aged 65 or over.

Israel is equipped with a dynamic, culturally active, heterogeneous population; arabs (Muslims, Christian Arabs, and Druze) represent 8% of the elderly population. The Arab population is relatively young, however, and the proportion of elderly among the Arab population stands at 4%, compared with 13% in the population of “Jews and others” (Jews, non-Arab Christians, and persons not classified by religion., The country’s heterogeneous population requires reference to each population

specifically. Formal care should take into consideration the populations manners such as: language, culture, food and habits.

CBS population projections expect the elderly population to reach 1.66 million in 2035 – an 84% increase from 2014. In historical terms, the proportion of elderly in the general population has doubled since the 1950s and is expected to reach 15% by 2035. The percentage of Arabs in the elderly population is expected to rise from 8% to 14%. The rate of increase of the elderly population is expected to be 2.3 times that of the general population in this period. Only 21% of elderly Jews were born in Israel compared with 75% of the Jewish general population. 22% of the elderly population immigrated to Israel since 1990, the majority from the former Soviet Union.

Geographical perspective the country's largest city, Jerusalem, is home to more elderly than any other city in Israel – 72 000 people. Despite this, Jerusalem is a relatively “young” city, with the elderly constituting just under 9% of the total population.

Bat Yam, Haifa and Kiryat Yam have the highest percentage of elderly per locality (20% on average, 2.3 times that of Jerusalem). 39% of the elderly population lives in Israel's eight largest cities: Jerusalem, Tel Aviv-Yafo, Haifa, Rishon Leziyon, Petah Tikva, Be'er Shiva, and Netanya. These cities account for 32% of the total population.

(Comment: Elderly in Israel Statistical Yearbook, 2014)

#### 1.4 Summary

The following table shows a short summary of the results gained in the national literature reviews. It is shown that there are some similarities (especially in the types of care) but also some differences (especially in the supports for carers and the elderly) between the countries.

Country	No. Inhabitants (data from year)	No. Persons 65+ (%)	Quota or number of people in need of care	Life expectancy	Types of care (no. of persons receiving care)	Existing supports for carers and elderly people in need of care	Requirements in relation to the provision of formal care
<b>Austria</b>	8 543 932 (2014)	1 572 083 (18.4%)	not provided	men 79.2 women 84 years total 81.7 years	- Care allowance (455 000) - 24 h-care (16 600) provided by formal or informal carer - old peoples home - day care facility - assisted living - nursing home	- Conversation - Hospice and palliative care - Internet platform - Care phone	Requirements to receive care: - care allowance classification
<b>Bulgaria</b>	7 202 198 (2014)	1 440 329 (20%)	not provided	men 70.6 women 77.6 years total 74 years	Formal care by health and social security system: - specialized institutions - community services Informal care	- Institutional support (homes for older adults) community services (day care centers) - Hospices - Private organizations providing social services	Requirement to become a formal carer: - nurse qualification - specialized training course, or - certification
<b>Germany</b>	80 767 463 (2013)	17.05 Mio (20.6%)	3.3% of all Germans (no. and quota raises with increasing age while the highest number of people in need of care is	men 77.72 years women 82.8 years	Formal care: - nursing home (764 000) - homecare (1,86 Mio) - by outpatient care provider or together with informal care 616 000) - only informal home care (1,25 Mio)	Family caregiver: - Care consultation - Financial support (care allowance) - Support groups - Care service - Short-term care - Prevention care - Free nursing care courses - Cures	Requirements to receive care: - medical prescription or care allowance classification

			in the age group 75-85 years)			<ul style="list-style-type: none"> <li>- Family care time</li> <li>- Online support</li> <li>- Paper based support</li> </ul>	
<b>Greece</b>	not provided	2 038 251 (19%)	not provided	men 79 years women 84 years	Formal care: <ul style="list-style-type: none"> <li>- Help-at-home service</li> <li>- Aid at domicile of pensioners programme</li> <li>- day care or open protection centres for the elderly</li> <li>- residential care homes</li> <li>- private not-for-profit organizations</li> </ul> Informal (home) care (75.9%)	<ul style="list-style-type: none"> <li>- Lack of support (financial such as cash or allowance)</li> <li>- Few support and training groups in bigger cities</li> </ul>	Requirement to become a formal carer: <ul style="list-style-type: none"> <li>- nurse qualification</li> <li>- specialized training course, or</li> <li>- certification</li> </ul>
<b>Ireland</b>	4 832 765 (2014)	12.4%	18.7%	men 78.28 years women 82.97 years	<ul style="list-style-type: none"> <li>- nursing homes (22 000)</li> <li>- formal care remains unregulated, the funding for care mainly lies in residential care rather than home care</li> </ul>	<ul style="list-style-type: none"> <li>- Organizations focussing on providing personal and legal support to carer</li> <li>- Private and voluntary nursing homes</li> <li>- Free home care packages</li> <li>- Home care services and domestic help as well as befriending services</li> </ul>	Requirements to receive care: <ul style="list-style-type: none"> <li>- Elderly people apply for support (Care Needs Assessment and Financial Assessment)</li> </ul>
<b>Israel</b>	8.3 Mio (2014)	9.8%	143 912 persons received long-term care in 2010	not provided	<ul style="list-style-type: none"> <li>- home care service</li> <li>- institutional care</li> <li>- personal care</li> </ul>	Special services (description in chapter 1.2.6) <ul style="list-style-type: none"> <li>- Yad LaKashish</li> <li>- Family care- Reuth-Eshel</li> <li>- Eshel</li> <li>- TTAD</li> <li>- Shilo</li> </ul>	not provided

## 2 Physical activity and nutrition counselling as part of healthy living

While talking about “healthy living” and “health”, one has to be aware of the different dimensions of health. In 1946, the World Health Organization (WHO) defined health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (Grad, 2002, p. 984). This definition is often criticised due to several reasons but there exist some proposals for an adaptation of the definition. We would like to follow the proposal from Huber et al. (2011) that describe “health as the ability to adapt and to self manage” (Huber et al., 2011, p. 3). With their proposal, they cover the physical, mental and social health. This approach is similar to Beckers’ approach (2007), who does not only want to focus on risk factors for health (bio-medical understanding) but on personal (physical and psychological) and social health resources that maintain individuals healthy and that allow the elderly and the carer to create their live as independent and flexible as possible. Physical activity and healthy nutrition can contribute to build these health resources that allow the elderly and the carer to stay as independent and capable to self-manage as possible even if the elderly are officially classified as a person in need of care.

Physical activity and healthy nutrition as part of a healthy lifestyle have many benefits for our physical, social and mental health as well as our quality of life. This chapter provides a short overview of the meaning of physical activity and diet for health without claiming to be complete. Professor Netz provided the following short summary of advantages of physical activity for older adults in the Active Needs Analysis Research Report (Active I, 2014, p. 24f). “Strong evidence demonstrates that compared to less active men and women, older adults who are physically active have (American College of Sports Medicine (ACSM), 2009; Haskell et al., 2007; Mechling & Netz, 2009):

- 1) Lower rates of coronary heart disease, hypertension, stroke, diabetes, colon and breast cancer and a higher level of cardiorespiratory and muscular fitness.
- 2) A healthier body mass and composition and enhanced bone health.
- 3) Higher levels of functional health and a lower risk of falling.
- 4) Better cognitive functioning (Colcombe & Kramer, 2003).
- 5) Higher levels of well-being (Netz, Wu, Becker & Tennenbaum, 2005).”

Furthermore, a “healthy and nourishing eating helps to promote health and prevent chronic disease, and contributes to daily life activity, energy and mood, as well as maintaining functional independency in elderly” (Active I, 2014, p. 29). One has to consider, that for older adults both a mal- and an excess-nutrition may be a problem.

Both aspects of a healthy lifestyle are important for people in all ages, regardless if they are older adults, elderly persons in need of care or caregiver. All people can benefit from a healthy lifestyle. This is also shown in a self-perception study conducted with cancer survivors and their caregivers participating together in an exercise and nutrition program: After participating in a 12-week long program, the caregivers perceive an improved muscle strength and muscle endurance, balance, flexibility as well as enhanced activities of daily living performance for themselves and the cancer survivors that they are caring for (Anton, Partridge & Morrissy, 2013). Another study with Alzheimer’s patients and their caregivers showed that compared to a control group, the participants (patients) of a 6-month motor intervention program could maintain their capacity level (mobility and communication) while the level decreased in the control group. The caregiver who followed the program had a reduced care burden in comparison to the control group (Canonici, Andrade, Gobbi, Santos-Galduroz, Gobbi & Stella, 2012).

Besides these benefits already mentioned, one must not forget the psychosocial benefits that one could expect from physical activity as part of daily care. Being physically active together may bring diversity and fun in the daily nursing routine, and may enhance the mood of carer and care receiver as well as the relationship between the carer and care receiver (“quality time”, Anton et al., 2013). For the carer, being physically active can also act as a stress-reliever (Loi, Dow, Ames, Moore, Hill, Russell & Lautenschlager, 2014) may reduce the (perceived) care burden (Loi et al., 2014; Orgeta & Miranda-Castillo, 2014) and offers time for oneself as proposed in several adviser (e.g. BAGSO, 2012). Especially the nutrition part may also improve the caregiver self-perceived abilities (Anton et al., 2013).

As stated above, these are only few data showing the benefits of physical activity and nutrition counselling for carer and care receiver. There already have been more studies focussing on different health benefits, different target groups and with different programs. The data provided above are seen as a short overview proofing that physical activity and a healthy nutrition have may different benefits for health. The next chapter gives an overview of already existing programs and resources for older adults and their caregiver.

### 3 Practice examples

The following section contains an overview of existing programmes and resources for formal/informal carer and elderly people in need of care in all partner countries (chapter 3.1), as well as international programmes and resources for carer and elderly people in need of care (chapter 3.2). An overview of programmes and resources can be found in chapter 3.3 (summary).

#### 3.1 Programmes or resources for formal/informal carers and elderly people in need of care in the partner countries: reach, effectiveness and content

In the partner countries, there already exist some programmes or resources for formal/informal carers and elderly people in need of care. The programmes identified by the partners and provided below are not only in the context of physical activity and/or nutrition but do also consider the proper qualification of the carer, the use of electronic devices in the care setting or social aspects. The focus of research was slightly different in each country (also based on the experiences/background of each partner organization) and does not claim to be complete, but overall, there exists a great variety of programmes and resources throughout the partner countries covering physical activity, electronic devices, social care and qualification of caregivers. There are only a few results covering the aspects of healthy nutrition.

##### 3.1.1 Austria

In Austria there are programs for formal and informal carer. On the one hand there is professional care (home nursing, mobile services) and on the other hand there is the situation of the relatives (how they can be supported in their situation). (Pochobradsky, Bergmann, Brix-Samoylenko, Erfkamp, & Laub, 2005).

The health promotion of people over 65 years, living at home, is more or less not-existing. Also in a nursing home they focus primarily on prevention of complications, not on health promotion.

Another growing part in care (not nursing) is the 24 hours care. This is carried out mainly by foreign people. These people do not need any additional training in nursing care. Especially for these people the project WHOLE can be a support. The 24 hours care is an essential part in care for disabled people. (Eiffe et al., 2012)

##### 3.1.2 Bulgaria

Examples for programmes/projects in the field of social care for elderly:

- As successful social services for support of families in care of a dependent family members, can be mentioned: "personal assistant", "social assistant" and "home carer". These social services are provided since 2003 by the **National Programme "Assistants for people with disabilities"**, which provides home care to people with permanent disability or seriously ill people, through inclusion of unemployed people as their carers. In the same area also NGOs are working and the models of social care services, implemented by them, are very innovative. [http://www.az.government.bg:7777/eng/internal\\_en.asp?CatID=15/09&WA=YearBuletin/Buletin\\_2005/4.2.htm](http://www.az.government.bg:7777/eng/internal_en.asp?CatID=15/09&WA=YearBuletin/Buletin_2005/4.2.htm)
- **Project "Home care for an independent and dignified life"** in the frame of Bulgarian – Swiss program "To reduce economic and social differences in EU" – partners Bulgarian Red Cross, Ministry of Social Care and Labor, Health Ministry, Swiss Red Cross – established 4 centres for home care services in 4 small municipalities [http://www.redcross.bg/projects/active\\_projects/home\\_care\\_new.html](http://www.redcross.bg/projects/active_projects/home_care_new.html)
- **Social care service „Home care"** – health and psychological support for elderly, help in everyday activities - Bulgarian Red Cross - <http://home-care.bg>

- **Program “Home care”** - Association Caritas Bulgaria - For the elderly people Caritas implements a Home Care Program. There are 8 Caritas Home Care Centres in Sofia, Ruse, Belene, Burgas, Plovdiv, Rakovsky, Malko Tarnovo and Zhitnitsa. They provide, through the Caritas mobile teams, complex social services and health care at the homes of the needy elderly people. In Burgas and Pokrovan operate Day Care Centres for lonely elderly people <http://www.csr.bg/caritas-bulgaria/603-programa-domashni-grizhi-za-vyзрастni-bolni-i-samotni-hora>
- **Program “Development of Human Resources”**, Measure “Help for home” <http://archive.eufunds.bg/bg/page/58?programme=5&status=2&id=557>
- **Home care for elderly** - Mobilizing own resources of a person in a critical social situation. <http://www.piamater.org/fondazija> - Fondation “Pia Mather”
- **ENS4Care Project**, development of guidance on inclusion of electronic services in the performance of health and social activities <http://www.ens4care.eu>
- **H-Care Project** – H-CARE: “Launching of Sector Skills Alliance for Training & Apprenticeship of Health Care and Food Supplements Salespersons” <http://healthcaresales.eu/?lang=bg>
- **Project innovAGE** – social innovations promoting active and healthy ageing – participant from Bulgaria - Association Alzheimer Bulgaria
- **Project CompAAL** - Developing qualification profiles for jobs in Ambient-Assisted Living, LLL, Leonardo da Vinci, multilateral. Rationales of this project were the demographic change and the resulting increasing demand for geriatric care on the one hand, as well as the increasing individualization of society on the other hand. A set of new qualifications and skills profiles for these new challenges relevant to employees from various backgrounds, were developed in the frame of the project – Association Generations, Sofia [http://www.generations-bg.eu/?page\\_id=118&lang=en](http://www.generations-bg.eu/?page_id=118&lang=en)
- **Project EngAgend** - In this project a harmonized European curriculum based on the principles of ECVET was developed and validated that qualified people for the job role of an AAL specialist or consultant – Association Generations, Sofia [http://www.generations-bg.eu/?page\\_id=126&lang=en](http://www.generations-bg.eu/?page_id=126&lang=en)
- **Project SEACW** (Social Ecosystem for Antiaging, Capacitation and Wellbeing) was a European project whose main goal was to become an e-meeting point for all those interested in Active and Healthy Ageing through the use of Information and Communication Technologies (TICs) – Research Institute for Neurobiology by Bulgarian National Academy of Sciences and Association Generations, Sofia <http://www.generations-bg.eu/?cat=4&lang=en>

### 3.1.3 Germany

In January 2016, no programme or resource could be found that follows the same aims to WHOLE.

However, there are some first projects and supports for caregivers and people in need of care to include physical activity/mobility in care situations. Most of the projects/programs found so far focus on people with dementia (the list does not claim to be complete):

- **Neue Aktionsräume für Menschen mit Demenz und ihre Angehörigen (NADiA)** in Cologne [New scopes of action for people with dementia and their carer] (<http://www.nadia-projekt.de/>)
  - idea: people with dementia do physical activities together with their family caregivers in a NADiA-group
  - offer: the well-established “fit for 100” movement program (originally developed for nursing homes) is implemented in special NADiA-groups for people with dementia and their family caregivers
  - includes exercises to maintain and improve strength and coordination (2x60 minutes per week over a period of 12 weeks)
  - spreading: 21 groups in 16 cities in the state of North Rhine-Westphalia

- effectiveness: a pilot RCT study showed feasibility, but no effects
- **Alter in Bewegung** in Hamburg [Age in motion] (<http://www.lsv-sh.de/index.php?id=690>); Forum Pflegegesellschaft et al., 2015)
  - idea: to integrate physical activity as part of daily living of older adults (people in need of care and their caregivers, special focus on people with dementia)
  - offer: based on the successful cooperation between sport clubs and nursing homes, sport clubs now create offers in agreement with non-residential care provider and support the groups with qualified trainers
  - contains exercises to maintain and improve strength, endurance, flexibility and coordination (weekly group meetings à 60 minutes over a period of 12 weeks)
  - spreading: 18 cooperation between non-residential care provider and sport clubs in 2015
  - effectiveness: no information available
- **Physical activity training in patients with Alzheimer's dementia** (Holthoff et al., 2015)
  - idea: to assess the effects of a home-based physical activity training on activities of daily living and caregivers burden of care
  - offer: passive, motor-assisted and active resistive leg training in different directions with a movement trainer over a period of 12 weeks (3 times per week for 30 minutes) for the patients (the caregiver did not underwent the training)
  - spreading: study population: 30 patients with Alzheimer disease and their family caregivers
  - effectiveness: patients: the activities of daily living performance remained stable after 12 and 24 weeks of intervention while the control group worsened in their performance
  - effectiveness: caregivers: burden of care remained stable in the intervention group while the control group had a higher burden of care
- **Kinaesthetics Pflegende Angehörige und Kinaesthetics in der Pflege** [Kinaesthetics for family caregivers and Kinaesthetics in formal care] (<http://www.kinaesthetics.de/programme.cfm>)
  - idea: Kinaesthetics offers support to self-support (capacity building) to improve daily activities in daily care by sensitizing caregivers for their own movements and that of their people in need of care. By this sensitization, the caregivers learn to adapt their support to various situations in interaction with their peoples in need of care and can adapt their care in such a way that the persons in need of care can still use their own abilities as far as possible. With this concept, the persons in need of care can stay as independent as possible and the caregivers can improve their personal physical health as the amount of lifting decreases.
  - offer: diverse trainings to train caregivers offered in the internet
  - effectiveness: participants of the training report improved quality of life and self-esteem of people in need of care, and a facilitation of diverse activities such as lifting as well as less back pain for caregivers
- Additionally the care system in Germany implemented some principles for a good care situation: One of them is activating care to maintain or re-establish activities of daily living. This means that the abilities of people in need of care that still exist are used and supported by the caregiver (Bundesministerium für Gesundheit, 2015a).
- The German Nutrition Society (in Hessen) offers advanced trainings for non-residential care givers “Richtiges Trinken und Essen für Pflegebedürftige” [Correct drinking and eating for people in need of care] (<http://www.dge-hessen.de/en/angebote/fuer-zielgruppen/ambulante-pflegekraefte.html>) and family caregivers “Richtig trinken – mehr als Durstlöschen” [Correct drinking – more than a thirst quencher] (<http://www.dge-hessen.de/en/angebote/fuer-zielgruppen/pflegende-angehoerige.html>).

More programmes that are similar to WHOLE in Germany:

- One is called “**Aktiv in jedem Alter**” [Active at any age] which means being active in every age. They have a homepage including all kinds of information for elderly people and their carers. They also have a training designed for gaining and keeping strength and balance as well as preventing falls. It is possible to do the training in a group or at home (<http://aktiv-in-jedem-alter.de/cms/website.php>).
- Another one is called the “**5 Esslinger**”. This mobility programme was developed based upon studies in gerontology as well as physics and physiology. The exercises are divided into five categories (strength, speed, balance, flexibility and endurance). This training is performed in a group with a therapist or a specially educated trainer (Kooperations-Netzwerk Fünf Esslinger, 2014; Runge, n.y.)
- The Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung, n.y.) published several booklets with information for active and healthy ageing. One booklet is including a training to maintain balance and strength with instructions and illustrations. The elderly persons can choose to practise at home or in a group (<http://www.gesund-aktiv-aelter-werden.de/?id=Seite1007>)
- In 2003 there was a project called “**richtig fit ab 50**”. It was sponsored by the Federal Ministry of Families, Elderly People, Women and Youth. In four sub-projects they wanted to find out which barriers exist to do sports and how these could be overcome (Deutscher Olympischer Sportbund, n.y.).
- Additionally, an internet platform was developed in the EU-Project "Healthy Ageing Supported by Internet and Community" (HASIC). This should allow people 65+ to maintain their healthy lifestyle. ([www.hasicproject.eu/de](http://www.hasicproject.eu/de))

It is difficult to say how well known and how effective these programmes are because there are no studies or surveys concerning these.

- One program for people in need of care called „**SENIORfit**“ offers exercises and activities for the body and mind to support the mental and physical wellbeing. The program combines exercises for the brain and the body to create variety in the daily care. ([www.senior-fit.com](http://www.senior-fit.com)). This program seems to be the most relevant for our project.

#### 3.1.4 Greece

In Greece, only few projects exist concerning care giving education and training. “The most famous effort to harmonize caregivers' market is a European project carried out in Greece, Cyprus, Lithuania, Spain and Hungary named *Elderly Care Vocational Skill Building and Certification* (ECVC). ECVC is the most relevant one, as it provides an e-training -theoretical and practical training for caregivers of elderly. It introduces the distinct qualification ‘ECV Certificate’ within the vocational education and training (VET) sector at the post-secondary, pre-tertiary level (ISCED 4VOC). The project developed a system for the recognition of competencies acquired in the non-formal and formal vocational training environment. The originality of the program stems from the fact that it can be by informal and migrant caregivers, which is crucial for the Greek market of care.

Another remarkable initiative is the *European project of Athens Association of Alzheimer's disease and Related Disorders* named ‘Set care, self-study, e-learning tool for the social home-care sector’. This project aims to improve the skills of care workers in Greece and Bulgaria by adapting an innovative Italian methodology of work qualification and recognition of competencies of professionals engaged in the field of home care assistance. It takes into account the specific needs of these workers, such as language barriers and lack of time, as well as opportunities and resources to access traditional courses. The training tool that has been developed in Italy provides training on elderly care by making use of e-learning (in order to be available anytime and to be cost-effective)” (Take Care project, 2014, p. 18f). “All new projects about training opportunities and certification of caregivers in Greece focus on:

- Vocational awareness
- Basic pathology (i.e. age-related pathology) or polypathologies
- Environmental Care
- Basic body care, Hygiene, Nursing, Handling incontinence, First aid
- Physiotherapy
- Mobility and entertainment
- Tools and materials for management

Nevertheless, we can see that basic education of nurses is more centred upon the provision of ‘technical’ knowledge (healthcare techniques, medication, etc.) than directed towards the teaching of social skills (crises management, awareness, etc.). Management or communication skills are developed only during training periods or during specialized Master degrees” (Take Care project, 2014, p. 19).

“One brilliant example of soft skills training of both formal and informal caregivers is the one provided by the *Psychogeriatric Association of Nestor in Athens*. The organization offers:

- *individual counselling* for caregivers by qualified psychologists (for caregivers in the early and middle stages of dementia); nurses (for caregivers in seriously stages of dementia) offer caregivers information on dementia and tips on caring for caregivers.
- *individual psychotherapy for caregivers* by qualified psychologists. This service is particularly important and is determined by the very substantial burden the caring for dementia patients constitutes.
- *Psycho-education groups* for caregivers by specialized social workers aiming to provide information and guidance on many issues concerning personal coaching, education of caregivers about the disease and its management, the treatment of any psychological burden.
- *Group exercise to improve the caregivers’ emotional state* (caregivers of patients with dementia, with the aim of identifying negative emotions and their impact on everyday life of the person through cognitive - behavioral techniques.
- *Courses on dementia and depression (theoretical seminars)* by qualified scientists (doctors and other health professionals) in the hall of the Alzheimer Centre on a monthly basis. These courses are conducted in collaboration with the Association of Carers of Patients with dementia and related disorders.”

(Take Care project, 2014, p. 20f)

### 3.1.5 Ireland

- **Age & Opportunity** ([www.ageandopportunity.ie/](http://www.ageandopportunity.ie/)) is a national non-profit organisation whose aim it is to offer opportunities in art, culture, sport and learning to older people in Ireland. They have been active for over 20 years and are working in partnership with the HSE, the Irish Sports Council and the Arts Council. Their own research shows that their programmes have provided both participants and organisers with significant health and social gains. Their most relevant programme to WHOLE is Go for Life.

“Go for Life is the national programme for sport and physical activity for older people which began in 1994 and is delivered by Age & Opportunity. It has been funded and supported by the Irish Sports Council since 2001 and has a steering committee with representatives from older people’s organisations and other interested groups. Working to the strategies of both organisations, the main aim of Go for Life is to involve more older adults in all aspects of sport and physical activity more often. It is based on an ethos of empowerment of older people who participate in workshops to become volunteer Physical Activity Leaders (PALs). The PALs go on to organise and lead sport and physical activity programmes with their peers.

Go for Life is implemented through a number of sub-programmes:

- The Leadership Programme which aims to promote greater participation by independent older people in all aspects of health-enhancing physical activity and recreational sport including planning, organising and leading
- The Targeted Initiatives which promote greater participation by older people at risk of social exclusion in health-enhancing physical activity and recreational sport
- The National Grant Scheme which assists local clubs and organisations for older people to increase physical activity opportunities for their members
- The Physical Activity Awareness Programme which aims to increase older people's awareness of the benefits of an active lifestyle and of the wide range of opportunities for involvement in active living and recreational sport" (Ní Léime & O'Shea, 2010, p. 22).
- They published a report in 2009 detailing the effectiveness of each of their programmes. (Ní Léime & O'Shea, 2010)
- **Get Ireland Active** ([www.getirelandactive.ie](http://www.getirelandactive.ie)) provides information and resources for older people who want to stay or become active. Their website offers advice on how to get active and also has a database of suitable locations such as parks and forest trails. The website is easy to use and accessible but not aimed specifically at elderly people (Get Ireland Active, n.y.)
- The **HSE** ([www.hse.ie](http://www.hse.ie)) website also provides advice on healthy living, information regarding the benefits of staying active, and contact information for different organisations providing resources for elderly people. It also offers a list of services for older people in different Irish towns and cities.

### 3.1.6 Israel

In recent years, there has been increasing awareness and acknowledgement in every sector of society of the importance of adopting a healthy lifestyle. Physical exercise is one of the most important factors in maintaining a healthy way of life. About 25% of the 65+ age group engage in physical exercise three times a week or more (30% of elderly men and 22% of elderly women), in comparison to 20% of the broader Israeli population (age 20 and older).

Day centres and enriched social clubs day centres and clubs have become a central feature of the basket of services for the elderly in recent years, especially for those who are disabled. These facilities provide different types of assistance, such as personal care, counselling, guidance in dealing with different problems, social-cultural activities (recreation classes, lectures), physical exercise and occupational therapy. In 2008, 170 centres such as these operated in 140 urban localities and 32 rural localities and were attended by 15 500 elderly people.

**"In a Ripe Old Age" programme:** The target population of this scheme is that of needy elderly people residing in the community whose monthly income consists of an old-age pension and an income supplement. The aim of the programme is to assist them in three major areas: health (subsidies for medication, identifying hearing and sight problems and supply of medical aids), housing (refurbishing homes, repairs and obtaining equipment needed for the home) and nutrition (referring the elderly to catering services provided by community organisations). In 2009, the programme was run in some 30 population centres and has given assistance to some 17 600 elderly people.

**Social clubs for the elderly:** these clubs, which operate throughout the country, serve as activity centres mainly for the independent elderly, although clubs do exist specially for elderly people who are blind and deaf. The clubs feature social-cultural activities, which include recreation classes, social gatherings, games and parties. In 2005 (the last year for which we have statistics), 850 clubs operated in approximately 130 towns and 30 rural centres, with some 80 000 participants.

**Sheltered housing:** sheltered housing consists of a network of housing units for elderly people who are functionally independent. Residents run their households themselves, but can benefit from a variety of services offered on the premises and in the community, including services given by a doctor, nurse and social worker, social cultural activities, physical exercise classes or facilities and an

emergency call answering service operative at all hours of the day. In 2004 (the last year for which data was published), there were 165 such facilities in Israel, with 21 000 housing units.

Israeli organizations for elderly people and their families:

**Israeli government:** Has created an online calculator (in Hebrew) for Holocaust survivors to calculate whether or not they are eligible for benefits, one needs to have Israeli citizenship to use this tool.

**ESHEL:** JDC-ESHEL strives to improve the status of the elderly population in Israel, developing conditions and services to guarantee better quality of life for the elderly, and to improve the image of older people to society as a whole. Programs include homes, daycare centres, employment programs, volunteer programs, health promotion programs, projects for the Ethiopian elderly, housing and supportive communities, programs for Holocaust survivors, publications and videos, and the Audiovisual Centre for the Elderly.

**Family Care- Reuth-Eshel:** Reuth-Eshel one of Israel's leading nonprofits in the fields of health, welfare & old age, Reuth Medical & Rehabilitation Centre is today one of the country's most advanced facilities for rehabilitation and long-term care.

**Yad Sarah:** Yad Sarah provides a spectrum of free or nominal cost services designed to make life easier for sick, disabled and elderly people and their families. Services include activities for the homebound, emergency alarm response system, geriatric dental clinic, Golden Garden coffee shops, home services department, home visits by volunteers, information services for parents with special needs children, legal aid for the elderly, Lifeline emergency bracelets, Oxygen services and special equipment, the "Karten" Rehabilitative Computer Centre, a toy library, an enrichment centre for special children and their families, skills training, an employment centre and transportation for people in wheelchairs. Yad Sarah has branches all over the country.

**The foundation for the benefit of holocaust victims in Israel:** in 2012, the Foundation assisted over 60 000 needy Holocaust survivors in Israel in a variety of ways, such as: providing nursing assistance in survivors' homes, grants and refunds for essential expenses (like hearing aids or medical treatment), emergency alert buttons, financial assistance with dental treatment, eyeglasses, home renovations, volunteer groups, free legal assistance to survivors, operating a large-scale volunteer network for socializing with survivors, operating social clubs (the British Clubs), and so on.

### 3.2 International programmes or resources for formal/informal carers and elderly people in need of care: reach, effectiveness and content

Internationally, there also exist programmes for carer with a similar aim to WHOLE:

- **Nutrition for elderly: Crossectoral approach for training and coaching (2014-1-BE02-KA202-000431)** (<http://ec.europa.eu/programmes/erasmus-plus/projects/eplu-project-details-page/?nodeRef=workspace://SpacesStore/86f08bc8-e142-4be8-8c0c-6c38b7941bda>)
  - idea: Staff in the food industry, catering and meal delivery services as well as staff in the health care sector should be educated to fight malnutrition of the elderly.
  - offer: Curriculum and learning units that are offered with open educational resources.
  - spreading: The project takes place in Belgium, France, Germany, Bulgaria and the Netherland
  - effectiveness: no information available
- **ICT – Innovative Caregivers' Training Rethinking competences for a sustainable and effective homecare system (ADAM-11746)** (<http://www.ictproject.net/public/>)
  - idea: To develop and provide an innovative ICT training model for health care professionals.
  - offer: Tools, methods and technology for learning at home and at work are developed and provided.
  - spreading: The project takes place in Switzerland, Belgium, Italy, Poland and Finland

- effectiveness: no information available
- **SET CARE: Self-study E-learning Tool for the Social Home-care Sector** (ADAM-8629) (<http://ec.europa.eu/programmes/erasmus-plus/projects/eplus-project-details-page/?nodeRef=workspace://SpacesStore/5c6a75f6-3aa2-4943-b376-f08dc05a9f47>)
  - idea: To transfer an Italian e-learning system for caregivers to improve their competencies and skills to Bulgaria and Greece.
  - offer: Set Care e-learning platform.
  - spreading: The project takes place in Italy, Bulgaria and Greece
  - effectiveness: no information available
  - see also 3.1.4 GREECE
- **ECVC “Elderly Care Vocational Certificate”** (<http://eurocarers.org/carict/servicedetail.php?id=74&qstring=dGFzaz1wcm9qZW50cyZvcmlRlcj1uYW11JmRpci1BU0MmZGI9MiZrZXI3b3JkPWluZGVwZW5kZW50K2xpdmluZw==>)
  - idea: The ECVC project purpose is to fulfil the European Older People’s care needs by vocationally train skilled care workers with a common level of competencies and certified recognition by the partners who provide education, which could lead to an accepted EU level qualification. Briefly aims of the project are: 1. Promote e-learning via the “ECV software”; 2. Facilitate skill development through practical experience and vocational exposure; 3. Introduce certification of competencies acquired in non formal and informal elderly care; 4. Ensure community placement via the Civic Observatories; 5. Improve European political awareness of the ECV matters via the “ECV European Observatory. ”
  - offer: e-learning software for informal carer, paid assistants and formal carers.
  - spreading: The project takes place in Cyprus, Greece, Lithuania, Spain, Hungary
  - effectiveness: no information available
  - see also 3.1.4 GREECE

Many more projects for carer funded by the European Commission can be found under <http://ec.europa.eu/programmes/erasmus-plus/projects/> that offer learning and mobility opportunities for students in the health care and nursing sector to allow a proper education and exchange of good practices.

There also exist programmes for elderly people and elderly people in need of care with a similar aim to WHOLE:

- **Home-based intervention programme on the physical activity level and functional ability of older people using domestic services** (Bonney et al., 2012 [research article])
  - idea: Domestic home helpers should encourage older adults (80+) living independently at home to take part in the home-based physical activity programme for four month.
  - offer: Home-based physical activity programme consisting of 13 exercises to improve strengths, balance, endurance as well as mobility and protein supplements.
  - spreading: France
  - effectiveness: Maintenance of maximum walking time and walking distance in the intervention group while the control group decreased in walking time (significantly) and distance (not significantly). Significant reduction in the instrumental activities of daily living for the control group, while there was no change for the intervention group.
- **Action Fit as a Fiddle** (<http://www.healthyageing.eu/healthy-ageing-action>)
  - idea: Aimed at people fifty plus it offers new activities and opportunities across the countries such as gardening, cookery, walking and chair based exercise, to yoga,

- swimming, tai chi and bowls, thus improving fitness, health and wellbeing of older people (50 plus)..
- offer: Dancing for fun - dance, movement and music, in parts of Cambridgeshire and Peterborough; Fit as a Fish - swimming and water activities for older people in Devon and Gloucestershire; Greenagers - gardening in the West Midlands growing food and sharing skills; Slimmin' Wi' No Women - healthy eating groups dedicated to older men in St Helens
  - spreading: United Kingdom
  - effectiveness: no information available
- **MOOCs (Massive open online course)** (<http://desarrolloweb.dlsi.ua.es/moocs/web-accessibility-moocs-elderly-students>)
    - idea: Helping older people become integrated with the rest of society.
    - offer: e-learning courses for elderly students.
    - spreading: Spain
    - effectiveness: no information available
  - **Trinity EngAGE-AFI MOOC** (<http://agefriendlyireland.ie/newsletter/massive-open-online-course-mooc-on-positive-ageing/>)
    - idea: This Trinity EngAGE-AFI MOOC will provide the platform to empower older adults to advocate for their health and well-being, encouraging participants to share their experiences and personal strategies.
    - offer: platform.
    - spreading: Ireland
    - effectiveness: no information available

There also exist programmes existing for caregivers and their elderly people in need of care:

- **Leisure activities at home** (Hirano, Umegaki, Suzuki, Hayashi & Kuzuya, 2015 [research article])
  - idea: Caregivers of dementia patients do leisure activities with their care recipients at home to reduce the perceived care burden.
  - offer: 3x30 minutes leisure activities such as playing instruments, drawing, cooking or creating (integrated in the daily routine) per week for 24 weeks
  - spreading: Japan
  - effectiveness: Decrease in subjective care burden in the intervention group.
- **Strong Survivors: Nutrition and Exercise Program for Cancer Survivors and Caregivers** (Anton et al., 2013 [research article])
  - idea: 12 –week program to educate cancer survivors and their caregivers on healthy basic nutrition and physical exercises.
  - offer: Exercises covering aerobics, resistance and balance exercises as well as flexibility training for 2x1 hour per week. The caregiver is invited to take part in the sessions.
  - spreading: Midwestern USA
  - effectiveness (experience of caregivers): spending more quality time together; perceived health benefits in increased muscle strength and muscle endurance, flexibility and activities of daily living (for caregiver and cancer survivor); increased energy levels; informal support for caregivers

### 3.3 Summary programmes or resources for elderly people in need of care and formal/informal carer

The following table gives an overview of programmes and resources identified by the project partners. This list only provides some example and does not claim to be complete. Each partner did the research according to its background which mean, that the focus was different for the partners. Some covering more the “content-aspects” physical activity and nutrition, some more on the qualification of the carer and some more on the use of electronical devices.

Country	Elderly people (in need of care)				Carer				
	Physical Activity	Nutrition Counselling	Electronic Devices	Social Aspects	Physical Activity	Nutrition Counselling	Electronic Devices	Social Aspects	Qualification
Austria	focus on prevention of complications instead of health promotion	-		-	-	-		-	-
Bulgaria	Project innovAGE	-	Project SEACW	Programme Assistants for people with disabilities Project Home care for an independent and dignified life Programme Development of human resources Home care for elderly	-	-	ENS4Care Project Project SEACW	-	H-Care project Project CompAAL Project EngAgend

<b>Germany</b>	Project NADiA Project Age in Motion Physical activity training in patients with Alzheimer's dementia Programm Active at any age Programme 5 Esslinger Project SENIORfit	-	"Healthy Ageing Supported by Internet and Community" (HASIC)	Project SENIORfit	Project NADiA Project Age in Motion Programm Active at any age Project SENIORfit	-	Project Healthy Ageing Supported by Internet and Community" (HASIC)	Project SENIORfit	Kinaesthetics for family caregivers Kinaesthetics in formal care Correct drinking and eating for people in need of care Correct drinking – more than a thirst quencher
<b>Greece</b>	-	-	-	-	-	-	Elderly Care Vocational Skill Building and Certification (ECVC) Project Set care, self-study, e-learning tool for the social home-care sector	Skill training offered by the Psychogeriatric Association of Nestor	Project Elderly Care Vocational Skill Building and Certification (ECVC) Project Set care, self-study, e-learning tool for the social home-care sector Skill training offered by the Psychogeriatric Association of Nestor
<b>Ireland</b>	Programme Go for Life Website Get Ireland Active Website HSE	-	Trinity EngAGE-AFI MOOC	-	-	-	-	-	-
<b>Israel</b>	Day centres, enriched social clubs day centres, clubs ESHTEL	Programme In a Ripe Old Age	-	Day centres, enriched social clubs day centres, clubs ESHTEL	-	-	-	-	-

<b>International</b>	Home-based intervention programme on the physical activity level and functional ability of older people using domestic services. Strong Survivors: Nutrition and Exercise Program for Cancer Survivors and Caregivers. Action Fit as a Fiddle.	Strong Survivors: Nutrition and Exercise Program for Cancer Survivors and Caregivers. Action Fit as a Fiddle.	MOOCs (Massive open online course)	Leisure activities at home. MOOCs (Massive open online course).	Strong Survivors: Nutrition and Exercise Program for Cancer Survivors and Caregivers.	Strong Survivors: Nutrition and Exercise Program for Cancer Survivors and Caregivers.	ICT – Innovative Caregivers’ Training Rethinking competences for a sustainable and effective homecare system. ECVC “Elderly Care Vocational Certificate”	Leisure activities at home	Nutrition for elderly: Crosssectoral approach for training and coaching ICT – Innovative Caregivers’ Training Rethinking competences for a sustainable and effective homecare system. ECVC “Elderly Care Vocational Certificate”
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## 4 Conclusion and meaning for the project

This international literature review assessed the needs of the target group for the planned e-learning platform that will provide caregivers with information on how to implement physical activity and healthy eating counselling as part of daily care; justified the planned project outcomes by showing the benefits of physical activity and healthy eating for the target groups and provided best practice programmes that will ensure a high quality and appropriateness of the content.

It was shown, that there are high numbers of elderly people in all participating countries, whereas the proportion in relation to the total number of inhabitants differs. A big proportion of these elderly is in need of care. Care is provided by either family or friends (informal homecare) or professional caregivers at home (formal homecare) or in specialised homes for the elderly. There seems to be an overall trend towards formal care in all countries, whereas not all countries offer professional homecare services so far (e.g. Ireland). The care-offers cover different aspects of daily living such as hygiene, domestic care or nursing. Other services do also cover entertainment and creative activities. This, however, takes more place in day care centres (e.g. Greece) or for a certain target group (e.g. dementia patients in Germany) and is not part of all care programs. This shows the necessity of an orientation towards active ageing and social inclusion. Care should not only be restricted to nursing services, but it should be expanded in other domains too, where the elderly will have the opportunity to upgrade their quality of life and to participate in various health promoting actions. Another problem exists in informal care settings: At the moment, big parts of the care needed are still provided by informal caregivers, especially in Greece and Bulgaria. Even if there are several supports in all countries, a proper qualification/education of informal caregivers is often missing.

We also provided a short summary of benefits of a healthy lifestyle (physical activity and healthy nutrition) and listed some examples of programs or resources that already exist in the partner and other countries, both on the use of technical devices in care and healthy eating/physical activity for the elderly and caregivers. It became obvious that benefits can be expected in physical, social and mental aspects for both caregiver and care receiver and therefore, we should not only focus on functional training but also on social interactions that will improve the time that the caregiver and care receiver spent together (quality time). Additionally, the benefits that we expect for the health and social interactions of caregivers and care receivers, we will contribute towards the qualification of formal and informal caregivers in terms of their ability to be physically active with care receivers and giving healthy nutrition advices.

## Resources and hints for further reading

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## ANEX

### Some additional explanations and conclusions for Bulgaria

- Some of the key factors that have a negative impact on the institutional model of care and the demand for this kind of care are:
  - Insufficient number of services for elderly and people with disabilities , which could meet their COMPLEX needs; uneven distribution of these services of the territory of the country;
  - Insufficient financial resources, which often resulted in social exclusion of older people and people with disabilities and their placement in special institutions;
  - Lack of inclusive social and architectural environment;
  - Lack of institutional care, especially for elderly. Reason for this may be indicated the absence of real and safe alternative care that will ensure dignified and independent life in their own home and community;
  - Low paid home care services for elderly and people with disabilities, lack of social recognition and lack of motivation of social workers, involved in these activities;
  - Small number of offers for specialized elderly care and services for people with disabilities on entrepreneurial base ;
  - Lack of meeting the complex needs of elderly and people with disabilities (health and social) services in the home environment and financing of activities, Long Treatment and Aftercare.
  - Lack of home care services, meeting the real needs of elderly – in health and social aspect, lack of financing of after care and long term treatments.
- To improve the quality of all offered care services are necessary improvement of facilities, structures and professional capacity of staff and increasing control on compliance with the criteria and standards for provision of social services.
- There are no special definitions for professional caregivers In the Bulgarian legislation. Currently in the Bulgarian legislation is no separate special definition of long term care services and their providing; there is also no formal classification of persons who can use them
- Unlike other European countries, Bulgaria has no system for remuneration of family members who provide long-term care for elderly relatives.
- When hiring a caregiver is entirely by agreement between the family and he/she, there are no regulated prices. These prices vary by region. In Sofia the prices are much higher than in the most impoverished region of the EU - Northwestern Bulgaria. Prices can be from 350 to 1 500 BGN per month.
- The funding of services for elderly is either covered by the family in case of private services (Personal pensions of older people are not able to cover the fees in private nursing homes and hospices) or financed by the state, local budgets, from minimal user fees and European programs.
- State-funded services are usually managed by municipalities. There are conditions of competition between service providers registered in the Agency for Social Assistance. The negative side of this organization is, that it accumulates corrupt practices at the local level, it is also a lack of sustainability in the range of services and a very low service quality. Another big problem is the lack of sustainability by establishment of services for elderly. Those which are established in the frame of EU projects, usually after the project end don't exist anymore because of lack of finances. Just some of these projects continue existing as bodies, supported by the state, but not in the same range and not with the same service quality.

- There is a remuneration system for personal assistants and home carers who provide cleaning, personal hygiene, shopping and other daily tasks – formal social care service “Home Social Patronage”.
- Bulgarian legislation does not provide reconciliation of work to care for a sick family member. *(comments of lawyer Lora Ivanova - voluntary legal advisor of the Association "Alzheimer Bulgaria")*

**Private insurance:** Private insurance funds have covered 0.7% of the insured. These funds work with individuals who generate income and insure themselves. They do not work with people in retirement age and persons with permanently reduced disability.

**Volunteers:** In Bulgaria there is no law on voluntary work. In the organized social services and in the institutions for medical and health care there is no practice of voluntary work in caring for the elderly. In Bulgarian legislation there is no definition of "volunteer" and appropriate regulation of voluntary work in tax, insurance and security rules. In this regard, there is no clear mechanism for compensation of volunteer effort and restoration done by costs in carrying out the activities. It is uncertain as to their responsibility, which creates numerous practical problems. In this respect, volunteering in Bulgaria is episodic and only in the implementation of certain project activities.

The educational system does not support and encourage the volunteer work.

#### **Brief information on qualification measures for caregivers in Bulgaria:**

Bulgaria does not have an orderly system for psychological and emotional support to formal and informal carers. There are no accurate statistics, but more likely it can be argued that the informal care provided by family members predominate in caring for the sick elderly. The lack of a system for psychological and emotional support, as well as opportunities for recreation of informal carers, is detrimental to their mental and physical health. In 2011 Alzheimer Bulgaria made the first and only survey of life in the families who care for ill with some form of dementia. All respondents who care for sick relatives, answered that they lack social contacts, need support groups and can not rely on social support system.

Sporadic training of caregivers organize some programs of Association Alzheimer - Bulgaria, Caritas - Bulgaria, Bulgarian Red Cross.

#### **List of German organizations mentioned in the report and translation**

<b>German</b>	<b>English</b>
Bundesarbeitsgemeinschaft der Senioren-Organisationen e.V.	The Federal Association of Senior Citizens Organisations
Bundesministerium für Gesundheit	Federal Ministry of Health
Bundesministerium für Familie, Senioren, Frauen und Jugend	Ministry of Family Affairs, Senior Citizens, Women and Youth
Deutsche Gesellschaft für Ernährung	German Nutrition Society
Gesundheitsberichterstattung des Bundes	The Federal Health Monitoring System
Statistische Ämter des Bundes und der Länder	Federal Statistical Office and the statistical Offices of the Länder
Statistisches Bundesamt	Federal Statistical Office
Verbraucherzentrale	Consumer advice centre