Evidence-based Guidelines on Health Promotion for Older People:

Social determinants, Inequality and Sustainability

Overview on health promotion for older people in Germany – First Draft

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## Contents

1 **Introduction** .................................................................................................................. 3

2 **Policy initiatives for older people/health promotion** .................................................. 9

3 **Health determinants** .................................................................................................... 14

4 **Search strategy** ............................................................................................................ 18

5 **Themes** .......................................................................................................................... 20

5.1 **Promoting mental health** ............................................................................................ 20

5.1.1 Addressing depression ............................................................................................... 20

5.1.2 Addressing stress and burn-out ............................................................................... 22

5.1.3 Cognitive issues: memory training ............................................................................ 23

5.1.4 Self-respect / dignity ................................................................................................. 24

5.1.5 Emotional support .................................................................................................... 24

5.2 **Other** .......................................................................................................................... 24

5.3 **Empowerment** .......................................................................................................... 25

5.4 **Social participation – inclusion** ................................................................................ 25

5.4.1 Lifelong learning / education of older people (health): e.g. University of third age... 26

5.4.2 Social support / networks ........................................................................................ 27

5.4.3 Self-help groups ....................................................................................................... 28

5.4.4 Volunteering ............................................................................................................ 29

5.4.5 Other ....................................................................................................................... 30

5.5 **Lifestyle** ..................................................................................................................... 30

5.5.1 Nutrition and Physical activity .................................................................................. 31

5.5.2 Sexual activity ......................................................................................................... 33

5.5.3 Smoking and Alcohol .............................................................................................. 33

5.5.4 Drugs ....................................................................................................................... 35

5.5.5 Safety – e.g. prevention of falls, accidents and injuries ........................................... 35

5.5.6 Preventing abuse/violence against older people ...................................................... 37

5.5.7 Prevention of disease .............................................................................................. 37

5.5.8 Other ....................................................................................................................... 40

6 **Transversal issues** ......................................................................................................... 42

6.1 **Research Methods** .................................................................................................... 42

6.2 **Strategies of health promotion** ................................................................................. 43

6.3 **Settings** ...................................................................................................................... 44

6.4 **Inequality/diversity/gender** ..................................................................................... 47
6.5 Sustainability ................................................................. ................................................... 49
6.6 Cost-effectiveness ........................................................................................................... 50
6.7 Consumer involvement ................................................................................................. 51
6.8 Multidisciplinarity ......................................................................................................... 52
6.9 Other issues ................................................................................................................... 52
7 Conclusions/summary ...................................................................................................... 52
8 References ....................................................................................................................... 57
9 Annex .................................................................................................................................. 71
1 Introduction

In Germany, a long-term change in the age structure of the population has set in, with a similar tendency prevailing in all European countries. Ageing of the population, which will also continue in future, is a stable, long-term development resulting from a decline in the number of births and an increase in life expectancy (Deutscher Bundestag, 2002, 15f). According to current population development forecasts, the following changes are expected to take place in the Federal Republic of Germany by 2030 (Bäcker, Bispinck, Hofemann & Naegele, 2000, 232ff):

- An overall population decline from 82 million in 2000 to about 78 million by 2030.
- A rise in the proportion of persons aged over 60 from 22% (2000) to 35% in 2030.
- The proportion of persons aged 80 and over will increase from 4% in 2000 to more than 12% in 2030.

In the Federal Republic of Germany (FRG), there has been a steady increase in the average as well as the remaining life expectancy for both sexes since the 1990s. In 2002/04, the life expectancy of women at birth was 82 years, that of men 76 years (RKI, 2006, 15ff). Since 1990, the expected life span has increased by 2.8 years for women, and by 3.8 years for men. An investigation of the remaining life expectancy at age 65 over the same period revealed a national average of 19.8 years for women and 16.4 years for men. Here also, life expectancy has risen since the 1990s, i.e. by 1.9 years for women and by 2.2 years for men (ibid.). When considering “healthy life expectancy” that is, weighting of life expectancy in terms of years spent free of serious health problems, it becomes clear that women live longer with health handicaps than men. In 2002, women spent an average of 74 years in good health in the FRG; with time spent suffering from health impairment adding up to an average of 7.6 years. The figures for men were 69.9 years in good health and 5.9 years with health problems. The subjective health of the German population presents a positive overall picture, with satisfaction with personal health being slightly higher among men than among women. With increasing age, however, a decrease in positive health assessment is prevalent among both sexes (RKI, 2006,17f).

How far a higher life expectancy will be accompanied by an extension of life in good health or rather an increase in the frequency and duration of illnesses and

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1 The average life expectancy is the average number of years of life expected for a new-born baby in view of current mortality conditions, whereas the remaining life expectancy is the average number of years of life to be expected by the population upon reaching a certain age. On the international level, remaining life expectancy is calculated from the ages of 40, 60, 65 and 80 (RKI, 2006,15).

2 The subjective health of the population is examined by the following methods in the Federal Republic of Germany: 1) survey of health satisfaction (with a scale ranging from 0 “extremely dissatisfied” to 10 “completely satisfied”, reflecting satisfaction with the general condition of health), 2) self-assessment of health (e.g. “How would you describe your current state of health?”), giving interviewees a choice of five ratings from “extremely poor” to “excellent”) (RKI, 2006,17).
disablement during old age is an important question from a (socio-)political as well as social point of view, which has not yet been conclusively determined (Deutscher Bundestag, 2002, 184f). Although it must be assumed for the time being that with increasing age the probability of chronic illness, dementia and multi-morbidity will also increase, old age as such cannot be seen as a synonym for illness and need for nursing care. Important factors influencing the state of health in old age are personal behaviour patterns and ability to cope, as well as appropriate medical and social care. In addition to curative measures, rehabilitative and preventive measures contribute to health, quality of life and well-being (BMFSFJ, 2001, 69; RKI, 2002, 5). With an increasing frequency of chronic diseases that show little response to curative therapy and/or are incurable according to the current state of medical research, the significance of preventive and health-promotion measures in health care also increases. For the German public health care system, which follows primarily a curative strategy, this points to the necessity of intensifying health promotion and preventive care (Hurrelmann & Laaser, 2006, 749; Dt. Bundestag, 2002, et al.).

The definitions of the terms “health promotion” and “prevention” are not completely clear-cut, and the borderline separating their exact meanings is somewhat blurred, due to their different history and the fact that they originate from different scientific disciplines and fields of practice (Werle et al., 2006, 29f; Hurrelmann & Laaser, 2006, 750; Hurrelmann Klotz & Haisch, 2004, Walter und Schwartz, 2003).

Prevention (of disease) developed during the 19th century in connection with the socio-medical discussion about social hygiene and public health. Preventive strategies are aimed at avoiding outbreaks of disease, and reducing its spread and its effect on the mortality of the population. Based on knowledge about the development of various diseases (pathogenesis), preventive intervention is directed at identifying, avoiding or reducing incipient conditions and risks of disease (risk factors) (Avoidance strategy) (Hurrelmann & Laaser, 2006, 750ff, Hurrelmann Klotz & Haisch, 2004, 12). Prevention has a long tradition in the German health care system, which until the end of the 1970s was characterised by the behavioural approach to personal health education (behavioural prevention). Substantially influenced by the results of public health research, attention increasingly focused on social factors contributing health or illness during the following years (environmental prevention) (Deutscher Bundestag, 2001).

The term “health promotion” was introduced in the mid-1980s, in the context of health policy discussions of the WHO (Ottawa-Charta, WHO, 1986). Health promotion targets the strengthening of health as a result of improvement in the conditions of life. Based on knowledge about the development and maintenance of good health (salutogenesis), health promotional intervention is aimed at influencing conditions of life and behaviour patterns relevant to health in all population groups. Here, the main focus is on improving personal and social health competence and on policies directed at improving the determining health factors (promotion strategy) (Hurrelmann & Laaser, 2006, 750ff, Hurrelmann Klotz & Haisch, 2004, 12,
Kickbusch, 2003, 182). Health promotion takes into account “(...) medical factors as well as sanitary, mental, psychiatric, cultural, family-related, social, legal, educational, economic, architectural and ecological aspects. The aim is the preservation and stabilisation of health as well as the improvement and development of health potential for as many people as possible” (Hurrelmann & Laaser, 2006, 753).

Interventions to prevent disease and to promote health are similar in that they are both directed at achieving better health, either for individuals or for the population as a whole. There is, however, a difference in approach, since in the case of the former, the effort is aimed at reducing disease, while the latter is focused on improving health resources. Strict categorising does not appear desirable for the sake of existing - and necessary - interdisciplinary cooperation as well as in the interest of implementing comprehensive health care. Which of the two approaches is preferable must be decided in each individual case, bearing in mind that a combination of both is better than an isolated approach in order to achieve a lasting improvement of health (Hurrelmann & Laaser, 2006, 752). The following major trends, substantially influenced by findings of modern health-related research, have emerged in the Federal Republic of Germany during the last few years (Werle, Woll & Tittlbach, 2006, 25):

- A shift from curative towards preventive therapy,
- Supplementing of preventive measures for individuals with health promotion measures for the whole population,
- A shift of the theoretical focus from pathogenesis towards salutogenesis.

Health promotion and disease prevention are tasks set to society in general which are not confined to health care policy, but concern a number of different areas in politics and are the responsibility of local, as well as state and federal authorities (s. Abb. 1).
These tasks are the responsibility of institutions within the medical system, but they go beyond mere health care policy, touching on labour, environmental, economic and transport policies as well (Bäcker et al., 2000, 48).

As is the case in other service-providing sectors of the social security and health care system, the content and funding of disease prevention and health promotion is characterised by a wide-spread distribution of tasks and competencies among those participating and responsible (e.g. political institutions on the federal, state and local government levels, research institutes and scientific institutions, social security organisations, business enterprises, educational institutions, service providers and self-help groups). Consequently, sustainable and effective implementation of measures to prevent disease and promote health is hampered by a lack of concentration and coordination of existing forward-looking concepts and research findings (Apitz & Winter, 2003, 68). Another problem in this context is that spirit of “everybody’s responsibility for everything” which has prevailed among the various

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participants for a considerable number of years and led to an attitude of nobody’s being responsible for anything (Bäcker et al. 2000, 39).

In Germany, health, accident, nursing and retirement benefit insurance organisations and the social welfare department all play a part in health care and nursing care for the elderly and in making sure that such services are generally available. All aspects of the system are governed by federal law, supplemented by specific regulations imposed by each federal state (Bäcker et al. 2000, 51 ff.). On the whole, though, the provision of health care for the entire population is seen as the main task of public health insurance (GKV), which was introduced in 1883 with the original purpose of providing health cover for industrial workers (Bäcker et al., 2000, 51ff). Therefore a more detailed description of the general legal and structural framework of public health insurance in particular is given below.

At present, virtually the entire population (99.9%) is covered by some form of health insurance, with about 89% being members and pensioners or dependants insured in public health insurance institutions (GKV), about 9% covered by private health insurance and about 2% insured via alternative arrangements. Basically all of these insured persons have access to all services provided by the health care system. Thanks to the insurance principle, there are no financial barriers to the use of any requisite health care facilities (Bäcker et al., 2000, 47; Lampert, 2000, 163). The benefits provided by the public health insurance system include health promotion, prevention and early diagnosis of diseases, curative treatment of diseases and rehabilitation. The benefits of public health insurance can be utilised in kind (such as dental and medical treatment, hospital care and pharmaceuticals), in cash (sickness benefits) or in the form of services (such as counselling in the course of preventive medical screening) by all insured persons, generally without any additional financial contributions being required (Bäcker et al., 2000, 54).

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4 Strengthening of preventive measures in the sphere of responsibility of public health insurance is considered as one way of solving this problem (Bäcker et al., 2000,39). An extension of prevention and health promotion measures in the Federal Republic of Germany in the context of a prevention law is also in planning (see below).

5 Another task is the compensation for lost earnings from employment by income benefits (sick pay) (Bäcker et al., 2000, 51).

6 These are members of the federal armed forces, persons performing alternative civilian service and welfare recipients.

7 Various reforms to the health care system since the 1970s have been introduced primarily to address cost reductions. Besides the principle of benefit in kind, which provides health care according to medical need independent of the patient’s personal income and requires no financial contribution from patients, a system of co-payments on the part of insured persons (from the age of 18) has been introduced, in particular by the health care reform law (GRG, first stage of the health care reform) which came into force in 1989, in the form of requiring co-payments from patients for various benefits (such as pharmaceuticals, bandages and dressings, cost of transport to and from hospitals, emergency transport and ambulances, medicaments, hospital treatment and stationary rehabilitation measures, dental prostheses and orthodontics). A rising proportion of health care benefits is financed privately (such as self-medication, massages, alternative practitioners, etc.). Social security and excessive burden clauses for socially underprivileged groups (such as welfare recipients, unemployed people and students) and the chronically ill are intended to counteract excessive financial burdening of such groups (Bäcker et al., 2000, 48ff).
Although in addition to the conservation and restoration of health, the improvement of health is also one of the tasks of health insurance (see §1 SGB [Social Security Code] V), the main emphasis in the German health care system is on curative medicine (Bäcker et al., 2000, 48). The top priority is healing, relief or preservation of the existing state of health after the onset of a disease (ibid.). This does not include prevention and health promotion as integral parts of therapeutic, rehabilitative or care-giving measures, which take first priority. Cure, rehabilitation and prevention are all isolated domains, and mostly separated from each other in terms of time, place and organisation (Dt. Bundestag, 2001).

In spite of the increasing significance of chronic, degenerative diseases and a corresponding rise in the need for medical care (for instance in connection with cardiovascular diseases, cancer, diseases of the musculoskeletal system, obstructive lung disease or neuropsychological diseases), and regardless of obvious proof (see for example the “Deutsche Herz-Kreislauf-Präventionsstudie, Forschungsverbund DHP, 1998” [German study of preventive cardiovascular medicine, DHP research group], preventive medicine has played (and still plays) only a minor part in the German health care system (Bäcker et al., 2000,57; BMFSFJ, 2001,89; Deutscher Bundestag, 2001, Hurrelmann & Laaser, 2006, 774; Walter & Schwartz, 2001,198f). This is also shown by the expenditure of public health insurance bodies for preventive services, which makes up about 4% of the total expenditure8 (Bäcker et al., 2000, 57; Statistisches Bundesamt [Federal Statistical Office], 2006). In this connection, Bäcker et al. (2000, 57) state that “(...) the broad public consensus on health policy relating to the necessity of preventive health care falls far short of its actual significance.”

Although theoretically all groups of the population have equal access to institutions and services of the health care system, differences in morbidity and life expectancy due to social background exist also in Germany. As a consequence of the reunification and its associated costs, a generally difficult economic situation and demographic changes, a diverging development in conditions of life has set in (such as incomes below the poverty line, high levels of debt, unemployment and unequal educational opportunities due to social background), which, in turn, has an effect on the population’s health and life expectancy. Thus there is a definite correlation between social background (social class, income, level of education, unemployment, housing and environmental conditions) and health or illness even in a modern social security and welfare state like the Federal Republic of Germany (Lampert et al., 2005; BMGS, 2005).

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8  See Statistisches Bundesamt [Federal Statistical Office], Health Care Expenditure by Types of Benefit, as per 16.08.2006; in the years from 2002 to 2004, the expenditure for prevention/health conservation rose slightly, however it still remained just under 4% in 2004. 15.01.2007 from http://www.destatis.de/basis/d/gesu/gesutab5.php
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2 Policy initiatives for older people/health promotion

With the introduction of the Health Reform Act in 2000, health care policy began to focus more on prevention and health promotion (Dt. Bundestag, 2002, 404f; RKI, 2006, 125f). Thus public health insurers were once again legally authorised to pursue general (primary) prevention and health promotion (Social Security Code SGB V § 20, 2000). Preventive services are primarily intended “to improve the state of health in general and to contribute to reducing social inequality of health opportunities in particular” (SGB V § 20, Sec. 1). With this amendment to §20 SGB V, an aspect of salutogenesis and social responsibility was incorporated in the legislation (Walter & Schwartz, 2003, 260).

Demographic change, the expected increase in chronic disease and the concurrent increase in costs, plus massive criticism raised against the one-sided emphasis on curative medicine in the health care system, resulted in the development of a national strategy to advance prevention and health promotion on the part of the Federal Ministry for Health and Social Security (BMGS). This strategy also targets the reduction of social inequality in the health sector (RKI, 2005, 7f), takes older people into account and mainly consists of the following elements:

1. the “German Forum for Prevention and Health Promotion”
2. the Law for Prevention and Health Promotion;
3. the German Prevention Award
4. national health goals

1. The German Forum Prevention and Health Promotion

The German Forum Prevention and Health Promotion (Deutsches Forum Prävention und Gesundheitsförderung) is an initiative of 71 associations and organizations in the health sector, which was founded in July 2002 by the Minister of Health. These organisations include social health insurances and WHO “Healthy Cities”. After the commencement of the prevention law, the Forum will delegate seven of its members to the board of trustees of the new foundation. Then the Forum will remain in an advisory capacity. It is organized into several working groups, one of them called AG 3 “Healthy ageing” guided by the Federal Association for Health (Bundesvereinigung für Gesundheit BfGe). It sees ageing as a chance and achievement, with a focus on an increase in quality of life. Age should be looked at not only through the economic lens but rather be seen as a chance for health, independence, mobility and competence. The working group has two main goals: to create positive messages for an awareness campaign and to establish a preventive doctoral home visit. The messages for health promotion are addressed to the population over 50 and

http://www.forumpraevention.de/nn_366/Content/de/Internet/01__Wir_20_C3_BCber_20uns/05__AG3_20Gesund_20altern/Artikel.html__nnn=true

http://www.bvggesundheit.de/healthPROelderly – National Report Germany

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disseminators (information multipliers) in institutions, organizations and associations. They were compiled into 15 rules for healthy ageing\textsuperscript{11}. The content of the messages is the following:

- Regard age/ageing as chance,
- Maintain and promote health, productivity and autonomy
- Risk reduction
- Benefit from existing provision
- Identify and alleviate disorders
- Name contact persons for questions

One practical project the working group is discussing is the “preventive home visit” for the individual analysis of preventive possibilities. This service would address people over 70 who are not in need of care. Currently the usefulness of such a service is being evaluated\textsuperscript{12}. The preventive visit

- Includes early detection of risks and limitations in autonomy and productivity,
- Offers concrete counteractive measures,
- Includes several specialities and family members.

Although the effectiveness of preventive home visits has been proved by several different studies, there are some inconsistencies in the findings of existing studies seen in combination (see also Meinck et al., 2004). Apart from the absence of clearly identified specific success factors, there are still a number of questions unanswered concerning the target group (age group, selection criteria), the participating professional groups and organisation concepts, the content of benefits distinct from those already in existence, the frequency of visits and further cost-benefit analyses (Bundesvereinigung für Gesundheit e.V. [Federal Health Association], 2005, 4-7).

Therefore the Working Group 3 carried out a hearing of experts in November 2005 with representatives from the disciplines geriatrics, gerostomatology, care-giving science, general medicine and health care economics participating (Bundesvereinigung für Gesundheit e.V., 2005). The experts advocated preventive home visits to elderly persons in Germany on a trial basis in the form of a controlled, decentralised random study, with the aim of establishing preventive home visits as a long-term regular service\textsuperscript{13}.

\textsuperscript{11} The rules (“Regeln für gesünderes Älterwerden”) were developed by Prof. Dr. Andreas Kruse, Director of the Institute for Gerontology of the University of Heidelberg, for the Bundesvereinigung für Gesundheit e.V. on the occasion of the World Health Day “Active Ageing”, they were updated by the working group AG 3 and taken over into the messages for healthy ageing (“Botschaften für gesundes Älterwerden”).

\textsuperscript{12} A feasibility study for preventive home visits in Germany was carried out in Munich (“Prevention in old age – geriatric funded home visits for the elderly”). Prävention im Alter- geriatrisch fundierte Hausbesuche bei älteren Menschen, Machbarkeitsstudie, Bayrischer Forschungs- und Aktionsverbund Public Health http://www.forum-seniorenarbeit.de/media/custom/373_148_1.PDF?La=1&object=med%7C373.148.1&ModID=med.

2. The German Law for Prevention and Health Promotion

Federal legislation regulating prevention is currently incorporated in several different social codes\(^{14}\) (RKI, 2006,126; Walter, 2004, 71ff). Within as well as from one individual social code to another, different technical terms are used to define prevention\(^{15}\), each one of these to be understood in the context of defining prevention provided by a specific institution,\(^{16}\) and consequently as being subject to a different definition of preventive tasks.

Health insurance (§20 SGB V) and nursing insurance (SGB XI § 7) legislation explicitly includes the term health promotion. While SGB V specifies the need for health promotion at the workplace along the lines of the WHO setting approach, SGB XI only contains a general requirement that the support of insured persons taking part in health promotion measures should be encouraged (Walter & Bisson, 2006, 8). Therefore the hope of standardisation and integration of federal and state legislation is linked to the introduction of a national law regulating prevention. Moreover, this is seen as an opportunity to provide prevention with a solid foundation in health policy (Walter, ibid.).

The German Kabinett (Cabinet) presented a first draft of a new law concerning the strengthening of health prevention called “Encourage prevention- conserve health” (Präventionsgesetz PrävG\(^ {17}\)) on February 2, 2005.

To begin with, the prevention bill was passed in April 2005 by the Red-Green government against the votes of the opposition parties. Criticism from some of the federal states\(^ {18}\) led to the Bundesrat [Upper House] lodging an appeal to the conciliation committee in May 2005, following which the final passing of the bill was adjourned in June 2005.\(^ {19}\) At the beginning of February 2006, the Federal Minister of Health, Ulla Schmidt, announced that a further adjournment of the prevention bill to 2007 had become necessary because other pressing problems had a higher priority.

\(^{14}\) While legislation is located at federal level the implementation is carried out at state level mainly under the auspices of state ministries with special departments for health which exist in 12 states. Furthermore there are different providers of prevention and health promotion at community level. (Walter & Schwartz, 2003, 254ff).


\(^{16}\) In terms of social security legislation, the following participants must be taken into account as bodies responsible for prevention: the Federal Employment Office, health insurers, public pension insurance, accident insurers, nursing care insurers, youth assistance organisations, federal states, municipalities, welfare institutions (Walter, 2004).

\(^{17}\) Law of Prevention http://www.die-gesundheitsreform.de/praevention/praeventionsgesetz/

\(^{18}\) The federal states of Saxony and Thuringia had voiced some criticism against the bill before the Bundesrat (the Upper House) in March 2005 (one point criticized being the imposition of unnecessary bureaucracy by the proposed foundation for prevention and health promotion), which prompted the Bundesrat to request a revision of the bill by the Federal Government. Bauch (2005) remarks, that the bill met with relatively little criticism on the whole. Although there was a definite need for further discussion, Bauch fears that prevention will still be treated as a topic of minor significance (“low interest topic”, ibid., 44).

\(^{19}\) Source: Skizzierung des Verlaufs der Einführung des Präventionsgesetzes (outline of procedures for the introduction of the prevention law) dated 02.10.2006; 03.01.2007 from http://de.wikipedia.org/wiki/Pr%2C3%A4ventionsgesetz

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So there is still no clear legal basis for prevention and health promotion in place, although the federal government has emphasized their significance. That the strengthening of prevention is still a topic currently under discussion in connection with the health care reform of 2006 should be seen as a positive sign. The concept of developing prevention into an area of health care in its own right is being upheld. Regardless of the still pending legislation, health insurance organisations have already been committed to supporting health promotion at the workplace, prevention of working conditions with health hazards as well as the work of self-help groups and points of contact. The prevention law’s objectives are outlined in the next paragraph.

The prevention law is a general law concerning all populations and age groups, however, this law is of relevance since it is just being discussed and projects eligible for funding under this law will also concern demographic ageing. Its main focus is coordination and cooperation, quality assurance, environment-oriented measures and a new regulation of prevention within the social insurance. The Minister of Health Ulla Schmidt proclaimed, “Prevention and Health Promotion are not a question of age”. The law demands that the social insurance carriers invest 250 Million Euro yearly into preventive measures for all age groups, 180 Million Euro coming from the social sickness insurance. The retiree’s insurance will pay 40 million, accident insurance 20 million and social care insurance 10 million Euro. Individual services for attitude change, setting services (projects in the insured’s environment), and workplace health promotion should be covered by the insurances. The core of the new law is the creation of the foundation “Prevention and Health Promotion” (Stiftung “Prävention und Gesundheitsförderung”) which receives 20% of the total funds for health prevention. Besides projects and campaigns, the foundation is a networking agency and sets goals and quality standards. The Federal States receive 40% of the available resources. They are designated to work together with the insurances to create regional provisions and projects. To date, it seems that rather than initiating new projects, already existing projects are simply continued. 100 million Euros remain with the social insurance organisations. They can themselves determine what


21 Moreover, the health insurers may implement “bonus-malus” regulations similar to those already in place for dental prostheses (subsidies for dental prostheses are only granted against presentation of a preventive checkups record) also for the utilisation of early medical diagnosis facilities and preventive measures especially for insured persons in the 45-55 age group (ibid.). Source: Eckpunkte zu einer Gesundheitsreform 2006, 08.01.2007, from http://www.die-gesundheitsreform.de/gesundheitspolitik/pdf/eckpunkte_gesundheitsreform_2006.pdf


23 Press release from the Ministry of Health and Social Security (Pressemitteilung des Bundesministeriums für Gesundheit und Soziale Sicherung BMGS), Berlin, 2. Februar 2005,Nr.20 www.bmgs.bund.de or http://www.forumpraevention.de/nn_56/Content/de/Internet/03_Aktuell/Pressemitteilung_20BMGS_20Pr_C3_A4 v_Gesetz.html__nnn=true

24 www.forumpraevention.de and www.aok.de
to do with this amount, e.g. invest further into individual counselling for attitude change and work place health promotion.

3. The German Prevention Award

The Bertelsmann Foundation, the Ministry of Health and Social Security and the Federal Headquarter for Health Education awarded the German Prevention Award for the second time in 2005. The prize is endowed with 50,000 Euro. The theme in 2005 was “Healthy in the second half of life”.

The award winners and nominated projects are described collectively in a brochure. The judgement of the projects was based on the following criteria (Bertelsmann, 2005, 22):

- clearly defined, revisable objectives
- clearly defined target group(s) for the project (within the 50-plus target group)
- active involvement of the target group(s) in planning and implementing the measure
- documentation of the measure
- proof of achievement of objectives as originally defined
- continued viability of the measure after start-up funding ceases
- transferability of the measure
- innovation, for instance of the measure as such, in the form of cooperation or in funding
- accessibility for population groups in special problem situations (socially underprivileged persons, men and women advanced in years, migrants).

The first prize was won by the Hamburg project “Active health promotion in old age.”

The Albertinen-Haus is a Centre for Geriatrics and Gerontology. The idea behind the project was the training and assignment of nursing staff for health promotion and measures in the setting of preventive home visits. The goal was to evaluate different measures, to define the target population and to make recommendations to support family doctors. Further a curriculum was to be designed. The long-term goal was the

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25 www.deutscher-praeventionspreis.de
27 Aktive Gesundheitsförderung im Alter, Ein neuartiges Präventionsprogramm für Senioren, Hans Peter Meier-Baumgartner, Ulrike Dapp, Jennifer Anders, Kohlhammer healthPROelderly – National Report Germany
promotion of the quality of life of the elderly and the prevention of diseases, and thus
the need of nursing care. 14 doctors cooperated with the Abertinen-Haus.\textsuperscript{28}

This project was a low-key, holistic approach to health promotion for elderly persons
still living in their own homes and not yet in need of nursing care (60+), including the
areas of nutrition, physical exercise and social support. The implementation of the
individual measures has been assigned to a multidisciplinary team cooperating with
the family doctors of the participants. The other award winners and nominees are
listed in a tabular overview in the annex.

4. National health goals\textsuperscript{29}

The Ministry of Health and Social Security initiated the process to define national
health goals and their implementation. Currently the German Forum (Forum
Gesundheitsziele Deutschland) has selected 6 areas as Health Goals. Sub-goals,
strategies and measures have already been developed for the following areas:
Diabetes mellitus type 2, Breast cancer, Reducing tobacco consumption, Growing up
healthy: nutrition, exercise and coping with stress for children and youths, Increasing
health competency and patient’s sovereignty. Recently, depression has been defined
as another national health-goal\textsuperscript{30}; different sub-goals, strategies and measures
especially address older people as a vulnerable target group.

3 Health determinants

On the one hand, the state of health in old age is influenced by functional changes in
the entire organism or in individual organs, which bring about functional impairment
and increasing vulnerability\textsuperscript{31}. These do not by themselves necessarily fall into the
category of diseases, but they can aggravate and prolong any disease that occurs
and favour its development into chronic illness (BMFSFJ, 2001, 71; RKI, 2002,8). On
the other hand, each person’s individual biography must be taken into account,
including the fact that health risk factors accumulate and may grow in significance in
the course of a life. Moreover, series of diseases frequently occur in the higher age
groups (Ding-Greiner & Lang, 2004; Nehen 1998), sometimes also originating from
certain therapies used in treating some other disease. If several classic risk factors
are present simultaneously (such as high blood pressure, lipometabolic disorders, a
smoking habit, diabetes, adiposity, lack of physical exercise as risk factors for

\textsuperscript{28}http://www.bmfsfj.de/RedaktionBMFSFJ/Abteilung3/Pdf-Anlagen/aktive-gesundheitsfoerderung-im-
alter_property=pdf.pdf and
http://www.bmfsfj.de/RedaktionBMFSFJ/Abteilung3/Pdf-Anlagen/konzept-aktive-
gesundheitsfoerderung_property=pdf.pdf and

\textsuperscript{29}www.bmgs.de and www.gesundheitsziele.de

\textsuperscript{30}http://www.gesundheitsziele.de/xpage/objects/depression/docs/1/files/Gesundheitsziele_Depression_BMG_01-
03-06.pdf as of 15.12.2006

\textsuperscript{31}Typical examples are changes occurring to the sense organs (prebyopia, cataract, loss of hearing in the high-
frequency range) or of the musculoskeletal system (degeneration of skeletal muscles, decrease in the elasticity of
sinews, ligaments and muscles and the mobility of joints or the mineral content of bones) (ibid.).
cardiovascular disease), this may not only lead to such risks simply adding up, but actually to mutual amplification of such factors and increased mortality. The mortality risk increases almost fivefold in persons with three or more risk factors (BMFSFJ 2001,89f; Helmert, 2003, 547). Moreover, some risk factors can have multiple causes; for instance falls generally have a multiple origin and are often the result of a combination of risks (BMFSFJ, 2001,90; RKI, 2002,16).

More than half (56%, n=83) of the literature examined includes descriptions of factors that have an effect on the health and the health-related behaviour patterns of older people, although to a varying extent. In current literature, the following factors have been named: individual behavioural and life-style factors, socio-economic factors and social inequality, conditions of life and working conditions, social relationships and social support, and gender.

On the whole, there are great differences in the state of health of older people. With increasing age, however, the probability of developing chronic diseases that are typical of old age settings increases, and such diseases may also accumulate especially at an advanced age (multimorbidity) (Walter & Schwartz, 2001,170ff). In this context, the Berlin Study of Old Age (BASE) provides comprehensive material about age-related morbidity in terms of the overall population. For instance, 88% of persons aged 70 and over were diagnosed with five or more diseases; in 30% of these cases, multiple diseases objectively classed as moderately severe to severe were detected (Steinhagen - Thiessen & Borchelt, 1996,155f). The most frequent disorders are diseases of the cardiovascular or cerebrovascular system and musculoskeletal diseases. Cardiovascular diseases lead to a significant increase in mortality and are, for both men and women, the most frequent cause of death at an advanced age (Walter & Schwartz, 2001,197; Steinhagen-Thiessen & Borchelt, 1996; Dt. Bundestag, 2001,94). In subjective assessment of the degree of severity, however, diseases of the musculoskeletal system take first place, since they are frequently accompanied by chronic pain (Walter & Schwartz, 2001; Steinhagen-Thiessen & Borchelt, 1996). Chronic pain often leads to impairment of the capacity to perform various tasks and to a reduction of social contacts; it also has a significant effect on satisfaction with personal health and with life (RKI, 2002, 15f).

About a quarter of those aged 65 and over suffer from mental disorders, primarily dementia and depression (Helmchen et al., 1996, 195; RKI, 2002, 18). While dementia is relatively rare among persons under the age of 65, the probability of developing senile dementia rises exponentially between the ages of 65 and 90, which

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32 Clinical pictures include hypertension, arteriosclerosis, myocardial infarction and apoplexy (Walter & Schwartz, 2001,197).
33 Clinical pictures include in particular osteoarthritis (arthritis of the knee or the hip), dorsopathy and osteoporosis (Walter & Schwartz, 2001,174; Steinhagen-Thiessen & Borchelt, 1996).
34 The number of persons suffering from pre-senile dementia (i. e. aged between 40 and 64) is about 20,000, which is less than 0.1 % of the population and less than 3 % of the total number of persons suffering from dementia (Bickel,2001, 40).
means that the prevalence of this disease doubles with every five additional years of age (Bickel, 2003, 17). According to an estimate by Bickel (2000), an average of 900,000 persons over the age of 65 suffer from some form of dementia. Dementia diseases are among the most prevalent causes for loss of autonomy and the need for nursing care, which underlines the necessity to develop appropriate preventive strategies as well as facilities for treatment and care-giving (Bickel, 2001, 42ff; Deutscher Bundestag, 1996. Schneekloth, U., Potthoff, P., Piekara, R. & Rosenbladt, von B., 1996, 99ff).

Information about individual health-related behaviour is provided by representative surveys among the population carried out as part of national health reporting. Personal health-related behaviour has an effect on the development of disease and can be categorized as risk factors that can be influenced either directly or indirectly. Some risk factors that can be influenced directly are physical exercise, alcohol consumption and smoking, while factors subject to indirect influence, such as adiposity, hypertension and excessive cholesterol values, can also have causes not directly linked to personal behaviour, therefore these generally require extensive intervention. In considering the risk factors that can be directly influenced for the over-65 age group, the following should be noted (RKI, 2004, 13):

- in the over-65 age group 49% of the men and 53% of the women are not engaged in any sports
- 32% of men and 71% of women in this age group are non-smokers.
- 75% of older men and 91% of older women have claimed that they drink very little or no alcohol.

Concerning the risk factors subject to indirect influence, the following should be noted (RKI, 2004, 15):

- in the over-65 age group 23% of the men and 29% of the women are overweight

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35 Prevalence is the number of cases within a defined population group (Bickel, 2003, 11).
36 At an assumed prevalence rate of 7.22 %, calculated on the age composition of the over-65-year-old population in Germany at the end of 1996 (Bickel, 2000, 213).
37 First representative surveys (called “national health surveys”) about health-related topics were carried out in the 1980s and early 1990s. These were studies to obtain reference data for the German Cardiovascular Prevention Project (Deutsche Herz-Kreislauf-Präventionsstudie) (DHP). The main purpose of these studies was to explore in particular cardiovascular diseases and their risk factors. With the subsequent Federal Health Survey (BGS98) conducted between 1997 and 1999, the foundation was laid for creating a routine instrument of national reporting on health. The BGS98 provided for the first time extensive health-related data for the German population aged between 18 and 79 (including the frequency of certain diseases, symptoms, risk factors, complaints, health-related conditions of life and behaviour patterns, data concerning the utilization of medical services, drug consumption and significant indicators from pathological and medical diagnoses) (Stolzenberg, 2002, 22ff). Topical health reporting on the part of the Federal Government is now based on the data derived from the BGS98. A condensed evaluation provides a general impression of the state of health in old age (RKI, 2002). More data about the state of health of the German population were compiled in a telephone health survey carried out for the first time between September 2002 and March 2003 (GSTel03). By contrast to the BGS98, the GSTel03 included for the first time data supplied by the whole adult population (18+), without an age limit being imposed (RKI, 2004, 8ff).
• about half of the men (48%) and women (52%) in this age group suffer from hypertension
• almost every second older woman (48%) shows excessive cholesterol values, with a 40% share among men.

Less than 10% of both sexes in this age group are entirely free of health risks, whereas half of the men (51%) and of the women (47%) are affected by both categories of risk factors - those directly as well as those indirectly related to behaviour (RKI, 2004, 17).

Although the risk factors for many frequent (chronic) diseases in old age and appropriate methods of prevention are well-known\(^38\) (BMFSFJ, 2001,89; RKI, 2002,13; Walter & Schwartz, 2001,198f), the prevention potential available at present is not always sufficiently utilised. Apart from personal health-related behaviour, this is also due to the fact that risk factors are often not recognized (at an early stage). An appropriate method for early recognition of health risks and diseases is currently seen in “preventive home visits” (BMFSFJ 2001,89f). Renteln-Kruse, v., et al. (2003) identified health impairments and risks among elderly persons whose mobility was already restricted but who were still living autonomously (n=76). The most pressing problems to emerge were in the areas of hearing capacity, malnutrition, activities of daily living, lack of social support, danger of falling, multi-medication and recurrent pain. In a quarter of the test persons combinations of up to four different risk factors were found. These were latent danger of falls (just under 60%), need for assistance with daily living (58%; this was corroborated by an estimate of the need for social assistance prepared by a nursing care expert), latent malnutrition (about 53%), and cognitive deficiencies (38%). A geriatric assessment was carried out to uncover (health) risks that involved significant risk of loss of autonomy and need for nursing care, and that had previously been unknown to the family doctor (ibid.). At present, though, preventive home visits are not yet part of the standard services (see chapter on policy).

While extensive knowledge is already available about the state of health of elderly people, it is only within the last few years that the effect of the social position on the ageing process and the health situation at an advanced age has been increasingly analysed and discussed. First findings indicate that a connection between socio-economic status and state of health can also be observed within the advanced age groups, with a special significance being ascribed to income as a predictor of morbidity and mortality (BMGS, 2005; RKI 2005). However, the question whether the significance of social differences increases or decreases with age has not yet been

\(^{38}\) Walter & Schwartz (2001,197ff) mention the following diseases in this context: cardiovascular diseases, type II diabetes mellitus, diseases of the respiratory system, osteoporosis and falls, infectious diseases, bladder incontinence and mental illnesses (dementia, depression).
answered conclusively by empirical studies. On the one hand, social differences seem to become more significant in old age, since the ageing process may involve financial burdens that require appropriate resources (double-jeopardy-theory). On the other hand, it is assumed that social differences are levelled out since all elderly people are equally affected by biological ageing processes, regardless of their social status (Age-as-a-leveller-theory) (Lampert, 2000, 165ff; Tesch-Römer, 2005,45).  

4 Search strategy

Research on literature was carried out by searching international and national scientific databases. Additional relevant materials were extracted by an Internet search complementing the database search. First, the Medpilot meta-database was searched. For this search, the extended search function was used, extending the search to interdisciplinary databases (such as Medline, CCMED, CDSR, Dt. Ärzteblatt, databases of various publishers, the public health press service) and GEROLIT, SOMED, ZB MED Medizin. Here, the keywords “Gesundheitsförderung” (health promotion), “Prävention” (prevention) and “ältere Menschen” (older persons) were used and only German-language literature was searched. An additional search was carried out exclusively in the databases Medline and PubMed, using the keywords “health promotion”, “prevention”, “older people” and “Germany”. In view of the immense number of publications issued between 1996 and 2006, the literature search was terminated after approximately 200 publications had been found. After a first process of narrowing down the material by filtering out contributions from other German-speaking countries, only publications were included in the literature database which made explicit reference to “health promotion” and/or “prevention”, and to the target group of “older people”, and which preferably mentioned these terms in the title and/or as keywords. In a further short listing process only scientific magazines and monographs/essays in anthologies were selected.

Most of the total of 83 publications included (82%) date from 2002 or later. About half of the articles from the literature (48%) were found in national databases, followed by international scientific databases (25%); a further quarter was extracted from the Internet. One title included was an unpublished research report. About half of the publications (47%) came from scientific magazines, followed by monographs (16%) and essays in anthologies (13%). Final reports from research projects were just 10% of the hits. Four articles were classed as “grey literature”; one article was published in a trade magazine. 7% originated from other types of literature, which included two brochures and two surveys, one interim report and one website publication.

These two theories were originally proposed by Dowd & Bengtson (1978), quoted from Lampert (2000, 165).


Final report of the accompanying scientific research project carried out by the Gerontology Research Association (Schnabel & Schopf, 2006).
Consequently, this selection must be considered as an excerpt including such literature on the subject of “health promotion for older people in Germany” as was considered relevant for this project, without making any claim to completeness.

The Internet search was limited to the websites of the relevant federal and state ministries (such as the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth, and the Federal Ministry of Health), the fora described above (e.g. the German Forum Prevention and Health Promotion) and scientific institutions (faculties, institutes such as the Robert Koch Institut). German health networks sponsored by the World Health Organisation, in particular the German Network of Healthy Cities (deutsches Gesunde-Städtet-Netzwerk)\(^\text{42}\), the German Network for Health Promotion at the Workplace (deutsches Netzwerk für Betriebliche Gesundheitsförderung)\(^\text{43}\) and the German Network of Health-Promoting Hospitals (deutsches Netz Gesundheitsfördernder Krankenhäuser)\(^\text{44}\) were also included. The Network of Health-Promoting Hospitals recently installed a database about projects in hospital settings in its website which, however, can only be accessed by registered hospitals and was therefore not available for this research project. Current health promotion projects for older people in hospital settings were not identified by the Internet and literature searches. Moreover, further pointers to additional relevant websites were gathered from the selected literature.

In qualification it must be added that research projects dealing with indirect health promotion or health conservation effects (such as articles on the subject of life-long learning or the importance of social support in old age) have not been included. Moreover, it must be kept in mind that in various research projects (e.g. in connection with memory-training programmes) health-related aspects are not expressly mentioned in all cases, although such aspects are naturally either directly or indirectly present. Pilot and research projects focussing mainly on the improvement of suitable services to assist older, chronically ill people and/or people in need of nursing care (such as appropriate coordination and networking of services and service providers\(^\text{45}\)) have not been included either. This is due to the fact that, although in principle an indirect health-promotion effect can be ascribed to such projects, this effect is not part of the original objectives pursued by such projects.

No hits were found for the keywords self-respect/dignity, emotional support, sexual activity, drugs, preventing abuse/violence, and no supplementary, more detailed research has been carried out on these keywords either. While it is common knowledge that research on drug abuse concentrates on younger age groups, the absence of hits for the other topics could be due to the fact that the effect on health is only indirect in such cases, that the subject has not previously been dealt with, or that

\(^{42}\) [http://www.gesunde-staedte-netzwerk.de/](http://www.gesunde-staedte-netzwerk.de/)

\(^{43}\) [http://www.dnbgf.de/index.php?id=5](http://www.dnbgf.de/index.php?id=5)

\(^{44}\) [http://www.dngfk.de/](http://www.dngfk.de/)

\(^{45}\) The pilot project “Altenhilfstrukturen der Zukunft” [structures of assistance to the elderly for the future] can be mentioned here as an example. BMFSFJ (2004).
it has not been discussed under the aspect of health. Thus violence experienced by German women who are now elderly, for example, has been dealt with in a rudimentary form in connection with nursing care, however, on the whole, this subject has not been discussed in connection with health care (statement of the fact-finding committee "Future of appropriate health care for women in NRW", 2005, 174\textsuperscript{46}\	extsuperscript{47}).

5 Themes

5.1 Promoting mental health

A little more than a quarter (28%) of the literature dealt with themes related to the promotion of mental health. 5 articles out of 23 addressed more than one subject in this category. With the exception of subjects such as “Depression”, “Measures to promote cognitive activity”, “Relief for care-giving relatives” and “Resilience strategies”, only few titles were found dealing with the promotion of mental health in the context of health promotion and disease prevention. The majority of these were general studies dealing with the mental and cognitive aspects of health and their significance for the overall state of health at an advanced age (e.g. Kruse, 2002, Kuhlmei, 2006).

No texts were found that addressed the subjects of “self-respect/dignity” and “emotional support”. As applies to some other aspects in this category, it must be assumed that these are side effects of (health promotion) measures, which were often not mentioned explicitly or not the main target on which the measures in question were focussed. Yet their significance for the state of health in old age is beyond doubt.

5.1.1 Addressing depression

Depression is the most frequent mental disease in old age after dementia. According to a telephone health survey carried out in 2004 (Ellert et al., 2006), however, differences in the prevalence of depression are gender-specific rather than age-specific. For instance, among the group of female interviewees aged 70 and over,

\textsuperscript{46} 22.01.2007 from http://www.landtag.nrw.de/portal/WWW/GB_I/I.1/EK/EKALT/13_EK2/EnqueteberichtSeiten135bis248.pdf
\textsuperscript{47} In the context of appropriate health care for women, the subject of “violence against women” is explicitly addressed. Today’s older women may have experienced violence during and after the Second World War as well as domestic violence. In connection with entering nursing care, such traumatic experience gains a new significance, mental, physical or psychiatric symptoms resulting from it are frequently incorrectly diagnosed and consequently incorrectly treated, according to a statement issued by the inquiry committee "Zukunft einer frauengerechten Gesundheitsversorgung in NRW" (Future of appropriate health care for women in NRW) (2005, 171ff), 22.01.2007 from http://www.landtag.nrw.de/portal/WWW/GB_I/I.1/EK/EKALT/13_EK2/EnqueteberichtSeiten135bis248.pdf

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21% stated that they had already suffered from depression at some stage during their lives (males: 11%).

According to Kuhlmeier (2006), major strokes of fate, such as the death of the spouse, can become a danger to health. Women are certainly more frequently widowed than men (among persons aged over 70, 40% of the women are widows and 11% of the men are widowers). In the relevant surveys, half of the widows mentioned psychopathological and psychosomatic symptoms such as depression, exhaustion, rapid onset of fatigue, heart complaints, stomach problems and general nervousness. Where elderly people in nursing homes are concerned, Oswald et al. (2005) have also found that they suffer from impairment of mental health as well as of physical and cognitive capacity.

One objective of the recently proclaimed national health initiative “Prevention, early diagnosis and sustainable treatment of depressive disease” is also to provide comprehensive care and treatment to elderly persons suffering from depression (BMG [Federal Ministry for Health], 2006). This takes into account that on the one hand depressive diseases can aggravate other diseases and thus increase both morbidity and mortality, a particularly significant aspect for the higher age groups who frequently suffer from multi-morbidity. On the other hand, there is a clear correlation between depression and suicidal tendencies. In view of epidemiological findings related to suicidal tendencies and demographic change, older women in particular are mentioned as a target group for suicide prevention (BMG, 2006; Menning, 2006).

One project which explicitly targeted prevention of depression in elderly people was nominated for the German Prevention Award 2005. Gender-specific activities in nursing homes designed to cater to the great majority of residents who are female often lead to withdrawal, inactivity, immobility, resignation or depression on the part of male residents. The Mainz project “When is a man a man? - needs of men in residential homes for the elderly “ (Stierle et al., 2005, p. 64ff) has initiated some projects focussing primarily on male interests, such as handicrafts, model making or football. The objective is to promote the abilities and skills of men, thus preventing mental diseases such as depression.

http://www.gesundheitsziele.de/xpage/objects/depression/docs/1/files/Gesundheitsziele_Depression_BMG_01-03-06.pdf dated 15122006

healthPROelderly – National Report Germany
5.1.2 Addressing stress and burn-out

The reduction of stress and burn-out, and the acquisition of strategies for coping are two of the objectives of health promotion at the workplace; moreover, they play a significant part in connection with measures for the relief of care-giving relatives.

Most measures of health promotion at the workplace (“BGF” measures, according to Article 20, Par. 2 SGB [Social Security Code] V) have targeted the workforce as a whole; 39% of companies have carried out health promotion measures for special target groups; the proportion of measures specially conceived for older workers was about 14%. The main objective of such measures was the reduction of physical strain (70%), however stress management measures (such as conflict and time management, and dealing with psycho-social stress factors) took second place (37%). Compared to previous years, objectives of this kind have substantially increased in significance, which can be seen as a reaction to rising absenteeism because of illness as a consequence of “mental disorders” (MDS 2006, p. 69ff\textsuperscript{49}).

According to Morschhäuser (2005), an occupational and human resources policy taking into account the ageing process is primarily aimed at health promotion among the workforce. Practical experience has shown that qualification measures focussed on the ageing process, a regular job rotation process, group work or “split career biographies” can secure long-term employability of older workers and prevent burnouts. Huber’s remarks (2002) concentrate on issues of long-term preservation and promotion of workers’ health through group work. On the one hand, corporate workshops aim at generating a change in the workers’ own attitudes and working behaviour. On the other hand, the introduction of health-conscious work routines based on the results of the workshops should be encouraged (such as job rotation, avoidance of one-sided strain, physical safety measures).

Schmidt (2005) points to a lack of professional help made available to care-giving relatives. To address the question of options and measures to relieve care-giving relatives, Schmidt implemented a project of providing information and counselling for care-giving relatives as part of her public health training programme in an outpatient nursing service. This included the development of a brochure about health promotion and prevention, relaxation techniques and extension of competence. Furthermore, a training institution for health care, relaxation techniques and personal competence in daily life (BEGESIA) was established. Training courses in these areas for professional nursing staff as well as non-professionals are planned for the future.

\textsuperscript{49} MDS (2006). Documentation 2004. Services of primary prevention and health promotion at the workplace, provided by statutory health insurers. 02.02.07, from http://www.mds-ev.org/index2.html
The physical and emotional stress experienced by care-giving relatives of persons suffering from dementia has already been described many times (see, for example, Gräßel, 1998). A proven method to reduce the strain experienced by care-givers and the physical and emotional stress frequently connected with it consists in the assistance provided by supportive groups\(^{50}\), which have been established at various locations in Germany.

When considering the preventive courses being offered by health insurance institutions (according to § 20 SGB [Social Security Code]; individual primary prevention), it is remarkable that relatively few courses are offered that address stress and burnout: in 2004, about 17% of all measures covered this field of action, and about 16% in 2005. Measures relating to nutrition were almost as frequently implemented, i.e. 17% in 2004 and 14% in 2005 of all measures offered. The majority of courses offered covered physical activity, with the proportion of courses in this area continuing to rise to 65% in 2004 and 69% in 2005. Measures devoted to dealing with addictive drugs and stimulants made up less than 1% in both years. In 2004, about 24% of the participants in training courses were older insured persons (aged 60+); with the majority taking part in programmes for physical activity (78%). Nutrition-related measures took second place (12%), followed by courses dealing with stress (11%) and addictive drugs / stimulants (0.3%). The relatively small proportion of measures dealing with stress and nutrition could be due to the fact that such measures relevant to health are frequently influenced by measures related to physical activity. In 2005, the proportion of courses for the reduction of stress exceeded that of nutrition-related measures. This could be interpreted as a sign that the demand of insured persons in this area has risen, and that the health insurance institutions have adjusted their programmes accordingly (MDS 2006, 60ff\(^{51}\)).

5.1.3 Cognitive issues: memory training

Even though the possibilities for prevention and treatment of dementia are still limited, the results of the SimA study\(^{52}\) indicate that some potential for the prevention of dementia exists in stimulating cognitive and psychomotor functions. For instance, by a combined strategy of memory and physical training, improvements in cognitive performance have been achieved. This combined training strategy is seen as a

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\(^{50}\) Module 1 Introduction and recommendations for group leaders by Martina Humbach & Michael Apel (1998) http://www.uni-koeln.de/ew-fak/Klein/docs/ge_mod01.rtf


\(^{52}\) SimA (Autonomous in old age) The SimA-50+ training programme is based on the longitudinal intervention study initiated in 1991 "Conditions for the perservation and promotion of autonomy at an advanced age". Concerning different exercise and training approaches addressing the improvement and preservation of autonomy of elderly persons living alone, a strategy of combined regular psychomotor and memory training proved in particular far superior to all other approaches tested in terms of both immediate and long-term effect. Dated 05.01.2007 http://www.sima.geronto.uni-erlangen.de/index.php?title=Willkommen%20bei%20der%20SimA-Akademie%20e.V.&path=start
means of at least delaying the onset of dementia (Oswald, Hagen & Rupprecht, 2001).

Based on findings from the SimA study, Oswald, Ackermann & Gunzelmann (2006) have developed a multi-dimensional activation programme for residents of nursing homes. For a period of 12 months, the applicability and effectiveness of a rehabilitative intervention strategy was tested on 294 residents (aged from 70 to 99). The interventions consisted of a combined cognitive and physical training programme. For residents suffering from dementia, a specific, biography-oriented activation programme was implemented. Significant improvements in cognitive and functional performance were achieved. These therapeutic intervention measures also proved transferable, i.e. the measures had a positive influence on the performance of activities of daily life and led to a reduction of falls.

5.1.4 Self-respect / dignity

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5.1.5 Emotional support

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5.2 Other

In addition to the promotion of cognitive and physical activity, substantial health potential lies in preserving and strengthening of other psychosocial aspects. In this connection, Walter (2005) mentions the ability to cope with critical events in life and the ability to come to terms with losses suffered.

Moreover, information and counselling of older persons in connection with social and health-care services can contribute to strengthening autonomy in old age. However, the supply of information and counselling is often limited or not suited to the needs of older persons. Preventive action and the selection of suitable contacts in the case of changes in the state of health require early procurement of information on the person’s own initiative. Suitable information and counselling for older people should therefore meet the following criteria: professionalism, up-to-dateness, comprehensibility, accessibility, priority of user-orientation over supplier-orientation, a high degree of neutrality and consideration of local conditions (Döhner, 2001).

Wiesmann et al. (2006) have examined the sense of coherence, psychosocial resources and the subjective health of a group of older people who were active and “healthy” (n=58; average age 66.3 years; 65.5% women). 42 test persons took part from start to finish in this intervention study comprising a 14-week programme relating to physical activity or self-reflection (endurance or weight training, yoga or meditation courses). The study revealed that an improvement in the sense of coherence and health-related quality of life could be achieved for these “healthy”
older persons, and a strengthening of salutogenic factors (self-respect and personal initiative) was also possible. The freely selected courses and their positive assessment indicate that older persons will select measures for themselves to fit their needs and to strengthen and renew their resources.

A pilot project of the AWO [workers’ welfare organisation] Göppingen (Wohlrab, 2004) examines the family and social situation of older Turks and Yugoslavs. It is intended to counteract the isolation of older migrants with multilingual and multidisciplinary international teams and native-language nursing staff.

5.3 Empowerment

In connection with health promotion and prevention, empowerment – defined as the strengthening of personal responsibility and competence and the promotion of self-determination in matters of personal health - is an essential element.

The project “Active health promotion in old age” specially emphasizes the strengthening of personal responsibility for health care in older people (empowerment). With the assistance of a multidisciplinary team of health consultants (dieticians, physiotherapists, social pedagogues), older people are individually counselled in small groups and placed in a position to carry out health-promotion measures based on individual recommendations on their own initiative (Dapp et al., 2002a). Döhner (2001) points out that for self-determination in old age detailed information about the personal state of health or illness, and counselling concerning possible supportive measures and health-promotion activities are prerequisites for responsible decision-making in matters of health. In addition to general oral, written or electronic information, the following aspects are of particular importance:

- Personal information and counselling for individuals
- Personal counselling on a continuous basis and written information related to each individual’s own state of health or illness (“personal health kit”)

5.4 Social participation – inclusion

For older persons the private social network, consisting of family and friends, plays a significant role. Such social resources form the basis of emotional, cognitive, instrumental and material support for older persons and also enhance their self-respect. However, such social networks are less meaningful for health promotion as such, their significance lies primarily in individual connections. (BMFSFJ, 2001).

58 of the titles searched did not deal with social participation at all; of the other 27 texts, 12 contained multiple references to the subject. Among the specific subjects,
most references were found to social support/networks, followed by lifelong learning/education for older people.

5.4.1 Lifelong learning / education of older people (health): e.g. University of third age

The theme of lifelong learning was considered to include on the one hand measures encouraging a health-conscious lifestyle as a part of overall health education, on the other hand training measures for older workers aimed at the acquisition of additional skills, since additional qualifications and advanced training improve the prospects of employment in later life. Furthermore, health promotion at the workplace also includes health education projects (see also chapter 5.1.2). A total of 14 articles dealing with lifelong learning/education of older people were found.

Dapp et al. (2002a) developed a preventive health care programme for older people (“Active health promotion in old age”, see also chapter on the policy winner of the German Prevention Award 2005). This project addresses “healthy” older persons with the objective of counteracting the onset of diseases and need for personal assistance and nursing care by early implementation of preventive measures. The concept of “Active health promotion in old age” includes four aspects of health education that have shown some positive effect on this target group (Dapp et al., 2002a, 5ff):

- Multidimensional approach (intervention in the areas of nutrition, physical activity and social environment)
- Multidisciplinary approach (a health consultancy team including dieticians, physiotherapists and social pedagogues, led by a medical practitioner trained in geriatrics)
- Behavioural approach (a didactic concept of work in small groups with the objective of encouraging personal responsibility for an active lifestyle among the elderly participants)
- Environmental approach (geriatric networking: in addition to promoting the cooperation between outpatient and stationary medical services, contacts were established with organisers of health promotion measures in different suburbs of Hamburg, so that direct information about opportunities close to their homes could be made available to participants)

53 Participants must be at least 60 years old and not suffering from any form of dementia or already in need of nursing care (Dapp, 2002a, 5).

54 These measures fall into the category of primordial prevention (health promotion). Moreover, home visits were paid to participants who showed cognitive or physical handicaps in the course of the project, or to those who, for instance due to caring for a close relative, were unable to attend the geriatric centre. For older persons already suffering from disease, tertiary measures, i.e. rehabilitation and care-giving, were usually indicated.
In the context of health promotion for older workers at the workplace, impairment in decision-making competence is gaining significance in the area of employability and health. As a result of their studies concerning the preservation of employability of an older and ageing workforce, Tempel & Giesert (2005) reached the conclusion that training to become an “all-rounder” has a positive effect on the preservation of employability.

The concept of an “Academy for senior citizens” implemented in Heidelberg combines the approach of lifelong learning with the promotion of voluntary work. Senior citizens engaged in voluntary work pass on their knowledge and skills to other people in the same situation of life in training courses, lectures, sports groups and organized travel, and also benefit from the talents of others. Meanwhile, the Academy has grown to 3,744 members. In addition to an extension of sports programmes and cultural events, it is now planned to support younger families in future in keeping their careers compatible with family life. (Stierle et al. 2005, p. 76ff).

5.4.2 Social support / networks

In 15 texts the subject social support / networks was dealt with, here, however, as in the case of mental health, mainly by emphasizing the importance of social support for health in old age in general, or by describing some side-effects of individual measures (Kruse, 2002; Tesch-Römer, 2005; Oswald, Naumann, Schilling & Wahl, 2005; Knesebeck, v. d. et al., 2006).

Dapp et al. (2002a) report that the work in small groups, which was part of the project “Active health promotion in old age” met with a positive response from the senior citizens participating; in particular the opportunity for a personal exchange of ideas was greatly appreciated.

A project explicitly aimed at the improvement of social support or networking in the context of health promotion is the organisation “Kölner Seniorennetzwerke” (Cologne Senior Citizens Networks / Stierle et al., 2005, p. 34ff). Since 2003, locally oriented suburban senior citizens’ networks have been built up in twelve suburbs of Cologne. The objective is the promotion of integration and the prevention of isolation among older people. These networks are also intended to address marginal groups that are difficult to reach by traditional institutions, such as the long-term unemployed, older migrants or persons suffering from mental disease. The aim is also to encourage personal participation, autonomy and solidarity, and to find opportunities of employment suitable for older workers, taking into account their individual lifestyles.

The project “Begleitetes Wohnen e.V.” (“Assisted living” / Spirling et al. in Stierle et al., 2005, p. 46ff) is aimed at establishing networks of local support to preserve the independence of members as far as possible and to increase the level of activity of its clients. Individual care is provided for older people in their own homes, in hospitals
or nursing homes, with assistance tailored to their individual needs. This includes assistance with housekeeping and shopping and care-giving in cases of illness, as well as assistance with visits to government offices and official correspondence, and even organising removals.

Social support is also a vital element for older migrants, promoted especially by an approach of culturally sensitive care-giving, preventive home visits conducted in the person’s native language (Wohlrab 2004) and events and materials passing on information about subjects connected with social assistance law and health care (Schnabel & Schopf 2006).

5.4.3 Self-help groups

In Germany, about 70,000 to 100,000 self-help groups are in existence with an estimated membership of three million people. Self-help groups deal with a great variety of health-related, psychosocial and social problems. They target the people affected themselves as well as close relatives of persons suffering from illnesses such as dementia or alcoholism. The work of self-help groups, which exist beside and in addition to the professional health care system, focuses mainly on the promotion of independence and participation of the individuals involved. Additionally, occasional deficiencies in professional health care are dealt with and partly offset. A characteristic feature of such groups is that they go beyond professional counselling and information to provide in particular psychosocial support to persons affected by certain problems. Based on mutual understanding, assistance and exchange of experience with people in similar situations, self-help groups have a positive effect on the preservation of health and coping with problems (RKI, 2004).

In this research project, four pieces of literature were categorised under the subject of self-help groups. Here, the focus was in particular on dementia assistance groups and relief measures for care-giving relatives (v. d. Knesebeck et al., 2006).

The dementia counselling office in Mannheim offers four elements of assistance to persons suffering from dementia and their families. In addition to groups giving assistance to persons suffering from dementia and individual counselling, self-help groups for family members and monthly information events are also provided (Hoevels in Stierle et al., 2005, p. 84ff). In a 12-month European research project, a handbook was developed for group leaders organising training courses/self-help groups for care-giving relatives of persons suffering from dementia. A prominent feature of this guidebook is its salutogenic approach. This programme is centred around the psychosocial needs of care-givers. The objective is to improve the self-help potential of care-giving relatives. Provision of information, opportunities for exchange of experience and personal goals, as well as assistance with developing alternatives in dealing with individual problems, are intended to support self-help processes in care-giving persons. Active involvement of the group members in
planning and developing the group is a central element of this guidebook (Humbach & Apel, 1998).

However, self-help groups forming part of municipality-oriented health education programmes in which patients of various general practitioners were taking part were also mentioned (Wiesemann et al., 2004).

5.4.4 Volunteering

The promotion of voluntary work is an object and aspiration of current policy concerning senior citizens. Due to the continuing trend towards “deprofessionalisation” of older people and the simultaneous rise in life expectancy, senior citizens are increasingly seeking new challenges. One opportunity for an active life in retirement is voluntary engagement in social and cultural work, politics and churches (BMFSFJ, 2001). Commitment to voluntary work can also have a positive effect on health. For example, Kruse (2002) emphasizes that, besides physical and cognitive activity, an active daily life is of particular importance (Kruse 2002, p. 77ff). An active lifestyle includes playing various roles and exercising some functions in society. Educational opportunities may assist older persons in their search for new roles and functions.

However, this subject is rarely discussed in a health promotion context. Only few projects examined in this study could be categorized under this subject area. The “Pilot project for the promotion of social commitment and integration of female migrants and naturalised German citizens through voluntary work” staged by the city of Hanover (gEMiDe; Feise in Stierle et al., 2005, p. 52ff) was nominated for the German Prevention Award 2005. It provides a point of contact between female migrants interested in voluntary work and native citizens who are lonely, seeking new social contacts or in need of personal assistance. Voluntary work enhances self-respect, self-confidence and sociability especially among older female migrants.

Further experience with health promotion in a voluntary civil service context has been contributed by the continuation of the General Practitioners’ Research Project (“Hausarztstudie”, part III). Here, for the first time, health promotion has become an integral part of senior citizens’ social groups. This provides an opportunity to reach the elderly as beneficiaries as well as older “service providers” committed on a voluntary basis. The concept of “Active health promotion in old age” was adapted to the general structures and human resources in four widely differing senior citizens’ groups and successfully implemented.

55 http://www.uni-koeln.de/ew-fak/Klein/docs/ge_mod01.rtf; not included in the database
56 Module 4 J. Anders, U. Dapp Integration of voluntary civil commitment: “Health promotion in senior citizens’ groups” (day centres for senior citizens)
5.4.5 Other

Seven titles of literature were grouped in the category of “Other references”. Some of these dealt with the significance of forms of counselling and social participation (Meier-Baumgartner et al., 2004; Hikl & Bill, 2005). Another issue mentioned in connection with preventive home visits is the proxy function of care-giving staff, who can act on behalf of patients with their consent, for instance in emergencies (Renteln-Kruse et al., 2003). Moreover, for the group of older migrants, overcoming language barriers and illiteracy are important prerequisites for health promotion measures, since these can be substantial barriers against access to the health care system (Wohlrab, 2004; Schnabel & Schopf, 2006).

5.5 Lifestyle

In the literature under review, writings emphasizing the development of a health-promoting lifestyle are clearly in the majority. According to statements from the “Gesundheitsmonitor” (Health Monitor, Kruse, 2005) the proportion of older interviewees living on a healthy diet and avoiding tobacco and alcohol is substantially higher than among younger age groups. Preventive medical checkups are also more frequently used by the older interviewees. However, need for action is seen in the promotion of physical activity among older people, which is significant for the preservation of autonomy in old age, the reduction of health risks (such as hypertension and adiposity) and for the reduction or delay of need for personal assistance.

Ziegelmann & Lippke (2004) state that regular physical activity also has a positive effect on the state of health beyond the age of 70. Baum (2002) expresses similar views; in addition to an increase in muscular strength, positive effects on mood, satisfaction with life, memory capacity and competence in daily life are noticeable. Moreover, physical activity contributes to the preservation of mental health, for instance to reducing depression and states of anxiety (see RKI, 2005; Oswald et al., 2006, Ziegelmann & Lippke, 2004). Denk, Pache & Rieder (1997) state that with more than two hours per week of physical activity, there is also a noticeable positive change in attitudes towards old age. These statements are based on the cohort of 60-year-old test persons from the first survey of the ILSE long-term research project. Today it is undisputed that physical capacity can be preserved by training adapted to personal age. Thus endurance, strength, coordination and mobility can be improved or stabilised even at an advanced age (Rütten et al. 2005, p. 7 in RKI körperliche Aktivität [physical activity]; Werle et al., 2006, p. 81ff).

Although regular physical activity is known to have a positive effect on the quality of life and significance for the preservation of health and autonomy, there is a widespread lack of physical activity in Germany. The level of activity is generally higher among younger people than among older people. According to the Gesundheitsmonitor [Health Monitor] 2005, 25% of the 17 to 44 age group do not
practice any sports at all, while in the 45 to 79 age group 34% are not active in sports. A need for action exists in particular for older, physically inactive persons. For this group, education concerning the importance of physical activity for an active, autonomous life in old age as well as the promotion of physical activity itself are necessary (Kruse, 2005, p. 73).

A positive trend is shown by the telephone health survey. For instance, there was a significant rise in sports participation in the 50 to 70 age group between 1991 and 1998. Possible explanations are seen in the success of education campaigns, an increasing health-consciousness in this age group, but also in improvements / changes in sports facilities for this target group (RKI, 2006, p. 103). Participation in sports is also influenced by social position: members of the lower social class participate less often in sports; almost half of the men and women with this social background engage in no sports at all. By contrast, in the middle and upper classes only about a third of men and women are not active in sports (Rütten et al. 2005, p. 9).

With increasing age, the motivation for practicing sports also changes. Wiesemann et al. (2004) state that the main motivation for most of the younger participants is “fitness” and “fun” while motivations such as “making sense, being meaningful” or “anxiety, worrying about health” are mainly reported by the older active patients.

A total of 56 texts dealt with the subject of lifestyle, with 36 articles containing multiple references. Generally nutrition and physical activity are frequently mentioned as means of health promotion (Werle et al; 2006, p. 28). The literature under review also contains numerous comments or measures recommending or including a combination of these two components (e.g. Brunner, 2002; Dapp et al. 2002a,b,c; DHP, 1998; Heseker, 2005). Nutrition was a subject dealt with in 29 texts; 42 articles addressed the subject of physical activity.

5.5.1 Nutrition and Physical activity

Heseker (2005) describes the PATRAS Paderborn training study, which aims to support the promotion of mobility and strengthening of muscles in nursing home residents by specific training. Moreover, a detailed diet concept with individual nutrition records aims to improve each person’s level of nutrition with simultaneous preservation and strengthening of physical mobility.

The study carried out by Brunner (2002) included physically active and inactive older persons, questioning them concerning their knowledge and behaviour relating to nutrition and physical activity. Brunner emphasizes that older people have a good, detailed level of knowledge on the subject of suitable nutrition for senior age groups. Here, a significant function of preventive health education is ascribed especially to the media. Persons reporting about a change of diet (necessitated by a medical condition or not), showed more health-conscious nutritional behaviour. Moreover, a
positive connection between the amount of physical activity and both knowledge about and practice of health-conscious nutrition among persons interviewed was apparent.

In the municipalities covered by the DHP project (1998, p. 205ff) a comprehensive nutrition programme was implemented, which was adapted to local conditions in each case (urban areas vs. rural areas/areas with small towns); these included general information and education events, multiplicator training, nutrition courses, improvement of the locally available range of health promotion products and services, individual nutritional counselling. In spite of the wide-spread positive response and considerable interest in nutritional themes, no reduction of adiposity could be achieved in the areas of intervention, although a trend towards a change in eating habits was initiated.

In the project “Active health promotion in old age” participants received an analysis based on a standardised one-day nutrition protocol made by the dietician with suggestions for individual measures (especially recommendations on fluid intake and the consumption of fruit and vegetables) in the form of a “nutrition letter”. About 60% of participants were advised to drink more (293 test persons) and to eat more fruit and vegetables (301 test persons). Almost all participants (98.2%) presented the nutrition protocol and were given time to implement the recommendations in their daily lives during the following 6 months. Of the 494 participants, 94.7% were available for interviews about their implementation of the recommendations received. An increase in fluid intake was achieved by 77% of the 293 participants who had been advised to drink more; of the 301 persons who had been advised to increase their intake of fruit and vegetables, 46% actually did so (Dapp et al., 2002b, 5ff; Meier-Baumgartner et al., 2004, 56f). Based on a standardised “activity protocol”, a physiotherapist also prepared an analysis and recommendations for individual measures in the form of a “physical activity letter”. Almost all participants (97.4%) presented activity protocols and were given time to implement the recommendations in their daily lives during the following 6 months. Each participant received at least one recommendation to increase physical activity. Among the first recommendations handed out to the 490 participants, 237 persons (48%) were given recommendations for endurance training. 137 persons (28%) were advised to take up or intensify training to build up strength, and exercises for balance training were suggested to 116 persons (24%). More than half of the participants implemented the first recommendations from the physiotherapist and increased their physical activity in training for endurance, strength and balance (Dapp et al., 2002b, 9ff; Meier-Baumgartner et al., 2004, 58f). When considering the areas of nutrition and physical activity in combination, a quarter of the test persons succeeded in implementing two recommendations. Some persons (28%) even implemented three recommendations; in these cases a combination of recommendations from both areas was generally implemented (Dapp et al., 2002b, 15ff).
The project “Promotion of health and physical activity for persons of advanced age” (Regelin in Stierle et al., 2005, p. 60ff) staged by the Deutscher Turner-Bund e.V. [German Association for Gymnastics] is a positive practical example. Systematic training of strength, mobility and coordination is intended to help persons over the age of 80 to cope with their daily lives as autonomously as possible. These training programmes are carried out in both nursing homes and at local sports clubs.

Becker et al. (2006) describe an improvement of mobility among persons over the age of 75 as a result of regular, systematic training. Performance criteria examined included balance while standing up, getting up from chairs, walking speed and maximum length of steps. An overall assessment of the physical performance (total score) revealed that 62% of participants had stabilised their performance level (62%) or even improved it (50%).

The project “aktive55plus – healthy and active ageing in Radevormwald“ (a WHO pilot project) was aimed at improving the quality of life by activating and mobilising the population over the age of 55. Based on a concept of active ageing, the capacity of older people for personal activity was to be increased (empowerment). Health service providers were also to be sensitised for this issue. Moreover, existing municipal facilities were integrated in a general network so that they could be utilised for health promotion among older persons. 341 senior citizens took part in this project after they had received visits and counselling from project staff. After their needs, wishes and capabilities had been ascertained, the participants were informed about measures and facilities with health promotion potential, and existing entitlement to health benefits. Barriers preventing participation in certain areas were also identified and examined (method of active motivation and assistance for people to help themselves). During the project period of two years a minimum of three home visits were carried out, a total of 2,750 visits that led to 1,192 agreements to take up and practise health-promoting activities. It was noticeable that participants in this project made use of opportunities for social activities much more frequently than programmes offering physical or cultural activities. Moreover, 40% of all participants interviewed on the subject confirmed that the project had contributed to improving their quality of life (Hikl & Bill, 2005).

5.5.2 Sexual activity

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5.5.3 Smoking and Alcohol

A total of 14 texts made reference to the use of addictive drugs (tobacco, alcohol). Such references contain statements either about health behaviour or about the significance of such factors for the development of disease (see health determinants). In addition, two studies about factors influencing smoking behaviour were found; however, no literature about factors influencing the alcohol consumption
of older persons in a health promotion context was identified. This is also partly due to the fact that the subject of “addiction in old age” has been generally neglected so far, which applies in particular to alcohol and drug dependence (see Weidner et al., 2004).

According to the “Gesundheitsmonitor” [Health Monitor] the majority of older persons interviewed (aged 45 to 79) show health-promoting behaviour in their use of alcohol and tobacco. 74% of older persons interviewed are non-smokers, and 78% consume alcohol only moderately or not at all (Kruse, 2005, p. 75). The health survey (RKI, 2004, p. 13), reveals a marked gender-specific difference in the age group over 65 at least with respect to smoking habits. 71% of women, but only 32% of men claimed to be non-smokers. A difference between the sexes has also been found in alcohol consumption, although here substantially more interviewees in this age group claim that they drink only little or no alcohol (men 75%; women 91%). Distinct differences relating to social background have also been found (RKI, 2004, p. 13): the proportion of non-smokers among the lower class (44%) and upper class (43%) is significantly higher than that within the middle class (37%). By contrast, the group of ex-smokers shows a distinct gradient specific to social background: while 31% of the upper class are consider themselves to be in that group, only 20% of the lower class claim to belong to it (middle class: 26%).

Since the 1980s, smoking prevention and tobacco withdrawal have been a major issue of public health information and education in Germany. Smoking behaviour has a special significance in the development of mortality. In fact, smoking is the most important single risk factor for many chronic diseases (such as cardiovascular diseases and cancer) (Helmer, 2003, p. 546). Since the 1980s, tobacco consumption among women has risen. In addition to a growing similarity in the smoking behaviour of both sexes, this could result in a higher mortality among women (DHP, 1998, p. 215; RKI, 2006, 16; p. 107). The proportion of smokers decreases with increasing age, which is due, in particular, to higher morbidity and mortality rates (RKI, 2006).

In industrial countries such as Germany, a reduction of tobacco consumption could have a long-term effect on the health of the whole population. However, relevant preventive measures so far have been rather unsystematic. Most measures are aimed at a change in behaviour; only rarely are structural changes targeted as well (Health target: reduction of tobacco consumption, 2003). The national health target of reducing tobacco consumption addresses the population as a whole and includes the following partial goals:

57 Non-smokers in this context means people who have never smoked.
healthPROelderly – National Report Germany
1) Implementation of an effective tobacco control policy (general improvement of relevant legislation / structural conditions)

2) Promotion of breaking the habit and increased efforts to encourage tobacco withdrawal

3) Promotion of breaking the habit and increased efforts to encourage tobacco withdrawal among children and young people

4) Prevention of developing a smoking habit and promotion of non-smoking among children and young people

5) Improved protection from passive smoking

In the areas covered by DHP studies various smoker interventions were carried out (such as withdrawal programmes, strengthening the positive image of non-smoking among young people, encouragement of non-smoking by medical practitioners/pharmacists, structural measures such as smoke-free areas, discussions in the media about the consequences of smoking for health). Here, a reduction of smoker prevalence compared to the overall population was achieved, which was primarily attributed to intensified counselling by medical practitioners (DHP, 1998, 217ff). The gender-specific differences are remarkable here: a significant intervention effect was achieved exclusively among men.

Ulbricht et al. (2004) examined the question whether promotion of tobacco withdrawal among patients can be achieved by general practitioners. On a randomized sample basis 551 patients classed as smokers and aged between 18 and 70 years were selected from 39 GP surgeries (in the 65-70 age group 6.3% were female smokers). After training the general practitioners for counselling intervention to target the breaking of smoking habits, 80% of the patients were reached and motivated to give up smoking on the family doctors’ initiative, in spite of the extremely low motivation prevailing among these patients to begin with. Concerning readiness for change no differences could be detected between various age groups or between the sexes.

5.5.4 Drugs

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5.5.5 Safety – e.g. prevention of falls, accidents and injuries

Safety was a theme in a total of 12 texts, dealing almost exclusively with measures to identify risks of falling and to prevent falls. In this area a number of preventive strategies have already been developed for older persons living alone as well as persons in need of nursing care in private households and nursing homes. The
measures address the identification of risk factors, physical training and home environment counselling with adaptation of the environment where necessary (for example identification and removal of tripping hazards). In one case a project to improve the safety of visually impaired and blind older people.

Falls frequently entail fractures, especially among women. According to the Augsburg KORA study of fractures, approximately every second woman will suffer a fragility fracture caused by osteoporosis in the course of her life, but only every 10th man will be affected. Wildner et al. (2004) state that the highest number of fractures of the forearm and the lower leg among women occur in the 65 to 74 age group, while the highest number of such fractures in men occur in the 15-24 age group. Consequently, prevention of falls among older people will continue to be an important issue in public health.

Among a group of older persons living at home (n=268), Coll-Planas et al. (2006) identified a history of previous falls and the need for assistance when taking a bath as important indicators for an increased risk of falls. Taking a bath is the first activity of daily living (ADL) to require assistance in the developing process of the need for nursing care. The need for assistance with this ADL can easily be identified by professional care-giving staff and is therefore a reliable indicator for an increased danger of falls.

Freiberger & Menz (2006) report gender-specific differences in the occurrence of falls within a group of physically active older persons living alone (n=293, of these 163 males): while women suffered falls primarily in their home environment during their daily housekeeping, men more often had their falls during leisure activities outside the home. No gender-specific differences were found as to the frequency of falls. The majority of falls did not require medical treatment. However, women had more difficulties in restoring their mobility after falls and tended to consult a physician more often and at an earlier stage. On the whole, it has been found that falls frequently occur among physically active older persons, but that consequences requiring medical treatment are relatively rare. Prevention of future falls requires not so much an increase in activity, but rather a modification of behaviour.

The Ulm project for the improvement of mobility and prevention of falls targeted older persons in need of assistance and nursing care living at home. 483 senior citizens participated in this project. The interventions in this pilot project included more than 2,500 training sessions that took place in the participants’ homes. As a next step, training was continued in groups. In the course of the project, 28 training groups were established within the municipality of Ulm. Moreover, about 50 adaptations of the home environment were carried out and more than 300 participants counselled concerning devices to protect their hip bones. By means of mobility training, a significant reduction in the frequency of falls was achieved among the participants. The frequency of hip joint fractures and other fractures also fell below expectation for the test group (Becker et al., 2005, 3). There is still a need for research on fall prevention for senior citizens suffering from dementia; moreover, research projects
targeting groups of blind and visually handicapped senior citizens have not yet become available either (Becker et al., 2005, 59).

Deittert et al. (2000) outline a project to assist elderly persons with visual handicaps. Students of nursing care science at the University of Münster conducted and evaluated 16 qualitative interviews as part of their project study programme. From statements collected concerning restrictions of communication and safety imposed by visual handicaps, a guidebook has been compiled that can be obtained from the Münster University of Applied Sciences.

5.5.6 Preventing abuse/violence against older people

5.5.7 Prevention of disease

Prevention of disease can be subdivided into several consecutive stages of intervention with, however, somewhat blurred borderlines in practical application (see Table X).

<table>
<thead>
<tr>
<th>Intervention</th>
<th>primordial</th>
<th>primary</th>
<th>secondary</th>
<th>tertiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing</td>
<td>in good health</td>
<td>with recognizable risk factors for disease</td>
<td>in preliminary and early stages of disease</td>
<td>following treatment of acute disease</td>
</tr>
<tr>
<td>Target group</td>
<td>total population</td>
<td>risk groups</td>
<td>(potential) patients</td>
<td>rehabilitation patients</td>
</tr>
<tr>
<td>Objective</td>
<td>influencing of environmental conditions and lifestyles</td>
<td>influencing of parameters related to specific risks</td>
<td>influencing of causes and consequences of disease</td>
<td>prevention of secondary disorders and diseases</td>
</tr>
</tbody>
</table>

Table X Distinction of four stages of intervention; source: Hurrelmann & Laaser (2006, p. 754)

In a broad sense, influencing the lifestyle factors described above also contributes to the prevention of disease. The assumption that prevention (of disease) is important at any age, i.e. throughout our whole lives, is relatively new. Consequently, senior citizens are also increasingly taken into account as target groups for the prevention of disease (Kuhlmey, 2006, 10; Walter 2006, p. 537ff). In a more specific sense, nine essays dealt with the prevention of particular diseases or certain disease patterns. Kruse (2002, p. 104), for example, describes possibilities to prevent the following health risks of advanced age: falls, impairment of hearing and vision, dental diseases, cardiovascular disease and incontinence. These disorders

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60 Hurrelmann & Laaser (2006, 754f) advocate a similar subdivision for health promotion intervention. So far, this has only rarely been implemented in the sense of differentiating between health-promoting interventions before and after the onset of disease.
can be influenced at an early age as well as in mid-life and in later life by a health-conscious lifestyle and adaptations of the environment. In order to utilize existing potential, which is frequently not utilized, the promotion of participation in preventive screening is of special significance. Moreover, due to the multi-morbidity of older persons, there is a need for comprehensive diagnostics, such as can be established by means of a geriatric assessment (Kruse, 2002).

Preventive home visits (for instance by local nursing staff in cooperation with general practitioners) are an effective method to identify social and health-related risks at an early stage, as well as environmental deficiencies (conditions and deficiencies in the home environment), that could lead to an impairment of a person’s autonomy (Kruse, 2002, p. 166ff). Comprehensive geriatric assessments form the basis for preventive home visits as described by v. Renteln-Kruse et al. (2003) and Perschke-Hartmann in Stierle et al., 2005. “Preventive home visits” target persons living alone, whose independence should be preserved by means of regular geriatric screening and individual information and counselling (see also chapter “Policy and health determinants”).

Particular attention should be paid to the risk of falls. Falls at an advanced age generally have multiple causes and, as a rule, the risk can be influenced by preventive measures. Thus serious and sometimes lethal consequences of injuries resulting from falls and related costs can be avoided or at least reduced.

Tests of sight and hearing including counselling concerning suitable aids and adjustment of such aids are just as indispensable as the observation of the often neglected condition of dentures (Kruse, 2002). Under the project “Teamwerk – Zahnmedizin für Pflegebedürftige [dentistry for nursing care cases]” (Benz & Haffner in Stierle et al., 2005, p. 42ff) dental disorders in nursing care patients, especially risk patients (e.g. dementia patients) are treated in Munich nursing homes by means of regular preventive treatment and special training of nursing staff. In cooperation with dentists, a team consisting of anaesthetists, specialists for internal medicine, oral and facial surgeons, orthodontists and psychologists takes care of the patients during therapy in a specially equipped competence centre.

Another challenge is freeing aconuresis from taboos (Kruse, 2002). Aconuresis is especially prevalent among women, and to a considerable degree in both sexes at an advanced age.61 Embarrassment and prejudice often cause persons affected to treat this condition as a taboo. Continence is particularly important in connection with healthy ageing, since it is a significant criterion in the assessment of the need for assistance and nursing care. Aconuresis is closely connected with a need for more intensive care and consequently the necessity for admission to a nursing home. In Germany preventive measures such as training to strengthen the pelvic base

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61 The availability of data relating to incontinence in Germany must be considered as generally poor. Scientific research focuses primarily on women among whom the problem of incontinence is already prevalent in the middle age groups (DNQP, 2006). BASE (Steinhagen-Thiessen & Borchelt, 1996, 155) shows a diagnostic prevalence of 37% for aconuresis.
muscles only exist in isolated cases so far (Walter & Schwartz, 2001,198f); in this literature search no relevant measures were identified in connection with health promotion. The DNQP [German Network for quality standards in care-giving] expert standard about “training bladder continence in nursing” is a positive development in this context (DNQP, 2006). However, developing and propagating preventive measures prior to the need for nursing care could be an important next step.

In the area of cardiovascular health risks the effectiveness of including older persons in preventive strategies has been proven (measures such as a change of diet and physical activity); here the provision and utilisation of relevant primary and secondary preventive measures should be promoted (Kruse, 2002).

Approaches aimed at reducing cardiovascular risk factors have a long tradition in Germany (Scheuermann et al., 2000). One of the best-known research projects is the German cardiovascular prevention study (DHP) conducted between 1979 and 1994 (main research phase from 1984 to 1994). On the assumption that the German population was faced with a high risk of cardiovascular disease, the interventions of DHP were primarily aimed at preventing a further increase in risk levels and reversing this trend. By reducing the classic risk factors for cardiovascular disease (smoking, adiposity, hypertension and hypercholesterolemia) the attempt was made to reduce cardiovascular mortality in the German population (DHP, 1998, 279). With the help of preventive intervention in the areas examined, all risk factors were positively influenced, with the exception of weight reduction. In addition to long-term reduction of high blood pressure and cholesterol levels, a significant fall in the prevalence of the smoking habit was achieved (DHP, 1998,153ff).

In the Tübingen project “Prevention of type 2 diabetes” (TULIP study – Tübingen lifestyle intervention programme; Häring & Fritsche in Stierle et al., 2005, p. 68ff) patients with advanced glucose intolerance were examined at a preliminary stage immediately before the onset of diabetes. In particular, the purpose was to find out which factors (such as body fat distribution, nutrition, fitness level) can predict whether or not a change in lifestyle among older people with an increased risk of diabetes will be successful. First results have shown that persons who were already relatively fit prior to the project benefited most from the intervention.

For the “Apoplexy prevention” project (Hopp in Stierle et al., 2005, p. 72ff), an apoplexy information bureau has been established by the Düsseldorf city council to provide more information especially to the older population about apoplexy risks and symptoms and appropriate action in case of emergencies. In 2005 Düsseldorf hospital administrations reported that in cases of apoplexy symptoms 52.7% of the Düsseldorf population called in the emergency services without delay, compared to only 33% in 2000.
The “Swordfish Concept“ (Immler, in Stierle et al., 2005, p. 80ff) staged by the University of Kassel targets measures to reduce the daily energy surplus often arising from excessive eating and simultaneous lack of physical activity among persons over the age of 60. Such measures must be understood as primary prevention of adiposity and metabolic diseases. This concept is aimed at reconciling change of behaviour relating to nutrition and physical activity with genetic and pseudo-genetic conditioning of individuals. Based on a “daily energy surplus” calculated for each individual, older people are shown how they can reduce their energy surplus by a combined strategy of nutrition and physical activity.

Regular examination of medication schedules is also an important part of disease prevention; this applies especially to patients with multiple medication (more than 5 different medicaments). Similar significance must be attributed to pain assessment and medication for well-being and subjective quality of life (Renteln-Kruse, v. et al., 2003; Wohlrab, 2004).

5.5.8 Other

The following themes were categorized under “other references”: changes in working conditions, adaptations of home and environment, special options (relaxation methods such as yoga, meditation; combinations of physical activity with discussion groups), coping with impairments/prevention of handicaps, promotion of an active lifestyle.

The study carried out by Oswald, Naumann, Schilling & Wahl (2005) focuses on the significance of the home environment for “healthy ageing”. Compared with medical risk factors, the state of knowledge about the effect of the home environment on the preservation of autonomy and well-being in old age is still scanty. The European project “Enabling Autonomy, Participation and Well-Being in Old-Age: The Home Environment as a Determinant for Healthy Aging” (ENABLE-AGE (http://www.enableage.arb.lu.se/) examined the effect of the home environment on healthy ageing of persons at a well-advanced age (75-89) living alone in urban areas.

It was shown that in Germany, as well as in the other countries participating, the adaptation of the environment to the individual (accessibility) is significant for healthy ageing. However, the number of barriers proved less important. Besides continuity of the home environment, the possibility of autonomous everyday life had a positive effect on health.

The Magdeburg home environment project “Prevention in Old Age” (PiA; Kreuter in Stierle et al., 2005, p. 56ff) assists elderly and disabled persons with remodelling their homes into barrier-free residences. The assistance granted includes an analysis

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62 Participating countries were Sweden, the UK, Germany, Hungary and Latvia.
of the home environment and the existing need for adaptation as well as soliciting bids, counselling on finance and subsidies available, and acceptance of the remodelling work on completion. Moreover, the home environment adaptation is combined with a set of preventive activities on the part of the State of Saxony-Anhalt, for networking of regional services to assist the elderly.

Under the ABI project, a health management system taking account of the ageing process was established in three medium-sized enterprises in North Rhine-Westphalia. Based on the employability concept and the work performance index, the individual health of staff members in these firms, the working conditions (relating to human needs, age, ageing and gender), professional decision-making competence and management structures were examined. Following analysis of the actual situation, recommendations were made for the implementation of health-promotion measures. The recommendations covered behavioural as well as environmental preventive measures, such as training courses concerning health/risks at the workplace, the formation of working committees on the subject of “work, age and well-being”; technical improvements, improvements in lighting, noise protection, aids for lifting and carrying, flexible working hours, improvement in work organisation, etc. (Tempel & Giesert, 2005, 29ff).

Krämer (2002) examined the viability of a working life concept for geriatric nursing in the form of personnel development taking into account the ageing process. The objective was to examine possibilities for promoting employment of older persons in geriatric nursing. The working life concept is based on the assumption that improvements in working conditions can be achieved by means of lifetime working-time arrangements, flexible working-time arrangements, part-time jobs, sabbaticals etc. In the course of this counselling project, a check list to identify the working life-related needs and potentials for action in nursing homes was developed that can be used as a planning aid for the introduction of working life concepts.
6 Transversal issues

6.1 Research Methods

Hurrelmann & Laaser (2006, 773) observe a lack of foundation on evidence in health promotion; in most cases, systematic, empirical verification of approaches and programmes has not yet taken place. For future evaluation of health promotion measures, they consider the following aspects as indispensable: 1) external evaluation, independent of participants and interests involved in each programme, 2) inclusion of such evaluation in the planning of concepts and financing of such measures, and 3) linking of process evaluation with outcome evaluation.

One third of the texts examined were theoretical overviews (reviews) on the subject of prevention, health and health promotion for the elderly, seven of which were systematic overviews of literature. In addition, 14 surveys on various health-related themes were included, the majority of which had been conducted by the “Robert-Koch-Institut” (RKI). Moreover, five randomised controlled trials (RCT) and one case-cohort study on health promotion and prevention were found, the majority of which had implemented a comprehensive evaluation concept (s. Table X).

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Research Methods</th>
<th>Evaluation</th>
<th>Evaluation Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meier-Baumgartner, H.P., Dapp, U. &amp; Anders, J. (2004)</td>
<td>Aktive Gesundheitsförderung im Alter. Ein neuartiges Präventionsprogramm für Senioren (Active health promotion in old age. A novel prevention programme for senior citizens)</td>
<td>RCT 1,3,4</td>
<td>interviews, analysing the documentation of participants (e.g. nutrition protocol) evaluation of group interventions in the field of nutrition, physical activity and counselling, evaluation of preventive home visits</td>
<td></td>
</tr>
<tr>
<td>Oswald, W. D.; Ackermann A.; Gunzelmann, T. (2006)</td>
<td>Effekte eines multimodalen Aktivierungsprogrammes (SimA-P) für Bewohner von Einrichtungen der stationären Altenhilfe (Effects of a multi-modal activation programme for residents of geriatric nursing institutions)</td>
<td>RCT 2,3,4</td>
<td>psychometric test, evaluation of documentations, external ratings by nurses (n=294). Setting: nursing home residents</td>
<td></td>
</tr>
<tr>
<td>Wiesemann, A. et al. (2004)</td>
<td>Cardiovascular risk factors and motivation for a healthy lifestyle in a German community - results of the GP-based Oestringen study</td>
<td>RCT 2,3</td>
<td>cross-sectional study in the framework of a long-term intervention study; survey; random sample of 1044 patients + 50% of the health course attendees evaluation of interventions, questionnaires for participants referring to health behaviour/motivation</td>
<td></td>
</tr>
<tr>
<td>Wiesemann A, Metz J, Nuessel E, Scheidt R, Scheuermann W. (1997)</td>
<td>Four years of practice-based and exercise-supported behavioural medicine in one community of the German CINDI area. (Countrywide Integrated Non-Communicable Diseases Intervention)</td>
<td>RCT 2</td>
<td>cross-sectional random samples, questionnaires to investigate special exercise-based health groups, questionnaire related to behaviour and health beliefs in order to measure efforts of participants; local health information system to facilitate evaluation, management of data and organisation of the health programme</td>
<td></td>
</tr>
<tr>
<td>Wildner, M. et al. (2005)</td>
<td>Frakturen im höheren Lebensalter - eine Herausforderung für Prävention und Gesundheitsförderung Ergebnisse der KORA-Frakturstudie Augsburg (Fractures at an advanced age - a challenge for prevention and health promotion - results of the KORA study of fractures, Augsburg)</td>
<td>Case-Cohort-Study 2</td>
<td>questionnaire for participants and GPs; age- and gender-based incidence/prevalence of fractures; health consequences and predictors</td>
<td></td>
</tr>
</tbody>
</table>

Table X Overview of selected studies on health promotion for senior citizens

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Another 12 Texts dealt with non-randomised trials and also implemented a comprehensive evaluation concept in the assessment of measures/programmes/interventions.

For the development of evidence-based guidelines it is suggested a) to consider only projects/measures/programmes that have been evaluated and b) to assess the scientific informative value of the evaluation of such projects according to categories of evidence. A commonly practised system is based on principles laid down by AHCPR (1992) and SIGN (1996) in DDG (German Diabetes Association; year of publication unknown) to categorize scientific studies according to their informative value into different degrees of probative force and levels of evidence (s. Table X). According to this system at least part of the literature examined contains evidence falling into the second highest (Ib) and the medium categories (IIa + IIb).

<table>
<thead>
<tr>
<th>Levels of Evidence</th>
<th>Strength of Recommendation Supporting Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ia</td>
<td>Evidence based on meta-analyses of randomised controlled studies</td>
</tr>
<tr>
<td>Ib</td>
<td>Evidence based on at least one randomised controlled study</td>
</tr>
<tr>
<td>IIA</td>
<td>Evidence based on at least one well-planned, nonrandomised controlled study</td>
</tr>
<tr>
<td>IIB</td>
<td>Evidence based on at least one well-planned, nonrandomised and not controlled clinical study, e.g., cohort study</td>
</tr>
<tr>
<td>III</td>
<td>Evidence based on well-planned, non-experimental, descriptive studies, such as e.g., comparative, correlation, or case-control studies</td>
</tr>
<tr>
<td>IV</td>
<td>Evidence based on reports from expert committees or expert opinions and/or clinical experience of recognised authorities</td>
</tr>
</tbody>
</table>

Table X Evaluation of the informative value of scientific literature according to levels of evidence and probative force AHCPR 1992; SIGN 1996 in DDG (publishing year unknown, p.3).

### 6.2 Strategies of health promotion

Based on the Ottawa Charta, Altgeld & Kolip (2004, 44) describe the following strategies as core strategies of health promotion: a) intersectorality, i.e. a concept of health promotion as a cross-sectional task for different political departments, b) empowerment, and c) a concept of health-promoting settings. The latter represents the most significant implementation strategy, since it opens up possibilities to combine measures related to individuals with strategies addressing the environment (see also chapter on Settings).

Generally, it must be noted that no selective preventive programmes established on a national level are in existence in Germany (Laaser & Hurrelmann, 2006; Dt. Bundestag, 2002,405). Werle (2006, 247ff) states that this also applies to the

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approach of municipal sports management. Here, it is rather a matter of isolated programmes, limited to local areas. Setting national health targets is a contribution towards developing political orientation guidelines for prevention and health promotion and must be seen as a strategy of intersectorality (Hurrelmann & Laaser, 769).

Moreover, it must be noted that in Germany strategies of behavioural prevention outweigh environmental prevention approaches. Health education measures target changes of behaviour in individuals and mainly address physical health (Kruse, 2002; Lademann, 2005; Naegele, 2004). In this context, empowerment is an essential strategy with the main focus on the enablement of individuals.

Advanced training of staff members in various medical and nursing professions can also be seen as a health promotion strategy. Such a development is reflected in recent amendments to licensing regulations and training curricula in the nursing profession by a distinct focus on prevention and health promotion. By turning away from the traditional deficit-oriented, compensatory concept of nursing, preventive, health-promoting, rehabilitative and palliative measures are coming to the fore (Apitz & Winter, 2004,8). In the approaches described above, nursing care has a special significance in connection with preventive home visits (Meier-Baumgartner et al., 2004) and relief for care-giving relatives (Schmidt, 2005).

6.3 Settings

A total of 30 texts contain no reference to settings. The other articles deal to a varying degree with the setting approach. With the inclusion of multiple references, a total of 26 references concentrate on the municipality setting, followed by the home environment of participants (20 references). 11 texts focus on the workplace setting; six texts are centred around the nursing home setting. The neighbourhood is described as a setting in two articles. 18 texts refer to other settings, which include GP surgeries (n=9) or GP surgeries in cooperation with a geriatric network (n=5). One reference was made to each of the following settings:

- different settings in the 4 different participating federal states; cooperation between federal state sports associations and
  - general practitioners (Bavaria)
  - public/private companies (Thuringia),
  - building societies (Berlin),
  - institutions in the field of health and tourism, e.g. fitness/wellness programme suppliers (Schleswig-Holstein)
- assisted homelife/VHS
- one district of Munich (Neuperlach)
- out-patient care services
GP-oriented approaches to health promotion are based on the idea that the family doctor is an important and generally accepted contact person for the elderly. Therefore projects such as “Active health promotion in old age” (Dapp et al. 2002) or “Preventive home visits” (Meier-Baumgartner et al. 2004; v. Renteln-Kruse et al., 2003) are frequently based on cooperation with local general practitioners. Moreover, such measures were often implemented in the context of municipal settings, as was, for instance, the case with the DHP project, one of the best-known examples of municipality-related measures of prevention and health promotion (DHP, 1998, 287ff).

In the DHP project, an approach centring on medical practitioners was chosen with “Communal prevention/community-related behavioural medicine”. In this case, preventive measures within the community were initiated and coordinated by local medical practitioners. Where the medical practitioners could be persuaded to take on this task, one advantage of this approach was that the preventive measures were carried out by persons credited with a high degree of competence in this field and also widely accepted among the community.

By contrast, as a model of cooperative prevention, also implemented in a DHP project, the attempt was made to establish a new type of organisation, a so-called study centre, within the community, with this new organisation being able to function as initiator, organiser and provider of preventive measures. It was vital for this organisation to succeed in building up a reliable cooperation network with other, already existing providers and organisers and enlisting their support. However, in its choice of cooperation partners and access criteria, the study centre was not restricted to medical practitioners. Instead, it was able to fill gaps in supply itself by establishing services still missing. In combination with attractive offers of cooperation for existing service providers, possible rivalry could be prevented, initiating the transfer of services established into the local structure, which was necessary in view of the time limit allocated to the project.

Both approaches enabled the participating municipalities to achieve an extension of services provided in the area of health promotion and prevention. By making health a matter of public discussion, the inhabitants of the community were also encouraged to reconsider their own health-related behaviour and make positive changes, which led to an increase in demand for relevant services. The objective of the interventions was to establish a favourable climate for prevention and health promotion in the communities. Where communities succeed in connecting the issue of health with various aspects of everyday life, a long-term effect on behaviour patterns and structural conditions becomes possible.

Werle et al. (2006, 247ff) advocate municipal sports management with similar arguments. One advantage of health promotion by becoming active in sports in a municipal setting is receptiveness of the population within the immediate neighbourhood. The interventions include changes in organisational structures as
well as the control and coordination of cooperation and communication processes between the various organisations involved (such as clubs/associations, health insurers, churches).

The communal setting has proved particularly effective for older people. In addition to the possibility of implementing behavioural as well as environmental preventive measures, it is easier here to reach vulnerable target groups (such as older persons living alone or migrants) as well as the relevant actors (such as companies or welfare organisations). Here, however, there is still some need for action for the future. Even though health promotion in the sense of protection against the hazards of life is required of the municipalities by the German constitution, it has been treated as rather low in the order of priority compared to issues of supervision and inspection in local health policy. Moreover, older people have been (and still are) rarely considered as a target group for municipal health promotion. Consequently, “gerontologisation” of municipal health promotion and prevention is a vital necessity (Naegele, 2004).

Health promotion at the workplace addresses questions relating to an ageing workforce (such as employability of older employees with and in spite of health handicaps), but also questions of reinstatement into employment of (older) employees with (long-term) illnesses. In the Federal Republic of Germany, policy relating to health at the workplace is based in particular on statutory health protection (ArbSchG [Labour Protection Law]; SGB [Social Security Code] VII) and legislation governing health promotion at the workplace (§20 SGB V)64. The Labour Protection Law (ArbSchG) and statutory accident insurance oblige employers to put certain measures into effect. Only since the 1990s have some health insurance organisations and employers’ liability insurance associations started to support health promotion measures at the workplace. However, these are “voluntary” measures, implemented by employers out of economic self-interest or social responsibility. They can be effective as supplements to statutory labour protection (Oppolzer, 2005). The extent to which health promotion measures at the workplace are provided also depends largely on the size of the company (Werle et al.; 2006). Therefore the ABI project was aimed in particular at building up a system of health management, taking into account the age and ageing of workers, in medium-sized enterprises, where such measures are rather rare (Tempel & Giesert, 2005).

In the nursing home setting different measures were addressed in various projects. In addition to measures to prevent falls and promote mobility, measures to improve nutrition, cognitive performance and dental health were also implemented. Ackermann & Oswald (2006) criticise the fact that despite the availability of relevant

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64 Oppolzer (2005, 57f) mentions quality management (for instance integrated management) as a further necessity. Since the 1980s, the health of the workforce is also increasingly being discussed in connection with the introduction of quality management systems.
knowledge and proven rehabilitative therapeutic approaches for residents of nursing homes, no general implementation of such measures takes place, although this would be desirable as an activating nursing care concept. Here, the lack of general standards and quality criteria relating to “activating and rehabilitative” care presents some problems. A “paradoxical” interpretation of compulsory long-term care insurance legislation also has a negative effect in this context (stipulation of care-giving and social support (§§ 11 and 28 SGB [Social Security Code] XI) vs. exclusive reference to care-giving services in lists of services provided and remunerated).

The home environment of older persons is a suitable setting for behavioural as well as environmental preventive measures. Preventive home visits must be mentioned as an example in this context, since they generally pursue both strategies. Measures to adapt the home environment should also be included in this setting.

For the sake of completeness it must be added that the Internet is also being used as a “setting” frequented by all target groups and without limits set by distance. For instance, as part of the federal government’s pilot project "Richtig fit ab 50" (really fit from 50 onward), a website module (www.richtigfit-ab50.de) was installed. This homepage offers extensive information to older people about suitable sports and sports organisations (such as clubs/associations). It also includes hints on fitness, sports and nutrition, with specific instructions for actual training. The objective is to counteract prejudice and to increase the motivation of older persons to engage in sports and physical activity by means of detailed, specific information (Stiehr & Ritter, 2005).

It should also be noted that various WHO activities are being implemented in Germany, based on strategies originally developed as part of the Ottawa Charta, such as the Network of Healthy Cities in Germany (Gesunde-Städte-Netzwerk der Bundesrepublik Deutschland) and the German Network of Health-Promoting Hospitals (Deutsches Netz Gesundheitsfördernder Krankenhäuser). However, these networks did not supply any detailed information about health promotion for the elderly which, in the case of the latter network is, due to restricted access to the project database.65

6.4 Inequality/diversity/gender

The subjects of social inequality/inequality in health, diversity and gender are closely connected with each other. Overcoming inequality in health due to socio-economic factors is an essential challenge for future health promotion and prevention. Gender-specific differences also play a part here, resulting from the general income situation

65 Another relevant institution is the German Network For Workplace Health Promotion (DNBGF), which originates from an initiative of the European Network For Workplace Health Promotion (ENWHP) and is supported by the Federal Ministry of Labour and Social Affairs (BMAS) and the Federal Ministry of Health (BMG). Aims of the DNBGF are the strengthening of health promotion at the workplace in Germany and the improvement of cooperation between all national actors. From this network, no further details were gathered either.
that places especially older women at a disadvantage during the ageing process. Currently older women, in particular women of an advanced age living alone, are affected more frequently than men by socio-economically unfavourable conditions of life that can have an adverse effect on the health of women in old age (Kruse, 2002, 169).

Although the proportion of older persons with incomes below the poverty line is below average at present (RKI, 2006,83; Lampert et al., 2005,118), a more detailed study indicates a correlation between the financial situation in old age with gender and the size of the household: in fact, the poverty risk is particularly high for people over the age of 65 living in single-person households (BMFSFJ, 2006,137; Lampert et al., 2005,118). Where income is concerned, there are also marked differences between East and West Germany: older East German men (aged 70 - 85) and women (aged 55 years and over) are the groups with the lowest incomes (“Old age survey 2002 – at a glance”, the financial situation in the second half of life).

Further variations also exist between men and women in terms of morbidity patterns and different health-related lifestyles. Apart from bio-physical and genetic factors, the lower life expectancy of men is also due to gender-specific differences in health-promoting lifestyles, so there is a need for action to promote health-consciousness and health-oriented behaviour among men (Kruse, 2002, 169). There is also a marked difference in acceptance behaviour: women participate more frequently in health-promotion measures than men (Dapp et al. 2002b, 3ff; Kahl, Hölling & Kamtsiuris, 1999; Wiesemann et al. 2004). The social background also has an influence on acceptance behaviour. Richter, Brand & Rössler, (2002, 421) have found a significant connection between participation in health promotion measures and social background for women: only 4% of women from the lower classes compared to just under 17% of women from the upper classes take part in such measures. Readiness to finance health-promoting measures privately is also subject to a social gradient: in the upper classes it is just under 60%, in the middle class 43% and in the lower classes approximately 24%. The overall proportion of persons who have never participated in any health-promoting measures, however, is extremely high (83% of men, 75% of women) (Richter, Brand & Rössler, 2002). A significant approach to overcoming inequality in matters of health is the project “Health promotion for the socially disadvantaged” staged by the BZgA (Federal Centre for Health Education). The BZgA and the federal associations of health insurers (BKK, AOK) plus health promotion associations, relevant central offices and working committees of the federal states are united under the roof of a cooperation network by the same name. This network makes it possible to coordinate projects and measures on a national scale (Lehmann et al. 2005). Centralised measures are (ibid., p. 3):

- An annual congress on the subject of “Poverty and Health”
- Establishment and administration of a database containing approximately 2,700 health promotion projects targeting the socially disadvantaged
- Formation of regional clusters in each federal state
A simultaneous European model project “Closing the gap – Strategies to tackle health inequalities in Europe”

To improve the quality of measures provided and be able to identify and recommend good health promotion projects for the socially disadvantaged, the coordination team developed a list of criteria for the assessment of good-practice examples. In view of the selection of projects described in the following in connection with our own planned research project, an overview of the 12 criteria identified is given below. The first two criteria are mandatory criteria for inclusion which must be met; of the other 10 criteria, at least one must be fulfilled in an exemplary way. On the one hand, this method prevents certain measures from being overburdened with unrealistic expectations. On the other hand, the focus is on special features of individual projects that are particularly commendable and therefore worth emulating. This is an advantage since, as a rule, complete transfer of specific measures is neither possible nor desirable (Lehmann et al. 2005, 16ff):

1. Concept and purpose (a concept has been drawn up that is clearly connected to health promotion/prevention themes and includes a defined objective in this context; reduction of social inequality in matters of health is explicitly targeted.)

2. Target group (the socially disadvantaged)

3. Innovation and sustainability

4. Multiplier concept

5. Working methods (low threshold, scouting, attendant and/or following-up)

6. Participation

7. Empowerment

8. Setting approach

9. Integrated action concept / networking (bundling of resources and multidisciplinary cooperation, coordination and networking with other actors in the local environment; assurance of sustainability by integration of projects in networking structures)

10. Quality management/development

11. Documentation/evaluation

12. Cost-benefit ratio

6.5 Sustainability

Most reports describe interventions/programmes/measures planned and implemented for a limited period of time. Sustainability is a theme actually mentioned in 33 texts, yet it requires continuity of both organisational structures and positive effects on the target groups.

Considerable differences have emerged regarding the continuity of organisational planning structures. Among the German Health Award 2005 prize-winners or
nominated projects, for instance, some of the measures had already been well-established for a number of years, while other projects were limited in time. In some cases it was mentioned that continued implementation and funding of the project was subject to annual renegotiation.

Dapp et al. (2002a, 9f) obtained sustainable results by working out individual suggestions for changes in lifestyle, including practical information on locally available health promotion measures. Six months after the recommendations had been made, participants were interviewed as to which measures had been implemented. It emerged that the majority of participants were implementing at least one recommendation made by the health counselling team on a regular basis in their daily lives.

Furthermore, it must be emphasized that the sustainability of the project should be seen in close connection with the acceptance of the approach by the elderly, which can be considered as high for the “Active health promotion in old age” approach. Almost three quarters of the participants also regarded a personal financial contribution as reasonable. Thus a continuation of the project beyond the pilot project arrangement seems feasible. The subsequent extension of the project (General practitioner study, part 3) also targeted an extension and consolidation of organisational and networking structures as well as the creation of financial structures as part of standard benefits (Meier-Baumgartner, Dapp & Anders, 2006, 36).

The integration of health promotion measures in existing, accepted structures also contributes to their sustainability. For example, apart from acceptance, an additional advantage of the medical practitioner-centred approach of DHP was that, due cooperation with local surgeries, it was not restricted by a time limit, such as the fixed period for the research project (DHP, 1998, 287ff).

6.6 Cost-effectiveness

By means of cost-effectiveness analyses, medical results of therapies are measured in physical units (such as lowering of the blood pressure in mm Hg, walking distance free of pain, additional years of life or prevention of blindness). The cost-benefit assessment of preventive measures presents a number of problems, one of which being the fact that the effect of such measures is not immediate, but lies in the future. In the absence of long-term studies, the cost-benefit ratio of such measures is often estimated by model calculations. In Germany, standardised measurements of results of preventive measures are an exception, economic evaluations are only rarely carried out (Plamper, Stock & Lauterbach, 2004).

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Anlagen/hausarztstudie3.property=pdf,bereich=,rwb=true.pdf

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In the literature examined, 26 texts address cost-effectiveness to a varying extent, with one study including a health-economic evaluation. In connection with a feasibility study for geriatric home visits to older persons, Manstetten & Wildner (2002) carried out a comparative cost analysis which included the actual costs and possible savings, as well as the nursing care cases that could be prevented by this method (cost-effectiveness analysis). This health-economic evaluation, however, is not based on data collected in this particular study, but is also derived from model calculations. Therefore another comprehensive empirical study to find reliable answers to some further open questions is considered necessary in this area also. In addition, the state of health was recorded, and the assessment, the home visits and the criteria for access judged by the participants.

In the evaluation of some measures various physical units were taken into account. In the DHP study (1998), for instance, the effect of interventions was measured by changes in the prevalence of selected risk factors in the West German population (hypertension, cholesterol values, adiposity, smoking habits). Wiesemann et al. (1997) examined the effect of measures by means of a questionnaire relating to the health-relevant knowledge and behaviour of participants. Heseker (2005) took into consideration the documentation concerning participants’ state of health, in particular their weights and eating and drinking protocols.

In some studies other criteria for the assessment of results were considered, such as rates of participation or evaluation of the measures from the participants’ point of view. An example is the federal government’s pilot project “Richtig fit ab 50” (really fit from 50 onward). This project included an evaluation of the cooperation between the state sports associations and various external partners, an evaluation of the various options available in terms of efficiency, effectiveness and sustainability from the point of view of participants (Stiehr & Ritter, 2005). Dapp et al. (2002) based their judgement of the effectiveness of various measures on the extent to which recommendations were actually implemented in daily life.

### 6.7 Consumer involvement

Consumer involvement is mentioned in 33 texts. In the case of intervention studies, questioning of participants to ascertain the results or to evaluate the measures is often an integral part of the project. Although it is generally considered important and necessary to involve the target groups in the development of measures, the actual development, planning and implementation is usually carried out by experts (Scheuermann, et al., 2000,1594; Walter & Schwartz, 2001). Scheuermann, et al. (2000,1594) point out that exclusive involvement of experts in the development of projects can also have a negative influence on their sustainability. By a wide-spread application of empowerment strategies, however, it is possible to win the participation of elderly persons as “co-producers” of health.
6.8 Multidisciplinarity

Multidisciplinarity in health promotion for the elderly is a theme in 25 texts. Here, the concept of “Active health promotion in old age” is named as an example of a project based on a multidisciplinary approach. The team of health counsellors is led by a medical practitioner who is a specialist in geriatrics, with dieticians, physiotherapists and social pedagogues taking part (Dapp et al., 2002a, 5ff). The project “Gesund älter werden” (Healthy ageing) (Perschke-Hartmann in Stierle et al., 2005, p. 38ff), which follows the preventive home visit approach, also operates with a multidisciplinary team of nurses, social pedagogues, psychologists, social scientists and nutrition counsellors. They provide information and support to insured persons of the statutory health insurers AOK Hanover, aged between 68 and 79, who are not in need of nursing care. For older migrants it is also significant that the teams are multilingual; Wohlrab (2004) mentions that in a health promotion pilot project for this target group bilingual “tandems” were formed within the project staff.

6.9 Other issues

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7 Conclusions/summary

The objective of this literature research was a description of the current state of health promotion for elderly persons in Germany. For this purpose, exclusively scientific studies dealing with health promotion for older persons were examined. Various scientific disciplines are involved in prevention and health promotion for older persons. In the literature examined, more than ten hits involved the following disciplines: gerontology/geriatrics (n=18), public health (n=13), medicine (n=12), psychology (n=11) and social/preventive medicine (n=10). Another 24 titles were grouped under “other disciplines”, of which five references were made to sports science / physiotherapy, three references each to medical sociology and health services research, followed by psycho gerontology (n=2) and other single references (n=11). As with other themes (such as quality of life) it must be noted for the concept of health promotion that it involves different research activities from a variety of disciplines under different aspects (see also Werle et al., 2006, 65).

This study of literature makes no claim to completeness; this is solely due to the fact that only texts under the heading of “Health promotion and prevention” were considered. However, results concerning positive health effects are also contained in other scientific studies not covered by this research project, since they make no direct reference to the theme of health promotion/prevention for older persons. For instance, no search differentiated by types of health service (medicine, nursing, rehabilitation) was carried out, but instead an open search using the general keywords of “prevention and health promotion”. On the one hand, this provided an
opportunity to demonstrate the many facets of health promotion for the elderly. It is remarkable that measures related to nutrition, physical activity and safety (especially prevention of falls) and prevention of disease predominate. Social participation and the promotion of mental health, including treatment of dependence syndromes (alcohol and drug addiction) at an advanced age, are relatively rarely dealt with in a health promotion context. On the other hand, a description of the individual subjects could only be made in the form of an overview, due to the wide range of subjects covered.

Significant preventive concepts for the second half of life that complement each other are currently “preventive home visits” and the project “Active health promotion in old age” (v. d. Knesebeck et al., 2006,168ff). Preventive home visits are based on health service organisations taking the initiative. Due to contradictory results regarding the effectiveness of this approach, they are not part of the standard health service benefits in Germany so far. The structure of the programme “Active health promotion in old age” is based on activity on the part of participants. Drawing on the empowerment concept, the focus is on areas subject to personal responsibility, such as nutrition, physical activity and social participation. It must also be emphasized that programmes “made to measure” are involved here, i.e. health recommendations adapted to individuals. However, this programme has not (yet) been taken up by the standard health services either (see also previous chapters dealing with both these approaches).

On the whole, the attributes of and future demands on health promotion for older persons in Germany can be summed up as follows:

**Creation of appropriate statutory conditions - passing and putting into place of proposed legislation to strengthen preventive health care**

The current debate concerning prevention and health promotion in the Federal Republic of Germany is essentially driven by an increasing awareness of social problems that are partly a consequence of demographic change. In view of the increasing life span of individuals, health promotion and prevention of disease have gained social as well as individual significance, which can be gathered from the abundance of current publications, pilot projects, relevant programmes and political initiatives. In spite of the significance and urgency of this issue, especially in view of an older and ageing population, appropriate statutory provisions besides those for curative therapy, rehabilitation and nursing are currently not yet in place.

**Multidimensional approach - Promotion and consideration of cognitive, mental and social health as a part of health promotion**

In the Federal Republic of Germany, extensive research has been carried out concerning the classic risk factors that are significant for the development of cardiovascular diseases and responsible for increased mortality. However, so far
only little is known about health-promoting factors such as individual and social health resources. While individual health resources include “internal control convictions” and “sense of coherence”, social health resources relate to potentials of social support. There is also still a considerable need for further research concerning differences of status in this context (Mielck & Helmert, 2006,620). The concept “Active health promotion in old age”, which includes interventions in the areas of nutrition, physical activity and social matters, is a positive example in this regard (Dapp et al., 2002a, 5ff). However, as has been shown in previous chapters, mental aspects have been dealt with relatively rarely so far in a context of health promotion for older people.

**Implementation of behavioural and environmental prevention**

In both prevention and health promotion, the main focus is consistently on behavioural measures. Therefore it must be taken into account in the development of prevention and health promotion strategies that “the onset and progression of chronic disease is influenced not only by personal behaviour but also by wrong types of stimuli, barriers and stress factors in the local, social, institutional and legal environment” (Kruse (2005, 72). In view of a comprehensive concept of health, Kruse (2002, 18f) defines the following objectives for prevention: identification and influencing of risk factors (in the individual and/or the environment) and attributes of a person’s situation in life,

- that promote/generate physical and mental diseases or
- that may lead to impairment of functions, abilities and well-being.

**Transfer of good-practice examples into standard health care and networking of existing options**

Since a great number of health-promoting and preventive projects for the second half of life already exist in Germany today, there is a need for action in the area of implementing an integrated health promotion and prevention concept in the future (Kruse, 2004, 53ff67), in order to:

- ensure the sustainability and transferability of projects
- better coordinate the individual projects in networks and enhance cooperation between the various actors involved (such as medical practitioners, nursing institutions and health insurance organisations)
- make the projects known and accessible nation-wide.

Kruse (2004, 57f) attributes the main responsibility for networking of health-promoting and preventive options and passing on relevant information to the target groups to

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the health insurance bodies, and above all to the municipalities. On the one hand, the functions of information, coordination and networking could be fulfilled by the municipal or regional coordination centres for senior citizens that are already in existence in many places, on the other hand they could be intensified by means of discussion platforms on the municipal or regional level. A vital prerequisite for the future improvement of health promotion and prevention is the inclusion of such themes in the basic and advanced training curricula of the medical and nursing professions, with special emphasis on the nursing professions (see also Weidner et al., 2004).

Incentives for utilization of health-promotion measures: comprehensive information, early identification of risks, accessibility

Werle et al. (2006, 263) have dealt with health promotion for older people by actively engaging in sports. They point out that randomised samples examined in sports science research concerning adults of middle or advanced age are highly selective, which means that they usually include (former) active sportsmen and -women, without taking into account the general population or persons who have not been actively engaged in sports. The position with other research projects concerning health-promoting measures for older people is similar: the majority of persons reached by such measures already have a health-promoting lifestyle.

In view of the low overall utilization rate of health-promotion measures, Kahl, Holling & Kamtsiuris (1999) see a need for further research concerning attitudes and incentives that motivate the older population to participate or not to participate. One major challenge is to motivate and include individuals who not at all or only rarely utilize such measures (for instance members of the lower classes (Kruse, 2004, 53ff68; Wiesmann et al., 2006). Kruse (ibid.) attributes a crucial significance in this respect to positively influencing social and personal conceptions of ageing.

Adequate and early information about health-relevant themes (Döhner 2001) with the objective of a high degree of autonomy is just as indispensable as the identification of risks at an early stage, appropriate counselling and recommendations for health-promoting measures (see also Dapp et. al., 2002; Kruse 2002; Meier-Baumgartner et al., 2004; v. Renteln-Kruse, et al., 2003). Moreover, low-threshold access is important: depending on the persons’ state of health, structures for initiative on the part of participants or on the part of organisational teams coming to participants’ homes need to be established. For older persons with a migration background, overcoming language barriers is also a prerequisite for utilization (Wohlrab, 2004; Schnabel & Schopf, 2006). Access to such options is also influenced by the availability of local public transport connections (Hikl & Bill, 2005).

Specification of target groups and age groups

Concerning target groups it must be noted that primarily “active” and “healthy” older persons living in private households are addressed. The inclusion of older persons with heavily impaired health is still lacking (Wiesmann et al., 2006). Consequently, special attention must be paid to the subject of health promotion and preservation of resources with and in spite of chronic disease in future (Garms-Homolova & Schaeffer, 2003, 685). Appropriate interventions such as preventive home visits for older persons in nursing homes are also lacking so far (Thomas & Steinhagen-Thiessen; 2004, 194). Moreover, older persons with dependency syndromes and older persons with disabilities were not at all, or the latter group only in isolated cases, identified as target groups for prevention and health-promotion measures. The age groups also vary, depending on the measure under examination; it is striking that the most advanced age groups, who are gaining in significance as target groups in view of demographic change, are relatively rarely addressed.
8 References


BMG (Bundesministerium für Gesundheit), (Hg.) (2001): Zweiter Bericht über die Entwicklung der Pflegeversicherung, Bonn.


Deutscher Bundestag, 2003, SVR?? Prävention im deutschen Gesundheitswesen eine nachgeordnete Stellung ein


### Project: Organisers/sponsors: Preventive objectives: Integration: Target groups: Term:

| Project: Active health promotion in old age | Organisers/sponsors: Albertinen-Diakoniewerk e.V., Hamburg  
E-mail: dapp@albertinen.de  
Web: www.albertinen.de | A low-key approach to health promotion for elderly persons still living at home, to preserve their quality of life and autonomy as long as possible, successful ageing | Multidisciplinary programme involving medical practitioners, dieticians, physiotherapists, social pedagogues and senior citizens' associations | Older people still living at home and not yet in need of nursing care care | Since the beginning of 2001, continuing |
| Project: PATRAS – Paderborn training study | University of Paderborn  
Paderborn  
E-mail: heseker@evb.upb.de | Improvement of nutritional condition and promotion of physical exercise among elderly persons in nursing care institutions, with the aim of preserving and improving their quality of life, autonomy, well-being and mobility | Nutritional scientists, graduated physical education specialists, nursing care staff of the local Caritas Association, Meinwerk Institute, Paderborn | Residents of nursing homes | Since October 1, 2003, to be continued for an indefinite period |
| Project: Kölner Seniorennetzwerke (Cologne networks for senior citizens) | Liga der Wohlfahrtsverbände Köln, e.V. Caritasverband für die Stadt Köln (League of welfare associations in Cologne, Caritas for Cologne) | Promotion of integration, prevention of social exclusion and isolation  
Inclusion of marginal groups, creation of networks for the entire municipal area | Politicians, representatives of senior citizens, all institutions dealing with older people within a suburb, including kiosk owners, barbers and hairdressers, associations and housing cooperatives as well as pharmacists and medical practitioners | Senior citizens living in suburbs with special needs for assistance (living alone, in need of nursing care or home care, or affected by old-age poverty), younger senior citizens over the age of 50, the 65-80 age group and persons over 80, migrants | Since October/November 2003, continuing |
| Project: Gesund Alter Werden (Healthy ageing) | Allgemeine Ortskrankenkasse (AOK) Niedersachsen (Public health insurance of Lower Saxony)  
Hanover  
E-mail: christiane.perschke@nds.aok.de  
Web: www.aok.de | Preservation of autonomy in old age with the primary objective that people can continue to live alone and cope with their own housekeeping | WHO European Office in Copenhagen, with the demonstration project “Healthy ageing”, which is also under way in Vienna and Radevormwald, German Association of General Practitioners, Municipal Senior Citizens’ Service Hanover | People aged between 68 and 79 not in need of nursing care and living in the following ten selected suburbs of Hanover: Linden, Limmer, Wettenberg, Mühlenberg, Ricklingen, Oberricklingen, List, Vahrenwald, Arnnum and Bormum. | Counselling from June 2004 to December 31, 2006. The scientific project is to be completed in the summer of 2007 |

First German Prevention Award 2005. Healthy in the second half of life (50 plus). Award-winners and nominees.

Source: Bertelsmann Foundation (2005), own publication.
<table>
<thead>
<tr>
<th>Project:</th>
<th>Organisers/sponsors:</th>
<th>Preventive objectives:</th>
<th>Integration:</th>
<th>Target groups:</th>
<th>Term</th>
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<tbody>
<tr>
<td>“Teamwerk” dentistry for nursing care cases. Dentists visiting nursing homes</td>
<td>Teamwerk GbR, Munich E-mail: <a href="mailto:cbenz@dent.med.uni-muenchen.de">cbenz@dent.med.uni-muenchen.de</a></td>
<td>Improvement of oral health of persons needing nursing care, i.e. less pain, better chewing ability, less extensive dental treatment for disabled persons and persons in need of nursing care</td>
<td>Selected nursing institutions in Munich with a total of 600 residents, municipal social services department, municipal health advisory council, AOK Bayern, (public health insurance), State dental associations, 72 sponsoring dentists (dental practitioners), university</td>
<td>Disabled persons and persons in need of nursing care who are incapable of visiting a dentist and unable to take care of their personal oral hygiene</td>
<td>Since June 1, 2002, continuing</td>
</tr>
<tr>
<td>Honorary Award Alexander Spirling and Ulrich Grundmann from the nominated project Begleitetes Wohnen (Assisted living)</td>
<td>Begleitetes Wohnen e.V. Dresden E-mail: <a href="mailto:bewodresden@gmx.net">bewodresden@gmx.net</a> Web: <a href="http://www.begleiteteswohnen.de">www.begleiteteswohnen.de</a></td>
<td>Strengthening of personal responsibility and competence, motivation to activity, such as shopping and housekeeping</td>
<td>Cooperation above all with statutory guardians, mobile and stationary care providers, the social welfare department, municipal working groups, service providers such as purchasing and household service companies</td>
<td>Older persons who are dependent on outside assistance due to physical or mental disease, need of nursing care or lack of social contacts</td>
<td>Since April 2000, continuing</td>
</tr>
<tr>
<td>gEMiDe Integration selbst in die Hand nehmen (Integration by personal initiative)</td>
<td>Pilot project for social commitment and integration of female migrants and naturalised German citizens through voluntary work (tgEMiDe) Hannover E-mail <a href="mailto:info@gemide.org">info@gemide.org</a> Web: <a href="http://www.bteu.de">www.bteu.de</a></td>
<td>Promotion of mutual readiness for integration in female migrants and German citizens, voluntary work as a necessity within society as well as for strengthening personal competence and autonomy and developing individual talents</td>
<td>Youth centre Linden-Nord, cultural centre Linden-Sud, Volkshochschule Hannover (Hanover adult education college), information and coordination office for voluntary work, Diakonischer Betreuungsvereen [an organisation of the Protestant churches], Evangelische Fachhochschule Hannover [Protestant advanced technical college], Bildungsverein Hannover [education association], networks, Youth Sports Association of Lower Saxony</td>
<td>All migrants and naturalised German citizens; currently 60% of all participants are over the age of 50, gEMiDe is open for everyone</td>
<td>Since July 2001; the project is extended for another 12 months every year</td>
</tr>
<tr>
<td>Counselling concerning adaptation of the home environment: Home life without trip hazards</td>
<td>University of Magdeburg-Stendal with self-help contact bureau “Prevention in Old Age” (PiA) Magdeburg E-mail: <a href="mailto:hans-heinz.kreuter@sgw.hs-magdeburg.de">hans-heinz.kreuter@sgw.hs-magdeburg.de</a> Web: <a href="http://www.hs-magdeburg.de">www.hs-magdeburg.de</a></td>
<td>Autonomy in old age, continuing to live in one’s own home and avoidance of transfer to a nursing home</td>
<td>Public health insurance (AOK) Saxony-Anhalt, State Ministry for Building Construction and Transport, social welfare authorities and associations, self-help groups, health institutions, associations of the disabled, government authorities</td>
<td>People for whom remaining in their own homes is becoming increasingly difficult, above all senior citizens, but also persons with disablement</td>
<td>Since 2000; originally on a temporary basis to the end of June 2005; extension of this project is renegotiated every year</td>
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<tr>
<td>Promotion of health and physical activity for persons of advanced age Physical fitness beyond the age of 80</td>
<td>Deutscher Turner-Bund e.V. (DTB) Frankfurt (German Association of Gymnasts) E-mail: <a href="mailto:petra.regelin@dtb-online.de">petra.regelin@dtb-online.de</a> Web: <a href="http://www.dtb-online.de">www.dtb-online.de</a></td>
<td>Strengthening of personal responsibility and competence, encouragement of physical, mental and social activities, opportunities for participation, environmental aspects</td>
<td>Sports scientists, medical practitioners, nursing homes</td>
<td>Men and women aged over 80, both in good health and with diseases typical of old age, such as diabetes, lipometabolic disorders or arthritis, dementia or cardiovascular disease</td>
<td>Since May 2004; training courses continuing</td>
</tr>
<tr>
<td>When is a man a man? Needs of men in residential homes for the elderly This is how a man remains a man</td>
<td>inverso. Institute for Advanced Education and Development in Assistance to the Elderly Mainz E-mail: <a href="mailto:bender-nickel@t-online.de">bender-nickel@t-online.de</a> Web: <a href="http://www.inverso-mainz.de">www.inverso-mainz.de</a></td>
<td>Strengthening of personal responsibility and competence in men in need of assistance and nursing care, improvement in the quality of life by the promotion of personal resources</td>
<td>Voluntary workers, a male choir and a soccer club participate in the work at the Carpe Diem park for senior citizens in Niederselters/ Taunus</td>
<td>Male residents of stationary institutions in need of assistance and nursing care</td>
<td>Since January 2004, continuing</td>
</tr>
<tr>
<td>Prevention of type II diabetes TULIP study – Tübingen lifestyle Programme of intervention</td>
<td>University Hospital of the Medical Faculty Tübingen E-mail: <a href="mailto:andreas.fritzsche@med.uni-tuebingen.de">andreas.fritzsche@med.uni-tuebingen.de</a> Web: <a href="http://www.medizin.uni-tuebingen.de/extweb/labor/tulip/">www.medizin.uni-tuebingen.de/extweb/labor/tulip/</a></td>
<td>Identification of predictive parameters for the necessity and the encouragement of preventive strategies in terms of a change in lifestyle, motivation for a healthier lifestyle, which means more physical activity and a healthier diet, prevention of diseases of civilisation such as type II diabetes, but also vascular calcification and myocardial infarction</td>
<td>Medical practitioners, nutrition specialists, sports scientists, sports physicians, nurses, exchange with other European countries</td>
<td>Persons with an increased risk profile for type II diabetes mellitus whose parents suffer from diabetes, women who have developed diabetes during pregnancy, people with reduced glucose tolerance, older people who are overweight (aged over 50) with a BMI of more than 27.</td>
<td>Since May 1, 2003, to continue for at least 6 years</td>
</tr>
<tr>
<td>Apoplexy prevention</td>
<td>Apoplexy information bureau, Düsseldorf E-mail: <a href="mailto:schlagenfallbuero@stadt.duesseldorf.de">schlagenfallbuero@stadt.duesseldorf.de</a> Web: <a href="http://www.duesseldorf.de/gesundheit/gesundheitskonferenz/schlagenfallbuero">www.duesseldorf.de/gesundheit/gesundheitskonferenz/schlagenfallbuero</a></td>
<td>Improved knowledge about risks and symptoms of apoplectic strokes among the population, correct reaction in emergencies by recognition of the symptoms of apoplexy, prevention of apoplexy and its consequences</td>
<td>All hospitals of neurology in Düsseldorf, the Medical Association North Rhine, German Apoplexy Foundation, local organisations for assistance and counselling, self-help groups, cooperation with other Lower Rhine municipalities</td>
<td>This project addresses all citizens, but in particular the higher age groups.</td>
<td>Prevention activity since 2002, originally planned to continue to the end of 2005, probably beyond</td>
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<th>Target groups:</th>
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<tr>
<td>Academy for Senior Citizens</td>
<td>Akademie für Ältere e.V. / gGmbH Heidelberg E-mail: <a href="mailto:gressler@akademie-fuer-aeltere.de">gressler@akademie-fuer-aeltere.de</a> Web: <a href="http://www.akademie-fuer-aeltere.de">www.akademie-fuer-aeltere.de</a></td>
<td>Preservation of mobility to an advanced age, mental and physical fitness in old age, mental agility, promotion of personal initiative</td>
<td>All senior citizens in and around Heidelberg beyond the age of 60, including disabled and underprivileged persons and migrants</td>
<td>People in their third period of life who do not want to give up and are seeking companionship in spite of impairments imposed by old age on their sight, hearing, memory, physical mobility and mental capacity, also migrants and socially underprivileged people</td>
<td>Beginning of first courses in May 1985, this self-help institution operates without interruptions, even during holidays</td>
</tr>
<tr>
<td>Swordfish Concept</td>
<td>Research Group Body and Health at the University of Kassel Kassel E-mail: <a href="mailto:immler@uni-kassel.de">immler@uni-kassel.de</a> Web: <a href="http://www.schwertfischkonzept.de">www.schwertfischkonzept.de</a></td>
<td>Reduction of daily excess energy intake for primary prevention of adiposity and metabolic diseases</td>
<td>Sponsors and multiplicators such as Hessisch-Niedersächsische Allgemeine Zeitung [a regional newspaper], Wort und Bild publishing house, German Diabetes Foundation</td>
<td>Persons with a BMI value from 25 to 30</td>
<td>Since September 1, 2004; for an indefinite period</td>
</tr>
<tr>
<td>Assistance for older persons suffering from dementia and for their families in the southern part of Mannheim</td>
<td>Dementia Information Centre Neckarau-Almenhof Mannheim E-mail: <a href="mailto:DemenzBeratungsstelle@Sozialstation-Neckarau.de">DemenzBeratungsstelle@Sozialstation-Neckarau.de</a></td>
<td>Networking of assistance facilities for persons suffering from dementia and for their families, close cooperation between all occupational groups involved in taking care of such persons, relief of welfare centres and improvement in the conditions of life of persons affected and their families</td>
<td>Persons suffering from dementia, and their family and social environment (family members, neighbours), voluntary helpers in the municipalities and different occupational groups, such as carers for the elderly, social pedagogues, medical practitioners, senior citizen’s counsellors, Fachhochschule Mannheim (Mannheim Advanced Technical University)</td>
<td>Older people suffering from dementia, their families, also older people who, in view of increasing forgetfulness, have fears of developing dementia themselves and are seeking information that can be understood by ordinary people</td>
<td>January 1, 2003 to the end of 2005</td>
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