NATIONAL REPORT
SITUATION OF CARE IN GERMANY

Catholic University of Eichstatt - Ingolstadt

May 2010
Germany

The aging of society, the cumulative need for care and the necessity of enhanced basic conditions for home care is the background of the biennial EU-Project "Pro-Domo – Change of home care", at which the Catholic University Eichstätt-Ingolstadt (KU) cooperates with partners from Italy, Spain, UK, Slovenia and Hungary (The project lasts from November 2009 till September 2011).

At the project's beginning the scientist teams will deal with the subject of the care system (with special attention on home care) and the consequences of social change in the relative partner countries. In a comparison of the different national studies some inferences from that will be done about successful offerings and existing needs.

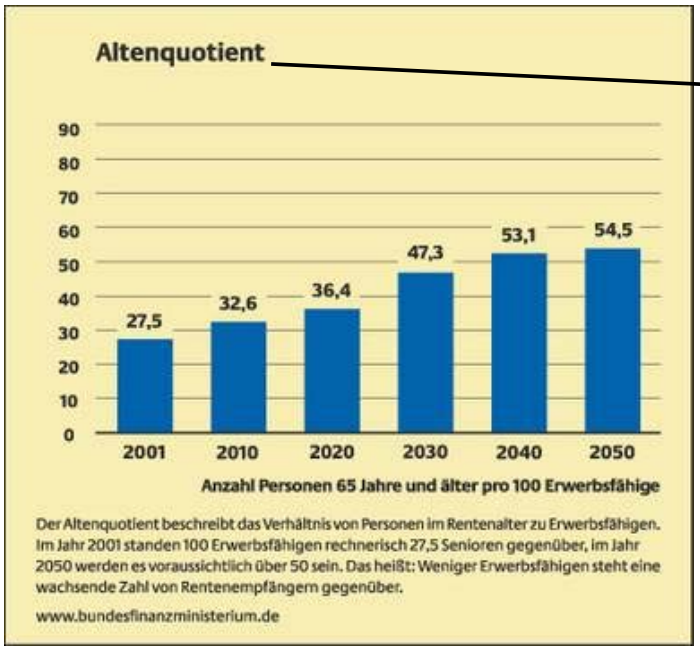
The report at hand shows the situation in Germany and gives a statistic view on the population structure prior to describing the German care system.

THE AGING OF THE (GERMAN) SOCIETY

The term "demographic shift" means the alteration of the consistence of societies age pattern. Although this social phenomenon quite many-faceted: associated to the term are aging and contraction of the society, the change of coexistence inside the families, the changing modes of the generation's coexistence and even the structural alterations like the depopulation of whole districts and cities.

Also the German society gets older – one of the most relevant indicators for a society's aging is the **old-age ratio**.

It describes the relation of the female and male citizens of an age by 65 years and older to society's active part between 20 and 65 years (fit for employment). This ratio raises continually, like the chart shows:



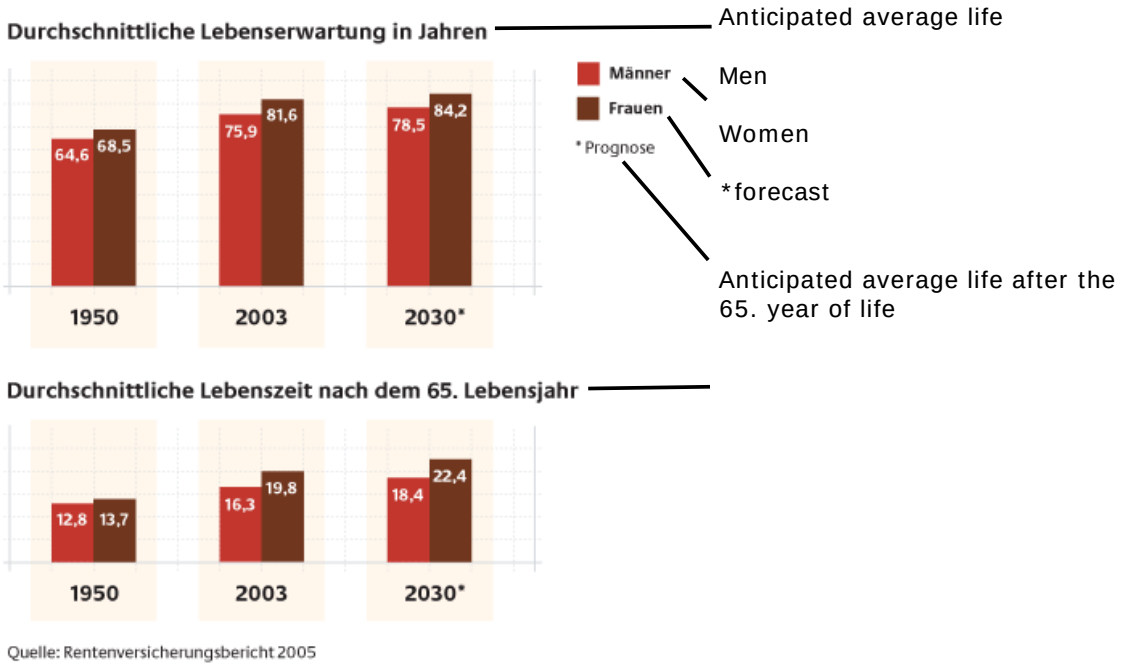
old-age dependency ratio

The old-age dependency ratio shows the proportion of persons on pension to one's who are able to work. In 2010 100 people who were able to work were calculational standing against 27.5 people on pension. In 2050 it will be over 50. That means: we will have less people who are able to work and more people on pension.

Number of persons 65 years or older per 100 people who are able to work

The demographic shift's effects appears most explicit at the pension scheme, which is based on the „Generationenvertrag“ (inter-generational contract) in Germany. Because for the achievement potential the age-ratio is essential, i.e. the numeral relation of the citizens in old-age pension as prospective benefit recipients to the citizens in employable age as suppliers.

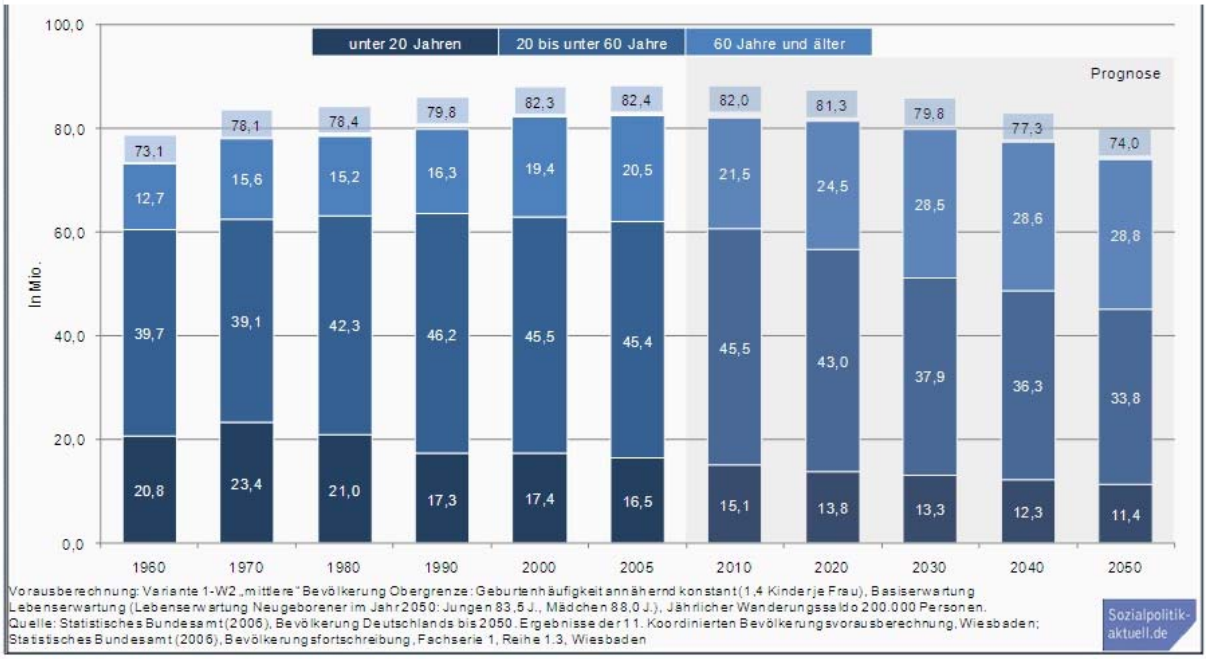
According to actual statistic reports the trend of a aging society increases. On the one hand the number of newborn children diminishes continually, on the other hand the people on average get older and older. Therefore a raising number of young people is compared to a growing number of old people in future. The data of the Deutsches Bundesamtes für Statistik (German federal office of statistics) shows a lasting increasing trend at the **lifespan**, on the average as well as on the increased expectation of life. This trend is showed by the chart:



Quelle: Rentenversicherungsbericht 2005

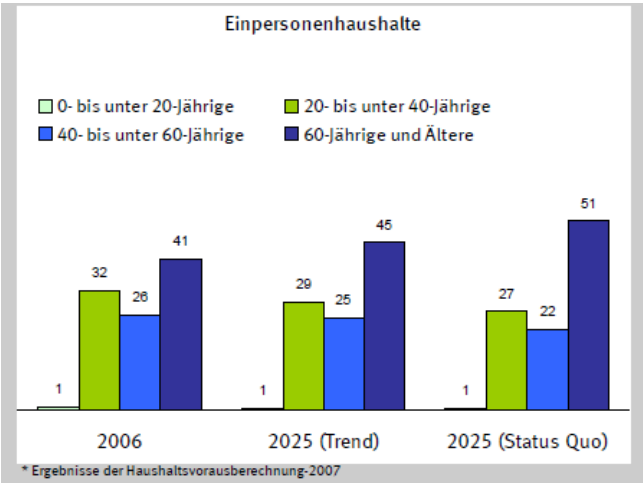
While the bias of groups aged under 60 diminishes, the contingent of groups aged over 60 has a accumulating bias. The chart below shows this development of the German society's **age pattern**. The population (right now round about 82.4 mill.) will stay constantly at approx. 83 mill. till the year 2020 and will then diminish to approx. 75 mill. Till the year 2050. A raising number of old people will face a decreasing number of young people. The average age will rise for about 10 years. Especially the number of very old people (over 80 years) will increase considerably.

Trend of resident population in Germany 1960-2050
In Mio. by age groups



Quelle: www.sozialpolitik-aktuell.de (19.04.2010)

The „winners of the demographic shift", the people aged over 65, mark a very important part of society – as „distributors" of experience of life and wisdom, as actively involved participants of society, as consumers, but also as potentially available needy people for the help- and care system. The graph below - the **population in personal households categorized in age groups** in Germany in 2006* and 2025* in % - shows that the people over 60 mark the biggest part of people living in one-person-households. Associated to the increasing risk of the need of care in higher ages this is a important for example statistic to point the way ahead for the home care, even in times of bad conditions in society.



Single-person households

Quelle: Statistisches Bundesamt, Gruppe VI

If you abstract the specified statistic developments you can see that they will affect the whole society but first and foremost the care system in a very serious way. Exemplary calculations of the Federal Office for Statistics show that the demographic shift and the aging of society will bring a boost for the people who need care for about 58 % and a boost for hospitalizations for 12 % in the year 2030 in reference to today. The number of those who need care will raise, based on the data, from 2.25 mill. to 3.4 mill.

THE CARE SYSTEM IN GERMANY

In Germany a highly developed social protection system has evolved. Besides the insurances of pension, illness, unemployment and accidents, the insurance of care is a important element of this social protection system which is funded by employers and employees at the same part. Nearly all citizens of Germany are insured of illness (88% with a state insurance, nearly 12% with a private one). With a total expenditure of about 10.7% (as measured by the GDP) for health and care Germany stays over the OECD-standard of 9.0%.

The social insurance is the most important part of the social protection. It is a state insurance for the risks of daily life. To secure the premium income mostly compulsory coverage exists for persons and organizations. One year's required services are nearly complete paid with the same year's premium income. The services are mostly done as non-cash benefits equal to all insured people (solidarity principle) or as cash benefits regulated by the fees (e.g. pensions, sickness benefit). The social insurance's duties are besides the benefits as well the prevention and rehabilitation.

1883 the state insurance of illness was developed as the first social insurance in Germany and in Europe by Bismarck. More social insurances followed: the insurance of accidents in 1884, the insurance of pensions in 1889, the insurance of unemployment in 1927 and at last the insurance of care (part of the insurance of illness) in 1995.

The insurance of illness is the only insurance with competition for members between the compulsory health insurance funds and the private insurance companies. The insurance of care is connected to the insurance of illness and with one's choice of a health insurance company one choose the insurance of care at the same time. The other insurances are contracted to the members in a quasi-monopoly way, i.e. there exists only one insurance company. The legal basis of the insurance of care is the Sozialgesetzbuch (SGB – Code of social law).

The social insurance is funded predominantly by fees and sometimes by taxes. The fees are geared to the gross pay and gross wages (in German called „BLG“) . Actual (February 2010) the social insurance fees take about 31.25% - 33.35% of the wages of medium and low paid employees . The fees are (with some exceptions) funded with equal representation by employers and employees.
The care system which is part of the health system is interesting for the ProDomo-Project. The term health system or rather public health means facilities and individuals whose duty it is to gain or to rebuild the society's health or to upgrade the state of health. To be contrary to it's appellation the health system cares for the opposite of health, the illness.

The German health system is, in opposite to other countries' health systems, historically identified through the fact, that the state gives the arrangement to self-governing corporate bodies and alliances, mostly to the state insurances of illness and the hospital operator's alliances. The insurances of illness are corporate bodies under public law, which get a allowance by the state for the doing of federal works.

They are under the federal bureau's control of legality (federal social insurance authority). That means the lawgiver sets the rules in which the insurances have to do their duties and the federal agencies administrate the corporate bodies. The care provider's professionalism is supervised and regimented by the federal agencies to guarantee the patient's safety.

The German system is dominated by small enterprises in the institutions which provide the care. The German health system is funded predominantly by the state insurance of illness' earnings and federal money. The provided service in the health system are ambulant health care, hospitals, nursing homes and carriers of federal facilities. In addition even alliances of public welfare and private care providers are among the providers of care in Germany. The service to preserve or regain the health are provided ambulant or residential.

Some alliances of public welfare are the Arbeiterwohlfahrt (workers' welfare association), the Caritas (charity), the Deutsche Paritätischer Wohlfahrtsverband (German joint welfare commission), the Deutsche Rote Kreuz (German red cross), the Diakonische Werk (outreach ministry) and the Zentralwohlfahrtsstelle der Juden in Deutschland (central welfare commission for the German Jews).

With the social insurance of care's introduction on 1. January 1995 the last big gap of social insurances was closed an a new basis for the need of care's risk coverage was founded. The social insurance of care helps the needy and their affiliates to take care of the personal and financial burdens. The insurance of care is connected organizational to the insurance of illness. Members of a state insurance of illness are automatic insured at a insurance of care.

Communal: main task of service for the public = to make a good accommodation with a adequate social infrastructure sure. The duty of the local authorities is written down in the German law concerning the care for the elderly. Important duty for the future: scheduling of work with the elderly to coordinate all offers of care and help for the elderly.

Benefits and conditions of the insurance of care are regulated by the SGB XI (social security code No. 11).

The insurance of care assures the needy of solidarity aid so that they live a self-determined life. Their benefits shall complete the familial care, the care in the neighborhood and any other honorary care and assistance. At the stationary care the insurance's benefits shall disburden the needy of the care conditional costs. According to this the insurance of care is not a insurance at full value. It is a social safety net in terms of auxiliary salvage which does not make the personal contributions of the insured and other providers expendable. If no or fail benefits of the insurance of care are delivered and the needy or their affiliates who are liable of support have not enough personal contributions to take care of the remaining costs for a needed and adequate care, also the benefits of the social welfare may be used to take care of the individual fulfillment of demand.

With payment of contribution and premium pay the insured acquire a claim to get help if the get highly-maintenance. The insured's business situation is irrelevant because the insurance of care's benefits are delivered independent from income and asset.
The degree of highly-maintenance is crucial, which benefits are delivered to the needy. This is assessed by the Medizinischen Dienst der Krankenkassen (MDK - Medical review board of the statutory health insurance funds). To take care of the different demands the lawgiver has arranged three care levels. The term „care level“ of the insurance of care complies with the custodial and budget-side necessity of

help of at least 90 minutes each day (Level 1) respectively at least 180 minutes each day (Level 2) etc.

The state insurance of care comes to aid, if common and constant to be done actions of daily life can't be performed enduring – estimated at least for 6 months - to the full extend in case of illness or handicap. At the care level's calculation difficulties with budget-side delivery and basic care (personal hygiene, alimentation and agility) are considered. Since insurance of care's introduction it's animadverted that the term of high-maintenance is argued somatic too narrow and one-sided in the SGB XI. Prevalent aspects would be blanked out of the discussion and not enough allowed for, as for example the communication and social access and the need for common assistance, supervision and guidance, in particular for people with limited daily living skills. So there's a danger to segregate people from the benefits of SGB XI, for example people with dementia.

The coalition parties which carry the federal government have agreed (with the coalition agreement, 26. October 2009) on the plan to aim for a new, differentiated definition of high-maintenance and to comprise the already existing approaches to the assessment. The new term as well as the new action of surveys shall lead to a change in perspective to the insurance of care. The new instrument aims for a broad regard of high-maintenance, so it avoids the cutback of high-maintenance to the need of help in some certain action of daily life. It covers handicaps as well as cognitive or rather mental penalties and behavioral problems, which entail special needs.

The public health care bankrolls different benefits for the needy of care. These benefits are delivered as cash or non-cash benefits with which the basic care and budget-side supply is funded. The needed help can be delivered private and unbureaucratic with the caring allowance. Frequently the effort of caring affiliates is annealed by the needy of care. The non-cash benefits bankroll professional nurses. Because this is much more costly than private help, the non-cash benefit's budget stands extensive over the numeracy for the nursing allowance. Both kinds of benefits can be combined. Furthermore the insurance supports with courses for care, renovations of flats, maintenance utilities, short term care and other.

On principle: „ambulant before stationary“, that means the needy should be aided in their homes as a basic principle. Is a home care impossible, for example because of a very heavy case of illness, the costs for a hospital residence will be accepted in part.

Right now the insurance of care's financial benefits are regulated in this way:

ambulant	Bisher €	2008	2010	2012
Stufe I	384	420	450	450
Stufe II	921	980	1040	1100
Stufe III	1432	1470	1510	1550

German “Stufe” = Level
Stationary

Out-patient care

Stationär	Bisher €	2008	2010	2012
Stufe I	1023	1023	1023	1023
Stufe II	1279	1279	1279	1279
Stufe III	1432	1470	1510	1550
Härtefälle	1688	1750	1825	1918

Inpatient care

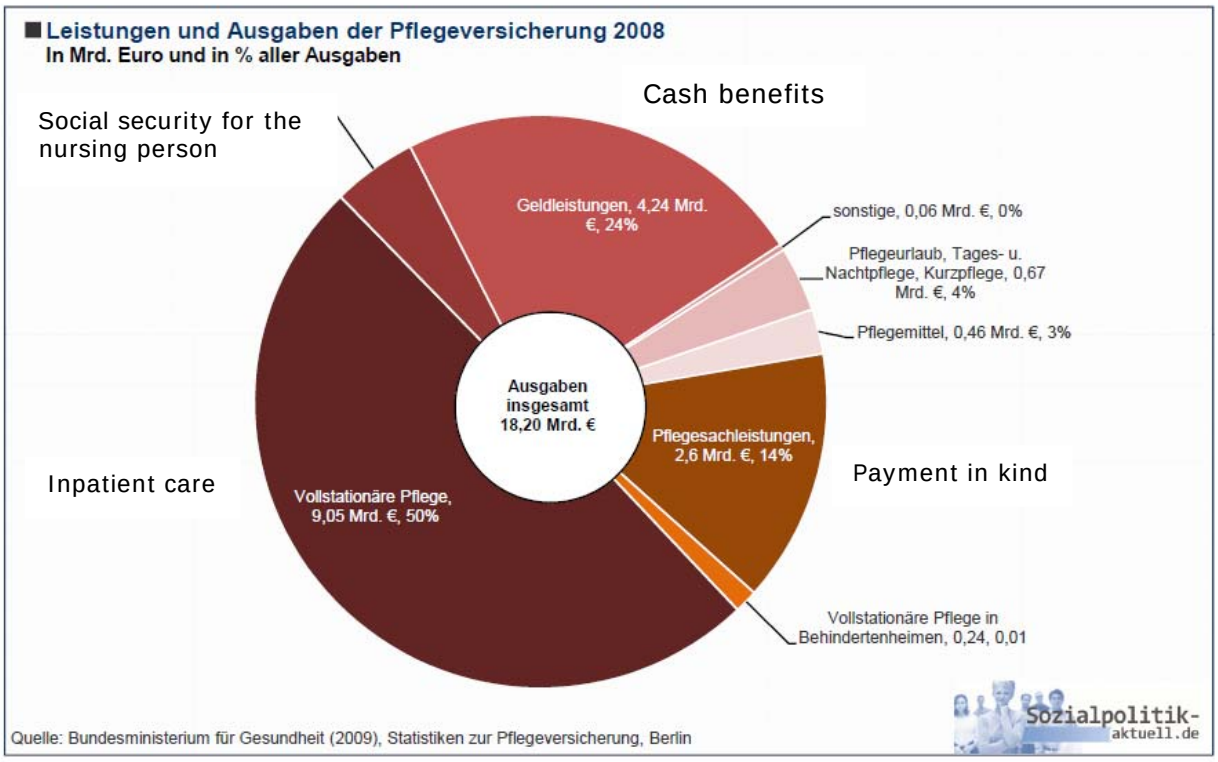
Anhebung des Pflegegeldes

	Bisher €	2008	2010	2012
Stufe I	205	215	225	235
Stufe II	410	420	430	440
Stufe III	665	675	685	700

Increase of nursing allowance

„Ambulant care“ takes place in the home (own flat / own house) of the needy, a professional provider of care carries the local supply. Ambulant care's benefits are provided by organizations of public welfare (Caritas, BRK, AWO) as well as by communal welfare centers or private, commercial providers of care. „Stationary care“ means, that the needy can't be aided at home any more and has to go to a care facility. „Nursing allowance“ is paid, if the needy is aided at home by affiliates or another self-chosen person (neighbors, friends) in a able way.

The following chart shows the insurance of care's benefits and costs in 2008 (In mill. € and in % of all costs):



Accreditation of care providers: The public health care may allow ambulant or stationary care only by care providers with who a care provision contract exists (admitted care providers). Only with the existence of this contract between public health care and care providers the provider may act and charge the actions to the public health care's account. **A care provider is in Germany only allowed to get an accreditation for the health fund**, if:

- the company engages at least 4 employees
- the healthcare services as well as the representation of graduated nurses have work experience in ambulant and stationary places
- to full-time employees are engaged
- and much more conditions concerning the premises.

In 2005 there were about 11.000 accredited ambulant care providers in Germany. About 14.000 employees were engaged at these providers, the percentage of women was at 87.7%. Respective the job-related qualifications the nurses are the main group (care bulletin). The main part of the 11.000 accredited ambulant care providers was in private sponsorship (57.6%). The part of the charitable providers was with about 40.6% subordinate. Public providers had – according to the other provider's precedence relating to SGB XI – a lower contingent (1.8%). In general a care providers aided 43 people who were needy of care.

In 2005 there were about 10.400 accredited full - or rather part-stationary nursing homes in Germany. The number of nursing homes with full-stationary long time care was about 9.400 facilities. At the stationary sector the predominance of the nurses respective the structural ability is not as big as at the ambulant sector; the contingent is at 33.6%. The main part (55.1%) of the full- or rather part-stationary nursing homes which were accredited in December 2005 referring to the SGB XI was in charitable sponsorship. The private part was about 38.1% and so clear lower. Public sponsorships are the least part with 6.7%. Almost every fifth nursing home had beneath the caring space a home for the elderly or assisted living. There mostly old people are aided, who don't get benefits referring to SGB XI. (care bulletin).

The care's **quality control** is an important institution in Germany: the „Medizinischer Dienst der Krankenversicherung (MDK - Medical review board of the statutory health insurance funds). The compulsory health insurance and social insurance of care's benefits have to be fair, purposeful and profitable. To implement these allowance of the lawgiver at the axiom and on individual case the MDK supports the state health and care insurance with it's medical and aiding experience. The mission is to advise the state insurances at common questions of principle and to arrange surveys of individual cases. The MDK's experts are autonomous with their medical and aiding benchmark. However, the decision for the benefits is on the insurances.

The MDK is a common area of the state insurances and in every federal state organized as a autonomous joint venture. Members of the MDK are the state health funds. Right now there exist about 200 of them in Germany, as well as six forms of health funds.

The MDK is funded by it's carriers, the health and care funds on federal state level. Their costs refer to the number of members. As the medical services do works for the health funds as well as for the insurance of care the health and care funds pay each 50 percent. The state insurances of illness and care's total expenditure was in 2008 at circa 540 mill. Euro.

The MDK's duty are written down in the Sozialgesetzbuch (SGB V – Code of social law). The health fund's advice contacts issues like disability, must of, form of, amount and time of benefits for rehabilitation or rather the need and time of hospital treatments. For the care funds the MDK examines, if somebody is needy of care, advises a care level, gives advice to form and time of benefits and phrases advices for individual caring blue prints. In addition it advises the care funds with common questions of caring delivery.

All care providers are in bond to increase and secure the quality of their benefits. The MDK checks in charge of the state health cares the quality of the care providers. The MDK gives advice with the aim to guard against quality defects as well as to increase the care provider's direct responsibility and to boost the carriers for the advancement of the care quality.

The head organizations of the care funds have concluded the guidelines for the quality management together as minimum requirements for the check of the bene-

fits in nursing homes as well as the accomplishment of these guidelines. The federal office for health accredited these guidelines on the 10. November 2005. The aim is to assure a standard approach on federal level at the MDK quality managements and advices. By this means not only the needed transparency and comparability of the quality managements is secured but at the same time the execution of those quality managements is much easier for all involved. The regulating of this guidelines is updated according to the experience especially of the nursing science, medicine and adjudications so that it helps the advancement of the quality on the basis of the check.

Care – who's appropriate?

The custodial accommodation of the society is a cross-social duty. The federal states, the communes, the care facilities and the health funds have to work very close with the MDK's participation to assure a capable, local structured, close to home and concerted ambulant and stationary caring of the society. They add to the development and upgrade of the needed caring provisions; this is aimed especially for the bargain's addendum of domestic and stationary care with new forms of part-stationary and short-term care as well as the expostulation of a bargain care-adding benefits and rehabilitation.

The federal states are in authority of an expostulation of a capable, numeral fair and commercial caring provision. Full particulars of care facilities' development and boost is regulated by state law.

The communes have to attend in terms of services for public (indemnification of the provision with fair social infrastructure) the socio-spatial design. The future's duty for the communes is, to upgrade the provision of care for the needy. Networked bargains and false-works may only be regulated communal.

ADVANCEMENT OF THE INSURANCE OF CARE:
LAW OF ADVANCEMENT OF CARE OF 2008

In 2008 some changes with the insurance of care were taken in hand: after 13 years of existence the state insurance of law was reformed and upgraded in some terms. That reform had some important changes with the structure and benefits of the insurance of care. Centers are:

- Upgrade of the benefits for people with handicaps
- Upgrade of the benefits with day- and night care
- activity's dynamic sampling
- Introduction of a nursing care time for employees
- Upgrade of the quality management and development of the transparency

A main advancement was achieved with the new reform package on the care by affiliateds. An employee may get up to 6 month of free time, if he or she cares for an affiliated in this time. This is called nursing care time.

Statistic data on the insurance of care, need of care and other numeral is provided to the most part by two sources in Germany:

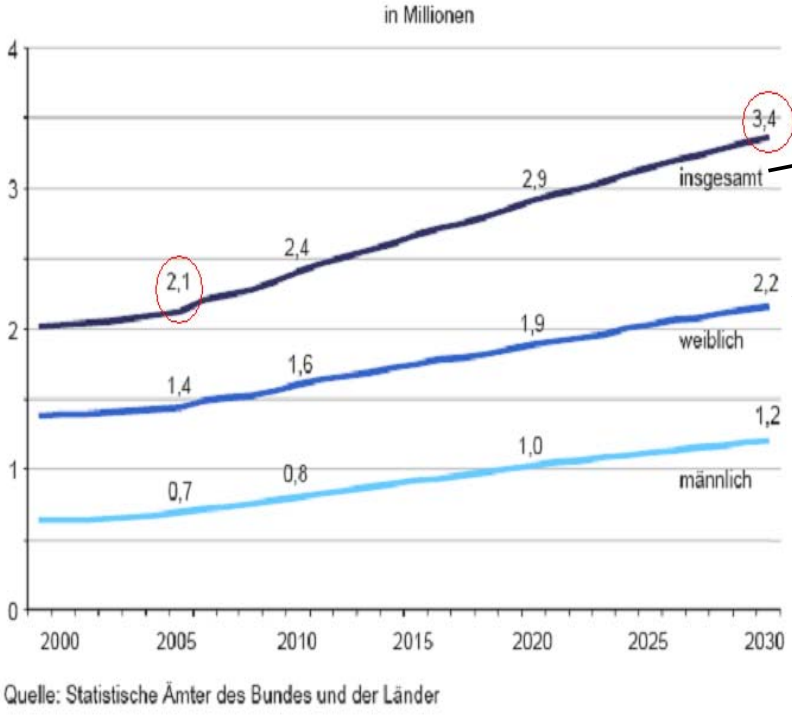
Since 1999 the federal and country statistic bureaus arrange a biennial statistic of care, with deadline in December. The statistic's aim is to collect data on demand and bargain of care referring to the insurance of care. The census refers to all ambulant providers of care and all nursing homes which provide full- or rather part-

stationary care on which a contract as accredited care facilities (basis for this are adequate agreements in SGB XI). Declarations of the care funds on the acceptors of benefits complete the bump. Besides the statistic the federal government's (federal ministry of health) bulletin of care is another important source of data.

This bulletin (appear triennial) shows basically numerals and facts on the insurance of care, the infrastructure of care and the provision of care as well as contents and aims of law-given development of the insurance of care.

The fourth bulletin of care appeared in January 2008 and contains data from 2004 till 2006.

Referring to the demographic development the number of needy people will rise, as the following charts displays:



People who need care in Germany from 1999 till 2030 (status-quo-scenario), in mill.

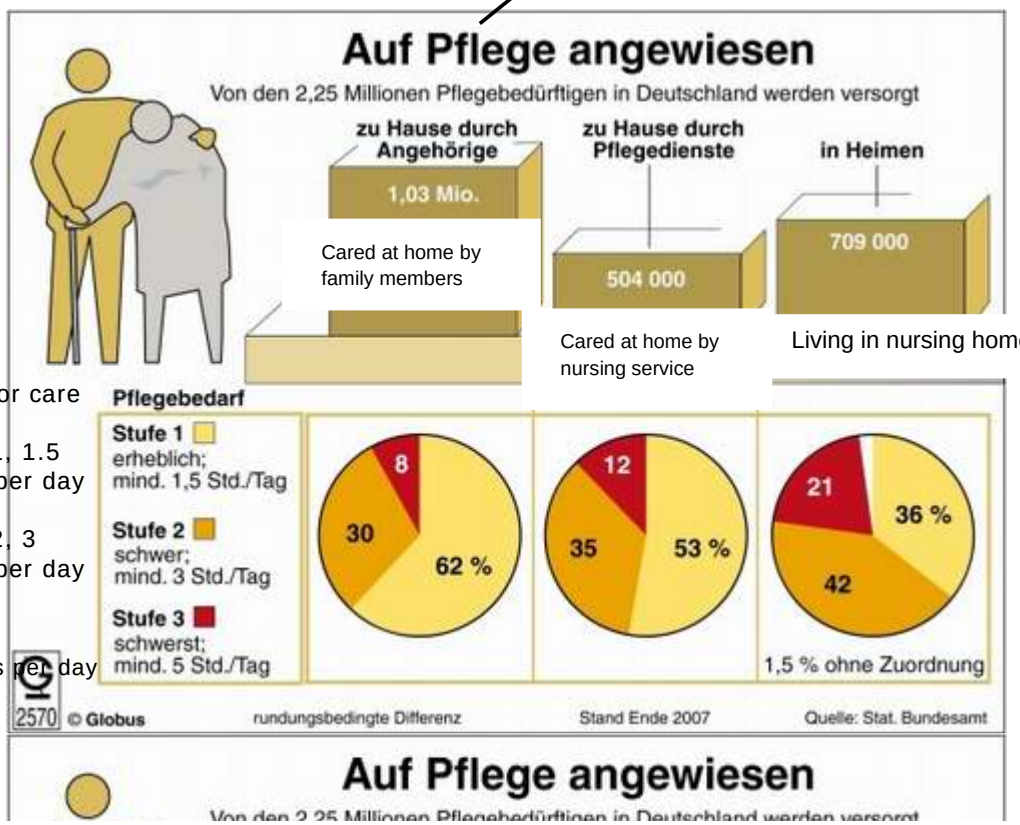
All up

Female

male

The actual number of the people who need care and the form of the provision is shown here (end of 2007):

Need for care
The 2.25 mill. Needy for care in Germany are aided like this



Level 1, 1.5 hours per day

Level 2, 3 hours per day

Level 3 5 hours per day

How does the **situation in Ingolstadt** look? The city commissioned a „care forecast“ till 2020 in 2006 to assert the development, demand and bargain. The following data is taken from this bulletin.

The society of Ingolstadt will, against the cross-social development, rise in future. The chief cause for this is a positive migration balance (more moving ins than removals). But the tide of the aging society will not leave out Ingolstadt: in the next 15 years the age classes between 45-65 years and from 65 years on will rise very strong, during the age class under 45 will stay on the same level and the number of children and youths will decrease.

More than 50% of the needy of care get new nursing allowance and will be aided private. About 30% live in stationary care facilities. The number of the needy will raise up for 1.000 people until 2020. Especially the number of the very old people from 75 years on and especially from 85 years on who need care will raise. An effect of society's obsolesce. The number of the habitats of nursing homes will rise but the 1.275 places which exists in 2006 are enough. The challenges for Ingolstadt and the area are the same as in every city: the number of children per woman decreases, the life-span raises, the areal mobility raises, the labor participation for women raises, the composition of the households and the ways of living will change. That means there will be more needy of care but less chances and resources to get aided at home by affiliated.

HOME CARE OF THE ELDERLY

Thai main wish of the most needy of care is to stay in the own rooms for as long as possible. About one half of all needy people are aided at home by affiliates in Germany, the other half takes professional care. In both situations the needy are able to get benefits from the public health care. If a care service is taken the benefits will only be paid if it is a accredited service. Accredited services are governed by some special quality demands and inspections. So it is guaranteed that only qualified personnel is employed and that only proper aid and benefits are delivered. The costs of a 24 hour care demands on the care level and hence on the support expenses. The costs stay right now between 2700.- and 3.200.- Euro.

If the care is provided by non accredited personnel (affiliates, neighbors etc.) or care providers, there only exists a claim for the public health care. The costs which are generated by the care can be brought in the health care, while you have to detect the costs by a bill of charges. If some medical decreed actions accrue, like change of dressing, these are incurred, if allowed by the health insurance. Who has claim for benefits from the insurance of care has the basic choice of two forms of benefits. He can choose the so called nursing allowance which can be used for the care by affiliates, neighbors or non accredited employees of care providers. Insofar he gets a monthly fixed amount. The needy person can also assign an accredited provider of care. As far as this providers takes care of the aiding the provider bills directly with the public health care, till the full amount, which depends on the care level. Insofar the needy person takes an ambulant care provider via self-organized care providers a combination of non cash benefits and cash benefits is possible. The part of the money decreases by the percentage, in which benefits of accredited providers are accessed. You can, for example, apply for 40% of the benefit money if you claim for 60% of the care benefits amount.

Caring affiliates, friends and neighbors carry the main burden of the home care. Although it is mainly the „quiet and mostly female buffer“ which takes care of the aid of the needy at home.

With the introduction of a care time into the healthcare reform 2008 the policy will set a sign for the society's acceptance of affiliates who need care. Care time means that a claim for unpaid social insured exemption from work up to six months exists. The assumption for this is an close affiliated with at least a care level of 1 who is aided in a home care. This claim exists only to employers with at normal about 15 employees. As close affiliates apply: spouses, life partners, partners of a partnership akin to a marriage, grandparents, parents, siblings, children, adopted- and foster children, grandchildren as well as parents- and children-in-law.

Who takes care of an affiliated, can't take this abandonment from today to tomorrow. He needs advice and instruction to obviate the danger of a physical or mental discharge and to assure a good quality of the care. In Germany more and more institutions, clubs and care providers offer such courses and orientations for free for caring affiliates Topics of these courses are for example modes of mobilization or bedding, spine-friendly lifting (for example from hospital bed to the wheelchair), diet, devices and rehabilitation measures, insurance of care and judicial questions. Besides the agency of these relevant topics the attendants get the possibility of get to now animations for their home situation, to communicate about their care situations and to inform on discharge supplies. The supply of those free courses is fixed by law in Germany, depending to § 45, SGB XI the public health care have to supply those courses for affiliates and honorary caregivers for free.

Despite all the prep for the business of home care the caring affiliates or rather friends have to get the possibility of a discharge supply. If it depends with regard to deadlines, on job-related cases or in case of rebound. To this discharge supplies are

among for example the care by hour or day of needy people by professional personnel or honorary personnel (in a social care support group or at home); ambulant services; home help; support at journeys; stationary short time care. Providers of these discharge supplies are: nursing homes and homes for the elderly, Clubs for people who suffer from dementia as well as initiatives like social care support groups, helping groups etc., communal supplies for the elderly, church institutions or welfare clubs.

CARE PROVIDERS OR RATHER HOME HELPS FROM FOREIGN

The assignment of a caregiver from foreign, mostly from eastern Europe is an alternative to the German nursing homes and ambulant care providers or the individual caring by affiliates, depending on the high costs of care in Germany. Mostly these caregivers from foreign work much more convenient than the German facilities. But it's very important to find a good agency or rather other office, to make sure to get qualified personnel and to assure the working communication even with different languages spoken.

The needy of care has to fund the employment of caregivers from foreign by himself but is allowed to spend the money for his individual care level on this case. Besides that he has to supply or fund an accommodation at least a room by 24-hour-care. Often the assignment of a foreign caregiver is the only alternative for affiliates because a caring by care providers is too expensive. But one should inform very good before the assignment, because the legal position isn't clear yet. The caregiver should have a work permit given from the Bundesagentur für Arbeit (Federal Employment Agency) and not only a „Touristenvisum“ (tourist visa). If a caregiver comes to Germany for three months to work and then switches with another caregiver this could be an advice for illegal work with a tourist visa.

There are many private branch exchanges, which are specialized on the intercession of caregivers from foreign. These companies build the contact link up and take care of the formalities. The official way leads to the ZAV, the central intercession agency for foreign workers of the Federal Employment Agency. At the local Federal Employment Agency one can apply for a home help in case of the need of care. Since January 2010 they are allowed to do simple caring which contains also works for which they don't need a special education. The Agency checks the German job market and if there is no help to find a worker from foreign is searched of. This takes about seven weeks. The person concerned can also search for help by himself and announce it to the Agency. These helpers are allowed to stay in Germany for up to three years and have to get paid like German home helps, depending on the Federal State about 1300 Euro gross per month including social security taxes. These costs can be declared as special expenses.

Even on the internet many companies advertise to take those helps to Germany. The aren't allowed to work as caregivers officially but in most cases they do. The danger of illegality is very high in these cases. There exists no sure numeral statistics about the number of illegal employed caregivers in Germany. Appraisals come from about 60000 up to 150000 caregivers in most cases from eastern Europe which support the affiliates at the home care or rather take full care of the home aiding. A home help which lives in a German home, is available 24/7 and works on the alignment of the affiliates or the needy of care works not under the EU-Freizügigkeit (EU liberality) but is in case of non-announcement a false self-employment and illegal. Another model of illegal employed caregivers is the employment over an care provider from foreign: in this case the caregiver from foreign is employed at a care provider in another country and is placed by a German office. Instructions by the German client are not allowed in this case but are daily use.

The following problems could appear for the needy of care in case of employing an illegal worker: communication problems depending on language and culture differences, missing security of faulty care of the needy, change of the worse care by false and unprofessional working, danger of deviation by employing an illegal worker. For the illegal employed people following problems could show up: occupational health and safety rules do not exist for illegal workers, missing coverage by social insurance, danger of exploitation in case of missing guaranty of fee, missing social insurance of continued pay in case of illness as well as isolation because of missing social contacts.

JOB MARKET / EDUCATION

The education for a nurse or caregiver is regulated by the state for all federal states equal. The education compasses about 2100 hours of theoretical and practical courses as well as the practical education compasses about 2.500 hours. The education is finished by a public registration. Assumption for the admission of the education for an elderly care nurse is the intermediate second education or in case of a CSE a professional education for at least two years. The education lasts for 3 years (with part-time 5 years). The school education is given at special schools, the practical education is given in a stationary caring facility and in ambulant care providers. Other parts of education, for example in hospitals with geriatric balance points are possible. The practical education's carrier concludes a contract with the students and pays an adequate fee for the whole time of the education. The theoretical and practical education are balanced very close to each other; education practical work change periodically. The education is aimed with regards to the knowledge and abilities, which are needed at the autonomous, integral and individual care, advice and assistance of elderly people in stationary facilities and in ambulant care.

Education's topics are for example duties and conceptions at the care of elderly (inclusion of theoretic base, care of elderly, gerontological founded work, communication, medical diagnostics and therapy, documentation, development of quality), the support of the elderly at life design, judicial and institutional basic conditions of nursing, nursing as a job (to develop a job-related self-image, to manage slumps and to master difficult social situations, to gain the own health).

In stationary and ambulant facilities of the elderly nursing the theoretic knowledge is enforced. That contains the teaching of institutional and judicial base and professional draft, the work with the elderly and take over of partial work including the advice, support and assistance and the work with the medical diagnostics and therapy under guidance or rather charge, help at the daily structuring, design of daily life and the gain of social contacts as well as individual autonomous work in projects, for example at the development of home care situations.

Elderly care nurses work in many fields of activity, mainly in nursing homes, ambulant services, short time care services and daily care homes. They are also employed at geriatric gerontopsychiatric professional hospitals, hospitals, hospices or in facilities of guided living. They work on a team – with co-workers as well as professionals of other healthcare jobs or social works. At the care and rehabilitation the work very close to the doctors.

The vocational field of elderly care nurses is the individual and self dependent care and assistance of old people who need care. It's duties are mainly the medical and care works but also social-care duties. It's in detail the professional care, the broad an planned care, the work at the care and rehabilitation of old and ill people, the broad support of mental ill people, of chronic ill and dying old people, the health care, the assistance and advice of old people in their personal and social topics, the

help for the gain and initiation of autonomous life and the advice of caring affiliates Concrete works are for example the planning of caring activities and the documentation of these, the notice of courses of diseases, change of bandages, the administration of medicine, the measuring of the blood heat, of the pulse or the level of blood sugar, the accounting of fluid, help with the personal hygiene and with food, the design of the daily routine, the guidance of free time activities and the advice of affiliates

A balance point of work is the assistance of a needy at home, the education of ambulant care normally takes place during the education of a professional nurse as a special education or in case of a following further training. In the ambulant care the caregivers are more self-concentrated than in a hospital. Colleagues or a doctor in duty are not at their beck and call at every time. Therefore in this working field a special education and a good quality of work is needed. To make the grade and to reach those goals some special personal and functional modes are needed as well as interpersonal skills.

Professional competence is for example:

- current knowledge on the different disease patterns
- knowledge of the adequate care actions
- knowledge of the actions in case of accident
- knowledge and execution of bedding techniques
- right exposure to medicine
- knowledge of the effectiveness of medicine
- right exposure to drip-feeding
- right exposure to hygienic directives
- knowledge of a documentation of care
- knowledge of a compiling of a plan for care
- knowledge of the insurance of care
- knowledge of regulatory affairs

Interpersonal skills clasp items like:

- ability to communicate with patients
- ability to communicate with patients' affiliates
- respect of the patient's privacy
- ability to cooperate with other careers

At the ambulant sector worked in 2007 at all 236000 persons, 88% of those were female, 71% worked part time. 69% of the employees had their primarily work at the basic care The main part had their education as health caregivers and nurses or as elderly care nurse. Compared to 2005 the impact of the ambulant services has grown, there was a boost at the employees for 10% (compared to 2005) (Statistisches Bundesamt – Federal Agency for Statistics).

At nursing homes were about 574000 people employed, 85% of those were female. More than a half were part time workers. The most of the employees (69%) had their primarily work at the care and assistance. Even in nursing homes the health caregivers, nurses and elderly care nurse were the most important educations.

Summing up this contemplation lone can say about the German health care system: all partners are confronted with challenges akin to each other. The part of the elderly people in society grows: and therewith the risk of the need of care. The care at home looms large and will still be on the first place in future. Social basic conditions as for example scarce familial „potential of care“ as well as socio-political basic conditions like high care costs make the families added employ (non legal employed)caregivers from foreign, mostly from eastern Europe, whose degrees from their countries are hard to accept here.

The question of a negotiability of the Parma-archetype is hard to ask in Germany: an absorption of costs from the insurance of care's money only takes place if accredited care providers are accessed. If services of non-accredited providers are accessed, the person concerned have to fund the service by himself to the fullest. In § 80 of the „Pflegeversicherungsgesetzes“ (Law of insurance of care) it's judicial regulated that the accredited services and providers are bound to stick to the actions of quality control.

If the care is done by non accredited personnel or services only the claim for the nursing allowance exists.