



## Country Document 2013

# Pensions, health and long-term care

## Denmark

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## **1 Executive Summary**

No major reforms have been adopted in pensions, health or long-term care from mid 2012 to the Autumn 2013. However, there has been noticeable changes as a result of changing demographics, austerity, and of reforms and projects under implementation just as there has been some input on coming policies as suggested by the government in health and by two commissions on, respectively, home help and nursing homes.

One million persons above 65 years of age was reached for the first time in the second quarter of 2013 when Denmark had a population of 5.6 million people. Social expenditures rose with 3 percent from 2011 to 2012 mainly due to more expenditures related to old age.

In pensions earlier reforms of increasing pension ages for the national old age pension and the voluntary early exit benefit are being implemented.

In health care there have been no major reforms. Already initiated projects and measures continued such as the renovation of old and building of new hospitals, municipalities getting a larger role for municipalities in preventive health, and digitalisation and other IT measures.

Moreover, the Government announced its health policy in May 2013 under five headings:

1. A integrated health system
2. Larger equality in health
3. Strengthened acute care
4. Better quality and focus on results
5. A modern and efficient health system (REGERINGEN 2013)

Although these headlines indicate the priorities of the Government they are only backed by 600 million DKK.

In long-term care, which is a municipal task, there has been no major reforms which may be explained by 2013 being an election year to municipalities (19 November 2013). However, ageing populations, stricter monitoring by central level of municipal finances, and generally more prudent municipalities has contributed to:

- De facto retrenchment in home help with fewer people receiving fewer hours of home help
- Continued expansion of home based solutions, including elderly housing, preventive home visits and earlier training and rehabilitation
- Rehabilitation and engaging citizens in meeting their own needs and making them more autonomous in general line of thinking that is reflected in both health and long-term care policy changes, government announcements and the recommendations made by Commissions.

## 2 Pensions

### 2.1 System description

#### 2.1.1 Major reforms that shaped the current system

The Danish pension system<sup>1</sup> of today is the result of three distinct waves of pensions reforms. In 1956 the national old age pension became a universal, flat-rate and non-means-tested benefit. Today, this is still the case, although the size of the benefit depends on number of years of residence and part of the pension is tested against other income. The national old age pension today forms the first pillar of the Danish pension system.

In 1964, the compulsory ATP scheme got into being providing small, but important supplementary pensions for people that have been active in the labour market. These are largely independent on the size of previous earnings and contributions. The ATP scheme today forms a hybrid of a first and second pillar of the Danish pension system, hybrid because it relates to labour market attachment but with little relation to earnings and contribution record.

In 1990, supplementary pensions, called labour market pensions, expanded to blue collar and new groups of white collar workers and as a result of collective agreements. Through further expansion of coverage and contributions by sector and through maturation these funded, defined contribution schemes today form the second pillar of the Danish pension system.

Recent reforms have been concerned primarily with withdrawal from the labour market and concern not only the national old age pension but also the voluntary early exit benefit scheme (efterløn) that is not officially a pension but which nevertheless is an important exit route out of the labour market for older workers.

#### 2.1.2 System characteristics

The pension system consists of a national old age pension (*folkepension*) in the first pillar, labour market pension schemes in the second pillar and a variety of individual saving vehicles in the third pillar. Also there are two supplementary pension schemes – ATP and SUPP - that cannot unambiguously be categorised as either first or second pillar schemes. In Table below these schemes are therefore placed under the pillar they have most commonalities with.

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1 In 2013, the Danish pension system has been rated by the Melbourne Global Pension Index as the best in the world (AUSTRALIAN CENTRE FOR FINANCIAL STUDIES & MERCER) (2013).

Table 1: The Danish pension system according to the three pillar categorisation<sup>2</sup>

	First pillar	Second pillar	Third pillar
Goal	Prevent poverty	Maintain income	Additional savings
Sector	Public	Private	Private
Basis	Universal (residence)	Mostly compulsory membership through collective agreements	Voluntary payments
Benefit formulae	Flat-rate benefits to all, means-tested or guaranteed minimum income	Earnings-related benefits	Flexible
Financing	Taxes, pay-as-you-go	Contributions, fully funded	Contribution based
Danish pension schemes	National old age pension	Labour market pensions	Individual pension savings
	ATP and SUPP		

Source: ANR (2012).

The Danish national old age pensions consist of a basic amount, a supplementary amount and the supplementary pension benefit. The basic amount is the same for everybody, i.e. DKK 69,648 annually or DKK 5,804 monthly (all amounts for 2013) (SOCIALMINISTERIET 2013).<sup>3</sup> The supplementary amount varies for single persons and others. For single persons the supplementary amount is DKK 72,336 or DKK 6,028 monthly and for others DKK 34,968 annually or DKK 2,914 monthly. The supplementary pension benefit is DKK 15,900 annually, paid out as a 'cheque' once a year.

All amounts of the Danish national old age pensions are taxable.

The basic amount and the supplementary amounts are automatically indexed each year according to wage and price developments. The level of the supplementary pension benefit, popularly called the Elderly Cheque, has from its introduction in 2003 been set politically (for more details, see ANR 2010).

The official retirement age is 65 years, that is increased gradually as a result of the Welfare Reform of 2006. In the future the retirement age will be increased with increases in longevity (see ANR 2010).

When people decide to retire at a later stage than the official retirement age they receive an increased national old age pension (opsat pension) in the remainder of their retirement. The national old age pension is then added with a waiting supplement (*ventetillæg*). The longer a person wait retiring, the larger the waiting supplement and thus national old age pension, the person can receive. Postponing retirement with one year result in an increase of 6 percent, two years with 12 percent, three years with 19 percent, four years with 26 percent and five years with 34 percent.

<sup>2</sup> The three pillar system misses out on two important policy programmes for early exit: the first is the scheme for workers above 60 years of age, the voluntary early exit benefit, and the second is the disability pension which is for workers and non-workers alike and disregarding age.

<sup>3</sup> 100 euro = 744.3751 DKK, yearly average for 2012 (NATIONALBANKEN 2013).

To qualify for the waiting supplement a person needs to work at least 1,000 hours annually in 2013. This number of hours has been reduced to 750 hours annually as of 2014.

Often the national old age pension is portrayed as a universal scheme. In reality, citizens residing in Denmark earn 1/40 national old age pension for each year they stay in Denmark between the age of 15 and 65 years. Persons residing for less than 40 years in this period of their life are entitled to a fraction of the full national old age pension, e.g. 33/40 of the full pension for a person having resided in Denmark for 33 years between being 15 and 65 years of age.

The virtue of the Danish national old age pension is that it constitutes a very good minimum pension effectively combating poverty in old age. Especially this is the case because virtually all benefits in kind are free of charge (except institutional care).

However, the national old age pension does not provide good income maintenance for middle and high income earners. The supplementary labour market pension, ATP *Arbejdsmarkedets Tillægs Pension*, does not significantly change this picture. The ATP provides a supplement to the national old age pension which is significant for groups with low to middle earnings but less important for middle to higher income groups expressed by its share of their income in retirement. In 93 of the 98 Danish municipalities the national old age pension and the ATP are more important sources of income than private pensions as their share of average pensions is greater.

Contributions to the ATP scheme and thus the ATP benefit in retirement depend on the working time, but is independent of the size of earnings. To partly compensate for the growth in labour market pensions that do not benefit persons not in a job, claimants of temporary social security benefits are also paying mandatory contributions to the ATP scheme with public authorities paying the 'employer part'. Typically, these are larger than the ordinary contributions to ATP (see ANR 2010).

Persons outside the labour market on more permanent basis also have the possibility of an ATP like scheme, namely the Supplementary Labour Market Pension for Disability Pensioners (*Supplerende arbejdsmarkedspension for førtidspensionister* - SUPP). The rationale of SUPP is to partly compensate for the lack of an ordinary labour market pension. Unlike the ATP contributions made for persons on temporary social security benefits, the SUPP scheme is voluntary. SUPP gives persons on disability pensions the possibility to contribute to supplementary labour market pension scheme. The insured person and the municipality pays, respectively, DKK 160 monthly and DKK 320 monthly to SUPP (SOCIALMINISTERIET 2013).

Because of the relatively low compensation rates for middle and high income groups provided by the national old age pension and ATP, there was a pressure for many years to introduce new supplementary pensions providing higher benefits. This resulted in 1990 in a big expansion of supplementary pensions that were negotiated as part of collective agreements, i.e. varying across sectors on the labour market.

These supplementary pension schemes called labour market pensions (*arbejdsmarkedspensioner*) are fully funded and defined-contribution schemes with benefits reflecting the contributions made and the return of investments.

Private pensions in the form of occupational pensions have become gradually larger as schemes established in the early 1990s are gradually maturing and as contribution rates to these schemes have gone up as part of collective agreements. As private pensions become

more salient, there will be smaller differences between the working and the retired population but greater inequalities among the retired.

### 2.1.3 Details on recent reforms

There were no changes to the public pension schemes as part of the Budget 2013.

Nevertheless reforms are being implemented. The Welfare Reform of 2006 increases the pension age from 60 to 62 years of age in the early exit benefit (*Efterløn*) between 2019 and 2022 and from 65 to 67 years in the national old age pension and ATP from 2024 to 2027. The Reform of 2006 also meant that pension age will be indexed with increases in life expectancy.

Finally, on December 21 2011 a reform of the early exit benefit was passed. This reform was in fact agreed upon by a number of political parties already on 13 May 2011, i.e. ahead of the elections held in 15 September 2011, who promised that they would pass the reform if they got the majority of seats in Parliament after the election. The interesting aspect is that the parties encompass both opposition parties (Conservatives and the Liberal party) and the Social Liberals (*Radikale Venstre*) from the coalition government. The main elements of the reform are a reduction of the possible time on the early exit benefit from five to three years, a gradual increase of the age of retirement on early exit benefit and the national old age pension, and greater income-testing of the early exit benefit. Moreover, when average longevity increases so will retirement ages in both the early exit and the national old age pension scheme (for more details on the scheme, Welfare Reform of 2006 and the last reform, see ANR 2011).

## 2.2 Assessment of strengths and weaknesses

### 2.2.1 Adequacy

In general the Danish pension system provide adequate benefits by keeping old age people out of being at-risk-of-poverty and out of severe materially deprivation. At least this is the case when the at-risk-of-poverty is measured at the level of 50% of the median income which is a higher level than the conventional 60% of the median income used in the EU. In Denmark most scholars and organisations use the 50% rather than the 60% level. This is the case for the social partners, the Ministries, scholars and most recently the Expert Commission on Poverty (see EKSPERTUDVALGET OM FATTIGDOM 2013). The reason for using the 50% median income is partly also to reflect that old age people in Denmark have access to free universal health care as well as the most encompassing and free home help in the world, see sections 2 and 3, respectively. When using the 60% level students and old age people are the two main groups at-risk-of-poverty whereas using the 50% level the group become more diverse.

One group that is particularly exposed to inadequate pensions are those persons who have not lived 40 years in Denmark between the age of 15 and 67 years. As described above persons resident in Denmark earn an entitlement of 1/40 of the full national old age. To illustrate, a person who has lived 20 years in Denmark between the age of 15 and 65 is entitled to 20/40, or half of a full national old age pension. So-called 'fraction'-pensioners are thus more exposed to poverty. The Expert Commission on Poverty Measures found that the number of fraction pensioners at risk of poverty defined as having income below 50% of the median income had risen from 850 in 1999 to 2,800 persons in 2010 (EKSPERTUDVALGET OM FATTIGDOM 2013). Statistics Denmark also report of a growing number of old age people receiving a reduced pension, i.e. 'fraction'-pensioners (DANMARKS STATISTIK 2013c).

Similarly, another study by the branch association of Danish insurers found that the at-risk of poverty at the 50% of the median income level was as low as 0.15% for retired persons with Danish origin and 4% for retired persons with a non-western origin due to the fraction pensions (NIELSEN 2013).

The study by the association of Danish insurers also examined the development of inequality over the last 15 years. In particular, the study sat out to investigate whether the expansion and maturation of second pillar pension schemes from 1990 onwards had resulted in greater inequalities among retired persons. This was the predicted made by the Economic Council back in 1998. However, this was not found in the study. The study finds that:

1. more and more retired persons receive pensions from their own savings (i.e. second and third pillar pensions and savings),
2. retired persons have become richer
3. there are fewer retired in the lower income deciles and more retired in the middle income deciles
4. the gap in income have in this way become smaller, reflected also by an unchanged and slightly falling Gini coefficient based on retired peoples income (NIELSEN 2013)

### **2.2.2 Sustainability**

The Danish pension system has become more sustainable over the last few years as a larger share of the elderly work longer periods of their life in part as a result of pension reforms (see above) that has increased pension ages and made early exit more difficult.

Fewer people retire early on the voluntary early retirement scheme (*efterløn*). The Welfare Reform of 2006 and the reform of early retirement of 2011 combined with the economic crisis has led to a marked reduction of people on early retirement pay. In fact there has been a steady reduction from the third quarter of 2007 with a total of 39,700 persons (DANMARKS STATISTIK 2013d). In the fourth quarter 2012 there was 100,569 fulltime person on voluntary early retirement compared to 110,165 one year later, see Table below. In the same period the share of elderly taking early retirement on this scheme also fell, i.e. from 31.4 to 29.5 percentages. We can from Table below see that there are both fewer men and women retiring earlier on the scheme, but that the gender differences when women more frequently taking early retirement pay persists.

Table 2: Claimants of voluntary early retirement pay in absolute and relative numbers, 2011 and 2012

	2011	2012	2011	2012
	Full-time persons		Share of elderly, percentage	
Total	110,165	100,569	31.4	29.5
Men	48,019	43,197	27.6	25.6
Women	62,146	57,372	35.1	33.2

Source: DANMARKS STATISTIK (2013d).

More elderly people are working a longer period of their lives. Although most people withdraw from the labour market while they are in the their 60s there has been a remarkable development in the last ten years. The employment rate for 60-64 year olds has increased



from 28 per cent in 2001 to 46 percent in 2011 (DANMARKS STATISTIK 2012a). In the same period the employment rate for those above 65 years rose from 7.4 per cent to 10.4 per cent (DANMARKS STATISTIK 2012a). There are twice as many men as women above 65 that are working.

To assess the combined impact of maturation of second pillar pension schemes and the retirement reforms of the 2000s the Economic Council has made a study on retirement in the future (DET ØKONOMISKE RÅD 2013). The study shows three effects:

1. Far fewer people are expected to withdraw from the labour market on the voluntary early retirement pay (*efterløn*) than previously estimated. The Council estimate that there will only be 5,000 on voluntary early retirement pay in 2050. The primary reason for this low number is the restrictions in access made through various reforms, but also due to the greater economic incentives to continue working.
2. More people will continue to work after reaching the pension age. The Council estimate that more people will make use of the possibility of increasing their national old age pension by working beyond the official retirement age.
3. More people will retire without social security benefits, i.e. without national old age pensions or voluntary early retirement benefits. Due to larger pension wealth more persons will be able to retire earlier than made possible by social security benefits.

In total the Economic Council estimate an increase of employment with about 40,000 persons more than previously expected based on the labour force projection made on the DREAM model (DET ØKONOMISKE RÅD 2013).

### **2.2.3 Private pensions**

The Danish second and third pillar cover nine out of ten Danes. Despite an adverse economic climate the pension funds have overall been comparatively successful in accruing high rates of return on their investments. What is more the return on these pension and saving vehicles is subject to a tax of 15% which was raised to 15.3% in 2013.

The combination of broad coverage, high return and tax on return has resulted in large tax revenues to the government. In a normal year financially speaking, the tax on returns (the PAL tax) is estimated to bring a revenue of about 24 billion DKK. In 2011 the tax gave a revenue of about 39 billion DKK and in 2012 of 44 billion DKK. Out of the 44 billion DKK in 2012 the private pension funds paid 31 billion DKK and the ATP and LD 10 billion DKK.

The Table below shows that pension funds in Denmark were both better in nominal and real terms in annual returns over the last five years.

Table 3: Pension fund nominal and real 5-year (geometric) average annual returns in selected EU countries over 2008-2012, per cent

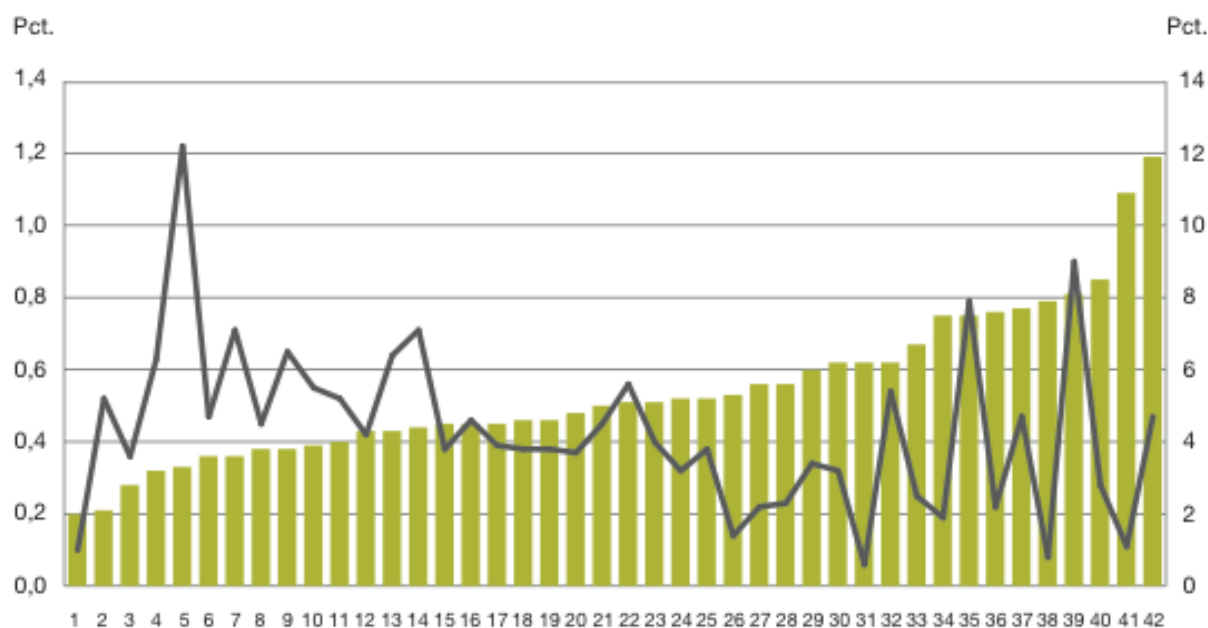
	5-year average return	
	Nominal	Real
Denmark	8.5	6.1
Netherlands	5.6	3.5
Germany	3.9	2.4
Italy	2.6	0.4
United Kingdom	1.7	-1.5
Spain	1.1	-0.9
Poland	1.0	-2.3

Source: OECD (2013).

However, the good overall performance of private pension funds masks great differences between pension funds in Denmark. Based on the first publicly available information on pension funds investment costs it is now possible to compare pension funds and examine how expensive they are and whether their investment costs are related to how good they are in maximising return on investments. This is exactly what the ATP set out to investigate in a study from Winter 2012 (ATP 2012a).

The Figure below gives information on 42 pension funds. The axis to the left indicate the yearly administrative costs in percentage. On average these costs amount to 0.45% of all activities in 2011 but with a spread between 0.20% and 1.19%.

Figure 1: Pension fund managers investments costs in 2011 and average rate of return 2007-2011, (costs marked by green pillars in percentage in left axis and return marked by the black line in percentage on right axis)



Source: ATP (2012a).

Returns vary even more. On average the pension funds gave a return of 4.9% before taxes in 2007-2011. The lowest return is 0.6% and the highest 12.2%.

Finally, the study by ATP found no relation between the level of administrative costs and the level of returns (ATP 2012a).

As the supplementary labour market pension schemes matures coverage of private old age people in the country still increases. In a study by the ATP the coverage of private pensions in 2000 and 2010 is compared (ATP 2012a). In 2000 two out of three municipalities had less than 40% pensioners receiving private pensions. In 2010 this was only the case in one out of eight municipalities.

To compensate for lack of private pensions for people with no or little labour market attachment the voluntary SUPP scheme, see above, exists. A recent study by the ATP finds that more than 105,000 persons on disability pensions saved for their old age in the SUPP scheme in 2010 (ATP 2012b). However, an even bigger group of 120,000 persons on disability pension did not have a SUPP scheme. What is more the group without SUPP was also without private pensions whereas the group with SUPP had private pensions. In other words, SUPP has so far been a success in gradually expanding to more and more persons outside the labour market, but a failure in reaching those most in need of saving for old age.

To increase transparency and knowledge about pensions, the website PensionsInfo allows people to get an overview of their pension claims. In 2011 the website got the European Gold Award for "Outstanding Industry Contribution". However, it is only now that the number of users is increasing markedly. In 2008 there were 300,000 persons visiting PensionsInfo compared to more than 1,1 million in 2012 (FORSIKRING OG PENSION 2013). The biggest increase has been among women, people in the 40s and 50s and people with short to medium level education. In short, the website is now used more broadly by the whole population.

#### **2.2.4 Summary**

The number of persons receiving the national old age pension increased with 170,000 from January 2007 to January 2013. Today there are 1,022,000 claimants of the national old age pension (DANMARKS STATISTIK 2013, nr 289).

An increasing number of claimants receive a reduced basic amount of the national old age pension (DANMARKS STATISTIK 2013, nr 289). The basic amount is reduced if the person has income or is not entitled to the full pension due to lack of sufficient years of residence. In particular retired persons with a non-western ethnic background are likely to be in receipt of reduced pensions and at-risk-of-poverty. In 2012 this concerned about 2,600 persons (EKSPERTUDVALGET OM FATTIGDOM 2013).

Overall, however, the Danish pension system provides adequate benefits and is sustainable. In the last few years there has been a steady increase of the number of elderly continuing to work up to and after the official retirement age.

### **2.3 Reform debates**

There has been little impact of EU social policies or EU country specific recommendations on pensions in Denmark.

In the country specific recommendations adopted by the Council in 2011 and 2012, Denmark was encouraged to, respectively, adopt and introduce, its planned reform of disability pension and voluntary early retirement pay (the *fleksjobs*). As a reform of these schemes was agreed

upon by the major political parties in 2012 and came into effect as of 1 January 2013 (see ANR 2011 and ANR 2012 for details) and the newest country specific recommendations adopted in 2013 acknowledge this and does not contain more suggestions or comments reforms on early exit schemes.

The issue of inadequate pensions for retired people on the fraction pensions, see above, is rarely framed as a reason for making the national old age pension less dependant on years of residence or the labour market pensions less dependent on work. For example, the branch association of insurers argue that this challenge should be met by improving the integration of immigrants from non-western countries (HANSEN 2013).

Overall, there are no debates or other signs that indicate there will be marked changes in the national pension system in the medium term. The debates on social protection reforms in general concern labour supply and thus even further increases in retirement ages cannot be ruled out.

To boost labour supply among the elderly the Economic Council has suggested to introduce an earned tax credit for people having reached retirement age (DET ØKONOMISKE RÅD 2013). The Economic Council suggests to give an annual earned tax credit of 100,000 DKK for people who have worked five years prior to retirement age and a given period after that. The Council estimate this would increase labour supply by about 6,000 persons and that the extra tax payments and fewer pension expenditures will offset the loss of revenue caused by the tax credit.

Abolishing the voluntary early retirement pay is not going to have much of an impact on the labour supply according to studies of the Economic Council. Although the voluntary early retirement pay may incentivises people to retire early it also encourages people to work longer in order to become eligible for the benefit. The Council expects that an abolition of the voluntary early retirement pay would remove this latter encouragement effect (DET ØKONOMISKE RÅD 2013).

The Economic Council also suggests to include the elderly cheque in the pension amount that can be increased for people who postpone their retirement beyond the official retirement age (DET ØKONOMISKE RÅD 2013).

The final recommendation of the Economic Council is to remove the special allowances for elderly with regard to housing. This both concern housing allowances for elderly and special tax allowance for elderly with mortgage (DET ØKONOMISKE RÅD 2013).

However, in the short and medium term reforms to increase labour supply are more likely to be in other areas of the social protection system than in the field of old age pensions, the disability pension or the voluntary early retirement pay. Instead in the autumn of 2013 it is the system of sickness benefits that is the subject of discussions and political negotiations including not only the parliamentary political parties, but also the social partners.

## **3 Health care**

### **3.1 System description**

#### **3.1.1 Major reforms that shaped the current system**

The Danish health care system has been developed mainly through gradual changes. The last major reform was the Structural Reform in 2007 when the whole public sector was

reorganised. Prior to the reform health care was predominantly taken care of by the 13 regions that also had the authority to tax. After 2007 the number of regions was reduced to 5, the tax authority taken away and most of the preventive measures were transferred to the municipalities. The same reform also reduced the number of municipalities from 273 to 98. Hence, larger municipalities today play a larger role in the health sector and larger regions a smaller role.

The liberal-conservative coalition government from 2002 to 2011 had free choice as a major policy, also in health care between different GP, hospitals and between public and private hospitals. The coalition government of the Social Democrats, Social Liberals and the Socialist Peoples Party that got into office late 2011 removed some of the fiscal measures favouring private health insurance, but has in other respects not made a fundamental change of policies.

### **3.1.2 System characteristics**

Denmark runs a universal, tax-financed health care system. The Danish health care service can be divided into two sectors: Primary health care and the hospital sector.

The primary health care sector deals with general health problems and its services are available to all. This sector can be divided into two parts: One which chiefly deals with treatment and care: general practitioners, practising specialists, practising dentists, physiotherapists etc. (the practice sector) and district nursing; the other part is predominantly preventive with preventive health schemes, health care and child dental care.

In case of illness, the citizen normally first comes into contact with primary health care.

The hospital sector deals with medical conditions which require more specialised treatment, equipment and intensive care.

In addition to the treatment of patients, both general practitioners and hospitals are involved in preventive treatment as well as in the training of health personnel and medical research. In the health care service, the general practitioners act as “gate-keepers” with regard to hospital treatment and treatment by specialists. This means that patients usually start by consulting their general practitioners, whose job it is to ensure that they are offered the treatment they need and that they will not be treated on a more specialised level than necessary. Normally, it is necessary to be referred to both hospitals and specialist treatment by the general practitioner.

The general practitioners also refer patients to other health professionals working under agreement with the health care service, and arrange for home nursing to be provided.

Like Denmark as a whole, the health care sector has three political and administrative levels: the state, the regions and the municipalities (national, regional and local levels). The health care service is organised in such a way that responsibility for services provided by the health service lies with the lowest possible administrative level. Services can thus be provided as close to the users as possible.

In the health field, the municipalities are responsible for home nursing, public health care, school health service, child dental treatment, prevention and rehabilitation. The municipalities are also responsible for a majority of the social services, some of which (subsidised housing for older people in the form of non-profit housing, including homes for elderly people with care facilities and associated care staff) have to do with the health care service and they are of great importance to the functioning of this service.

As the running of hospitals requires a larger population than that of the majority of the municipalities, this responsibility lies with the five regions. The regions organise the health

service for their citizens according to regional preferences and available facilities. Thus, the individual regions can adjust services within the financial and national legal limits according to needs at the different levels, enabling them to ensure the appropriate number of staff and procurement of the appropriate equipment.

The task of the state in health care provision is first and foremost to initiate, coordinate and advise. One of the main tasks is to establish the goals for a national health policy. The Ministry of Health and Prevention, in its capacity of principal health authority, is responsible for legislation on health care. This includes legislation on health provisions, personnel, hospitals and pharmacies, medicinal products, vaccinations, pregnancy health care, child health care and patients' rights.

The Ministry of Health and Prevention's legislation covers the tasks of the regions and the municipalities in the health area. The Ministry also sets up guidelines for the running of the health care service. This is mostly done through the National Board of Health. Moreover, the Ministry of Health and Prevention supports efforts to improve productivity and efficiency by e.g. the dissemination of experience and the professional exchange of information and by the introduction of economic incentives and activity-based payment.

The health care system is financed through general taxation. The major exception is dental care which has a large user co-payment. Similarly, medicine is paid by people themselves.

### **3.1.3 Details on recent reforms**

The perhaps most important reforms in health care came as a direct consequence from the change of government. As described in ANR 2010 and ANR 2011 the conservative-liberal government from 2001 to 2011 supported a marked rise of private health insurance through tax privileges and a marked rise of private hospitals through guarantees on waiting time, free choice of hospital and favourable payments to private hospitals for their treatments. The latter had been addressed by the Audit of State Accounts and led to renegotiation of rates of payments to private hospitals. The incoming liberal-socialist-social democratic government had as one of its flagships "a better and more equal health care system".

The scope of private health insurance has not become smaller despite the abolition of tax exemptions of employer paid health insurance and health treatments (see ANR 2012).

Municipalities average net expenses to the promotion of health increased by 12 percent from 2011 to 2012 (DANMARKS STATISTIK 2013e). The expenditure per person increased from 83 DKK in 2011 to 93 DKK in 2012. In part the increase is a result of municipalities larger part in co-financing health policies. Expenditure on rehabilitation and training has also increased, i.e. by 13% to an average of 279 DKK per person in the municipalities.

Home nursing expenditure rose by 5.8% to 533 DKK per person in the municipalities. This covers large municipal differences (DANMARKS STATISTIK 2013e). In the municipality of Læsø there were 52.1 recipients of home nursing per 1,000 inhabitants compared to an average of around 19 recipients per 1,000 inhabitants. Similarly there are also wide intra-municipal differences on the number of home visits per recipient per month ranging from 1.2 in Solrød over about 12 in Silkeborg, Gladsaxe and Faxe to about 50 in Kolding and Viborg.

The strategy of switching towards more ambulant treatment in hospitals is successful when looked on over a number of years. The number of ambulant treatments rose from 5.7 million in 2006 to 7.0 million in 2012 (DANMARKS STATISTIK 2013f). The number of inbed treatments fell in the same period from 4.7 million to 4.1 million. 1.6 million received ambulant treatment in 2012. On average every patient received 4.4 ambulant treatment in 2012. The number of ambulant treatments increase with age.

As described above municipalities were assigned a larger role for preventive health measures as part of the Structural Reform in 2007. In this connection the 2002 strategy 'Healthy all the life' (*Sund hele livet*) of the previous government was not well transferred from the regions to the municipalities. The strategy had objectives on increasing longevity, improving the quality of life and decreasing inequalities in health. Moreover, the strategy had a series of targets and indicators for smoking, alcohol and physical activity. However, after the 2007 Structural Reform there has not been any national plan for public health promotion. For this reason the Danish National Audit Office (*Rigsrevisionen*) started an audit on health promotion that was published in April 2013 (RIGSREVISIONEN 2013a) and a follow up in October (RIGSREVISIONEN 2013b).

## 3.2 Assessment of strengths and weaknesses

### 3.2.1 Coverage and access to services

Equal access to health care is the primary objective in the Danish health care system.

A study by The Ministry of Health and Prevention find that there has been a positive development with an increasing number of day surgery, fewer patient days in hospitals and a decreasing share of patients being resubmitted to hospitals (MINISTERIET FOR SUNDHED OG FOREBYGGELSE 2013). The same study also finds a decreasing trend in mortality post-hospital stays.

As mentioned the Socialist-Social Democrat-Social Liberal Government wants to decrease health inequalities. One of its first acts as government in 2011 was to abolish the favourable tax treatment of private health insurance that was introduced under the previous Liberal-Conservative government. Most recently Government has announced its intention to further reduce health inequalities by:

- strengthening prevention by setting national targets for health and give 120 million DKK to partnerships that aim to realise these targets
- use 112 million DKK on improved treatment of alcoholism and 42 million to stop smoking initiatives
- strengthening the psychiatric area so it comes on par with the other branches of the health sector. The government will present a plan for the psychiatric area in the Autumn of 2013
- improve care of pregnant and maternity with 40 million DKK, especially for vulnerable families (REGERINGEN 2013)

### 3.2.2 Quality and performance indicators

As described in earlier ANR reports for Denmark there has been a number of initiatives made to increase the treatment of cancer. However, the implementation of these initiatives have been criticised for not being good enough and providing value for money. In 2012, the Danish National Audit Office took initiative to an examination and recommended that the Ministry of Health and Prevention should ensure shorter maximal waiting periods and a better knowledge base for evidence based learning. In the Autumn of 2013 the Danish National Audit Office followed up on this and found that:

1. The Ministry of Health and Prevention has established a monitoring that makes it possible to follow the maximal waiting periods and the periods of treatment packages.

2. The Ministry of Health and Prevention has established data that improves the possibilities on improving the results of cancer treatment and that can strengthen the comparison of results in the health sector with a view to promote best practices.

Indeed regions are now compelled to report data for monitoring of waiting period and treatment periods, and the Ministry is overviewing whether regions live up to stipulated standards for both type of periods. (RIGSREVISIONEN 2013e).

### **3.2.3 Sustainability**

The Danish health system is facing an economic challenge with ageing populations and its associated pressure on the health system. In part for that reason the Structural Reform of 2007 has reorganised the public sector with a strengthening of the preventive policies at the local level of municipalities just as other initiatives have concerned developments in the regional health sector. The local preventive policies were, according to the Danish National Audit Office, not implemented adequately in the first years, but is now on track. The regulation of the building of new super hospitals has also been subject of criticism by the Danish National Audit Office, that also noted the search for efficiency gains should be integrated more firmly in the establishment of the super hospitals, see section 3.3. for more information on the critique on these points. Put differently reorganisation of the health sector and building of new hospitals may in the medium term make the health sector more economically sustainable.

### **3.2.4 Summary**

The Danish health care system is still in a process of transformation towards a more preventive and rehabilitative local division, see also the next section on long-term care, and re-organisation of hospitals to increase the quality and effectiveness of policies. The health care system is both changed by renovating existing hospitals and building of new super hospitals and by a large emphasis on new IT.

The performance of the health care system is improving with more treatments and better health care outcome in a number of areas.

## **3.3 Reform debates**

The new super hospitals have been target of much debate (see ANR 2010 and ANR 2011). In 2013 the Danish National Audit Office for the second time decided to examine the building of the super hospitals (RIGSREVISIONEN 2013c). This time the investigation was on the efficiency gains that have been planned in connection with the hospitals. In particular the Audit aimed to find out how and to what extent the planned efficiency gains were planned to take place. The Audit argue that if these efficiency gains were not properly addressed, the alternative may become cuts of the services to achieve the economic goal. The Audit acknowledge the difficulty of planning efficiency gains of policies that are to be implemented in the future and to meet to some extent unknown needs.

The audit finds that the Ministry of Health and Prevention and the regions has not had a sufficient focus on ensuring how the new hospitals are to achieve efficiency gains (RIGSREVISIONEN 2013c). The Audit finds that the Ministry and the regions should have made a concept for planning and monitoring measures to ensure efficiency gains at an earlier stage than May 2013. Also the Audit finds that it is not transparent how the regions attempts to realise efficiency gains.



In another follow up, the Danish National Audit Office looked into electronic patient journals (RIGSREVISIONEN 2013d). In the budget agreement for the regions in 2011 each region was to have a fully consolidated electronic journal by the end of 2013. The audit report of 2011 found that this was unlikely to happen and identified a need for a stronger national regulation in the field of electronic patient journals. However, also in the Spring of 2013 the audit found that progress and regulation has been unsatisfactory. A need to strengthen regulation and the priority of electronic patient journals, including also the National Index of Patients and the Common Medicine Card, as well as a greater degree of transparency on whether the intended efficiency gains are likely to materialize has been stated. The audit recommended that:

1. The Ministry of Health and Prevention make binding agreements with with regions on objectives and indicators for coverage and use of IT in health.
2. Larger projects in the regions follow the principles like the ones used in the State IT Project Council when regulating state projects in order to increase a better understanding of the economics, the progress, results and effects of IT investments
3. Large projects and projects that are at risk of failing are subject to external review after principles like the ones used the the State IT Project Council (RIGSREVISIONEN 2013d).

There is no marked impact of EU social policies on national health policies.

Part of the national reform debates concern the treatment of mentally ill where there is long waiting periods for a number of diagnosis.

The Government has announced a plan, “More Citizen, Less Patient”, for the health care system that allocate 600 million DKK for the following initiatives:

- a integrated health care system that is directed towards citizens. General practitioners, municipalities and hospitals work closely together to give citizens a coordinated and integrated package of treatment.
- A new and modern system of general practitioners with better collaboration with municipalities and hospitals, better availability and opening hours and where citizens has better access to information on good and bad quality among general practitioners.
- Increase of health equalities and stronger prevention with national targets to improve public health with initiatives of 334 million DKK 2014-1017
- Faster diagnosis and treatment of persons with mental illness, new plan for the psychiatric sector to be launched soon
- Stronger cancer treatment with a special focus on rehabilitation, prevention and equality and establishment of a special center for children with cancer
- Active involvement of patients and their relatives to be improved with 20 million DKK to form a strategy on this
- Increased focus on quality through a reform on transparency of results to inform best practice and contribute to faster diagnosis, treatment and care of the best quality
- An incentive structure that promotes a focus on quality and integrated patient packages as well as a focus on productivity and costs

- Better regulation, incentives, priorities and productivity in the health care system (REGERINGEN 2013)

## **4 Long-term care**

### **4.1 System description**

#### **4.1.1 Major reforms that shaped the current system**

In 1987 the Parliament decided that municipalities should build houses for elderly and stop building nursing homes. 25 years later, there are a total of 80,928 persons living in nursing homes (*plejeboliger*) and homes for the elderly (*ældreboliger*) (DANMARKS STATISTIK 2012b). This is 29,200 more persons than in 1987. As shown below, however, this total masks a fundamental shift from nursing homes to other forms of care.

#### **4.1.2 System characteristics**

The Danish system of long-term care for elderly is perhaps the most extensive in the world. The system is currently undergoing a process of retrenchment and restructuring. Retrenchment takes the form of fewer benefits offered to fewer people. Restructuring concerns an increased focus on prevention and rehabilitation, see section 4 below.

The system of long-term care is organised locally in 98 municipalities.

The goal of long-term care is to increase the quality of life for persons in need of care and to increase their possibilities to take care of themselves.

Long-term care may be provided by way of residing in institutional care facilities, or special housing typically with nurses attached, or home help.

Municipalities are responsible for long-term care for the elderly. Home help is provided by municipalities.

There were no elements with a direct bearing on long-term care in the Budget 2012 (FINANSMINISTERIET 2011).

#### **4.1.3 Details on recent reforms in the past 2-3 years**

There has been no major reforms of home help or of nursing home or elderly homes over the last 2-3 years. However, austerity has been reflected by the Parliament making a stricter regulation of municipalities economy. In turn the municipalities have been even more prudent than required by the Parliament. As a result there has been a defacto retrenchment of home help even in the absence of explicit policies at the central or local level.

### **4.2 Assessment of strengths and weaknesses**

#### **4.2.1 Coverage and access to services**

In particular the scope of home help is encompassing. In 2012 154,600 persons received permanent home help in their own home, down five percentage compared to the 162,800 recipients in 2011 (DANMARKS STATISTIK 2013i). On average recipients receive 3.14 hours weekly in home care (DANMARKS STATISTIK 2013j).

In total 80,928 persons live in nursing homes (plejeboliger) and homes for the elderly (ældreboliger) (DANMARKS STATISTIK 2012b). This is 29,200 more persons than in 1987.

In 1987 the shift from nursing homes to elderly homes was decided by the Parliament and that mover is very marked in the composition of people living in nursing homes and elderly housing. The Table show how the number of persons living in nursing homes has gone down from 49,088 persons in 1987 over 29,685 persons in 2000 to only 6,907 persons in 2012. Vice versa, the number of persons living in elderly homes has increased from 3,356 persons in 1987 over 34,600 persons in 2000 to 70,213 person in 2012.

Table 4: Number of persons living in nursing and elderly homes, 1987 to 2012

	1987	2000	2010	2012
Total	59,039	68,559	85,186	88,197
Nursing homes	49,088	29,685	8,761	6,907
Sheltered homes	6,595	4,274	1,804	1,313
Elderly housing	3,356	34,600	70,947	70,213
Housing for persons with handicaps	-	-	3,127	7,269
Other	-	-	547	495

Source: DANMARKS STATISTIK (2012b).

The share of the population in nursing and elderly care increases with age. 42 percent of persons 90 years or older live in nursing and elderly care, 23 percentage of those aged 85-89 years, 13 percentage of those aged 80-84 years and six percentage of those 75-79 years.

#### **4.2.2 Quality and performance indicators**

The waiting time for nursing home and elderly homes was less than two months in 95 out of the 98 municipalities in 2012 (DANMARKS STATISTIK 2013k).

There has for some time been focus on the quality and performance of home care, although this has not resulted in many research reports on long-term care over the last 12 months. However, we do have regular data on aspects of home care such as the number and occupation of staff (see above), expenditures (see above) and user satisfaction.

In 2012, there were 150,600 full time persons working in care and nursing, a reduction of 2 percent compared to 2011 (DANMARKS STATISTIK 2013, nr. 38). Nursing and care also encompass home care, institutional care, rehabilitation, residents for adults, 24h institutions for children and youth with special needs and various daytime offers. 131,400 employees work with care, nursing and pedagogical activities and the rest with cleaning, cooking and administration.

By far the largest share of persons working in the long-term care sector are social and health assistants. They amount to 67,600 persons out of a total of 131,400 full-time persons in long-term care. Still the share has decreased by 2 percent since 2011.

Table 5: Full-time persons working in nursing and care, 2011 and 2012.

Category	2011	2012
Care, nursing and pedagogical work	133,668	131,396
Nurses	9,175	9,266
Fysiotherapists	2,468	2,528
Ergotherapists	2,859	2,904
Pedagogues and teachers	27,427	26,031
Psychologists	593	591
Social and health helpers, pedagogical assistants	69,567	67,604
Social and health assistants	21,579	22,472
Supporting functions	11,955	11,534
Management and administration	8,084	7,673
Total	153,707	150,603

Source: DANMARKS STATISTIK (2013i).

Informal carers are primarily family members, but there is also a growing number of volunteers providing various forms of care to people in need of long-term care.

The Table below shows that in 2011 87% in their own home are satisfied with their practical care and 91% with their personal care which was almost the same as in 2009 where the similar figures were, respectively, 86% and 92%, and only slightly better than in 2007 with 84% and 87%.

Table 6: User satisfaction with the quality of home care according to housing situation and type of care, percentage share, 2007-2011.

	Own home				Nursing home or service home			
	Practical care		Personal care		Practical care		Personal care	
	Satis- factory	Very satis- factory	Satis- factory	Very satis- factory	Satis- factory	Very satis- factory	Satis- factory	Very satis- factory
2007	47	37	52	35	41	47	44	47
2008	44	39	52	43	57	31	50	40
2009	54	32	55	37	58	29	60	29
2011	51	36	52	39	54	35	56	36

Source: DANMARKS STATISTIK (2013a). Note: Indicator 1 – Quality of help.

User satisfaction is also very high and stable for people living in nursing homes and service homes. In 2011 89% expressed satisfaction with their practical care 92% with their personal care, i.e. slightly up from 87% and 89% in 2009 and slightly below the 88% and 91% in 2007.

User satisfaction is also high with regard to other aspects. Table 7 below shows that user satisfaction is high for personal and practical care both for persons living in their own home and for persons living in nursing homes or service homes. Between 75 % and 87 % are either

satisfied or very satisfied with care being delivered on the time agreed. The share of satisfied recipients is slightly lower among persons living in nursing and service home than among persons living in their own home.

Table 7: User satisfaction with the stability of home care according to housing situation, type of care, and aspect of care, 2009 and 2011, percentage share of recipients.

		Own home				Nursing home or service home			
		Practical		Personal care		Practical care		Personal care	
		Satis- factory	Very satis- factory	Satis- factory	Very satis- factory	Satis- factory	Very satis- factory	Satis- factory	Very satis- factory
Delivered on time	2009	48	36	54	31	56	31	51	24
	2011	49	36	53	29	50	36	48	27
Uniformity of services	2009	50	25	56	27	59	16	62	22
	2011	49	25	60	24	46	32	55	26
Number of helpers	2009	42	25	46	23	55	14	56	20
	2011	40	28	50	20	46	22	53	21

Source: DANMARKS STATISTIK (2013a). Note: Indicator 2 – Stability of help and Indicator 3 – Number of different helpers.

The majority of recipients also find that services are the same and uniform. Between 75 % and 84 % find that services are uniform, at least they express that they are either satisfied or very satisfied with the uniformity of services.

The lowest level of satisfaction can be found for the dimension of number of helpers. Between 67 % and 76 % express that they are either satisfied or very satisfied with the number of helpers delivering their home care service. The smallest share of satisfied recipients of care is for practical help in own home and the largest share of satisfied for personal care in nursing homes or service homes.

Free choice of types of services and providers was high on the agenda of the previous Liberal-Conservative coalition government (2002-2011). People living in their own homes that are eligible for home care can chose between municipal and private providers of practical care, personal care and both personal and practical care. Also people in living in their own homes that are eligible for home care can under certain conditions chose between different benefits and services within practical care, personal care, and within both personal and practical care. However, part of the discussion on long term care has been on whether people know about their free choices and whether they can indeed process such information. Table 8 below shows the share of recipients of home care in their own homes that have knowledge of free choice of providers and of flexible home care.

Table 8: Share of recipients of home help in their own home who has knowledge of free choice of providers and flexible home care, 2007-2011, percentage share.

	2007	2008	2009	2011
Free choice of provider	66	68	65	71
Flexible home care	42	37	32	33

Source: DANMARKS STATISTIK (2013a). Note: Indicator 4 – Knowledge of free choice and Indicator 5 – Knowledge about flexible home care.

Seven out of ten recipients of home care in their own home know that they have the right to choose between the municipal provider of care and a private provider of care. This share is stable across the five years observed. Much fewer persons know about their possibility of choosing between benefits and services, the flexible home care. Also the share knowing about flexible home care is becoming smaller quickly. In 2007 42% of home care recipients knew about flexible home care compared to 33 % in 2011, see Table above. Although not reported here knowledge of free provider of home care and flexible home care becomes smaller with age.

### **4.2.3 Sustainability**

The economic crisis affects the financial sustainability of the public sector and this has led to cuts either through direct dismissals or through not hiring new workers when older workers retire. Because long-term care and health care employ the lion's share of public employees there are also reductions of people working in these areas. The most recent figures are for the third quarter of 2011. According to the labour force at that time 2,664,000 people were in employment, 219,000 were unemployed, and 728,000 were not in the labour force (STATISTICS DENMARK 2012, statistikbanken, arbejdskraftundersøgelsen). Although not exactly comparable, there were 750,400 full-time persons working in the public sector, including 175,100 in health care and 254,200 in social protection which encompass long-term care (DANMARKS STATISTIK 2011, nr. 599).

Compared to the previous quarter employment in public administration and service fell with 0.5 percentage points equivalent to a fall of 3,900 full-time persons (DANMARKS STATISTIK 2011, nr. 599). Employment in the public administration and service reached its peak in the second and third quarter of 2010 and has been falling since. Employment has fallen in the three largest welfare areas when compared to the same quarter one year earlier. The biggest fall of employment was 4.5 percentage points equal to 12,000 full-time persons in social protection that includes long-term care.

The impact of the crisis can also be seen in the scope of home help provided. Although there is no hard evidence there seems to be a tougher visitation to home help. The number of recipients has also fallen from 182,000 persons in 2009 to 177,000 persons in 2010 (DANMARKS STATISTIK, nr. 177). The average number of home help received per week remained 3.7 hours from 2008 to 2010 with 0.9 hours being for practical help and an increase in personal help from 5.6 weekly hours 2008 over 5.7 in 2009 to 5.8 hours in 2010 (STATISTICS DENMARK, statistikbanken, ældreområdet indikatorer).

### **4.2.4 Summary**

Denmark has probably the most extensive long-term care system for the elderly. The system is organised, delivered and financed at the local level of the municipalities. The system is to a large extent based on help provided in the home of the elderly, in terms of personal and

practical home help. Persons residing in institutional care have become older and frailer as a result of the gradual shift away from institutional care to home help that started in 25 years ago. In the last two years the economic crisis and ageing populations has led to cuts in the scope of coverage of home help, the number of hours delivered and staff working with elderly care. However, the scope is still high and the services are largely still available free of charge and there are still many persons employed with the elderly care. In the last few years policies to keep elderly in their own home has become more comprehensive. Until recently the strategy consisted mainly of providing help in the elderly's own home and in adjusting home to the needs and capabilities of elderly. Now the emphasis is also on rehabilitation and prevention. Rehabilitation to get elderly to become physically and socially better fit to take care of themselves. Prevention by strengthening the physical, social, and cognitive functional capabilities of elderly. This prevention strategy even target non-elderly in some municipalities.

### **4.3 Reform debates**

One cannot trace a marked impact of EU social policies on long-term care. 2013 was the election year to municipalities and no local politician argued for cutting in care for the elderly. This may help explain the lack of reforms in the last year or so.

At the national level the socialist party (*Enhedslisten*) has made improved elderly care top of their demands for Budget negotiations 2014.

There is a strong interest across political parties, municipalities and interest organisations to focus on prevention, rehabilitation and independent living in designing the long-term care system for future elderly.

There is a long list of pilot projects for prevention, support for rehabilitation, schemes promoting independent living such as age-friendly housing, ICT, and more.

In view of ageing populations there has over the past many years been a debate about how to turn 'cold hands' into 'warm hands' in the provision of welfare to citizens. This is not least the case of long-term care. The debate deals with, at least, three issues. One issue is how to decrease the share of management vis-à-vis the share of workers in face-to-face contact with citizens. The second issue is how to enable those that are in contact with citizens to spend their time taking care of these citizens rather than spending time filling out paper work or adhering to other bureaucratic procedures that are of little direct value to the citizen. These two issues concern the organisation of long-term care. The third issue is about technology and how this may help in both reducing time spent on administration and on, especially, practical help to allow for more personal help.

The move from institutional to home care started already in first half of the 1990s under the slogan 'as long as possible in own home'. Hence, there is a long tradition of trying to support elderly staying in their own home also when they are in need of long-term care.

In the last few years two commissions has been studying long-term care in Denmark. The first commission, The Elderly Commission (*Ældrekommissionen*), was agreed upon by a majority of political parties as part of the Budget 2011 negotiations in October 2010. The Commission started its work in January 2011 and published its main report with 43 recommendations in February 2012.

Table 9: Nursing homes - 43 recommendations organised in ten thematic area

<p>I. Transition into life in a nursing home</p> <ul style="list-style-type: none"> <li>• Prior to moving into a nursing home a carer should visit the elderly in her own home or the coming resident and relatives should be offered a meeting at the nursing home</li> <li>• Clear alignment of expectations based on a good and open dialogue between carers, the new resident and relatives</li> <li>• Make a 'life history' of the resident that carers can use in their daily work and contact with the resident</li> <li>• Possibility of having pets irrespective of the carers and other residents</li> </ul>
<p>II. A healthy and active life as elderly</p> <ul style="list-style-type: none"> <li>• To increase the appetite the smell of food should fill the air before the meal</li> <li>• Food should follow the changing seasons and be nutritional correct and of good quality</li> <li>• Involvement of citizens in planning the menus and in the making of food</li> <li>• Carers should dine with the residents to inspire residents to eat more and to contribute to a more cozy atmosphere</li> <li>• A variety of activities on offer for residents that also takes into account both sexes</li> <li>• Residents should have the possibility of getting fresh air every day</li> <li>• Residents should be engaged in daily activities, i.e. cleaning, cooking and watering of plants</li> <li>• The institution should engage with the local community to arrange common activities for residents and local citizens</li> </ul>
<p>III. Care</p> <ul style="list-style-type: none"> <li>• Care should support residents autonomy and independence</li> <li>• Care is organised as to help and support the resident to maintain and if possible regain his or her skills</li> <li>• Diapers are a last exit and must never replace personal care</li> <li>• When welfare technology reduce manpower the gained hours should be used on more activities and time with the residents</li> </ul>
<p>IV. The health measures</p> <ul style="list-style-type: none"> <li>• Doctors should be associated with the nursing homes that have a special knowledge of geriatric illnesses</li> <li>• Nursing homes should have an 'acute oackage' with palliative medicine for the terminal phase</li> <li>• The associated doctors, pharmacies and carers should annually together check each residents medicine</li> <li>• Research in geriatric illnesses should get a higher priority</li> <li>• Staff should develop clinical competences in relation to observation of residents health condition and subsequent action</li> </ul>



#### V. People around the elderly in the institutional care

- Managers and middle managers must have a solid level of management skills
- Municipalities must on the basis of evaluations of managers and working climate surveys on a biannual basis assess the management of the institutional care home
- Managers and middle managers must have the necessary tools available that can support their daily work with planning, reports, developing skills of staff, collaboration with relatives, including conflict management
- Managers and middle managers must be assessable during the day so residents, carers and relatives can get in touch with them
- Managers and middle managers must be the first to show how the values behind care are important
- Carers should respect the choices of residents
- Carers should to the largest extent possible be together with the residents. They should participate and encourage a social life in the institutions
- The working hours of carers should be designed according to the tasks at hand – out of consideration to residents wellbeing it is therefore important with a good staffing in the evenings and weekends
- It should be made attractive for relatives to be at the instituton
- Relatives should respect the choices of residents
- Managers and middle managers should ensure that there is a dialogue between staff and relatives

#### VI. The voluntary efforts

- There should be volunteers at all nursing homes
- Lonely residents should be encouraged to get a voluntary visit friend
- There must be room and space for the volunteers
- Collaboration between staff, volunteers and the voluntary organisations should be supported by a volunteer coordinator
- Guidelines for the voluntary effort should be drawn up in collaboration with the volunteers

#### VII. The best end of life

- Nursing homes should collect and meet the wishes on how residents want to end their lives
- Residents should as far as possible have a painless end on life
- Residents wish of dying in own home should be supported
- The dying resident should not be involuntarily alone in the terminal phase
- Death should have a formal end of regard to carers, relatives and other residents
- Carers' competences with palliative care should be maintained and developed

Source: Kommissionen for LIVSKVALITET OG SELVBESTEMMELSE PÅ PLEJEHJEM (2012).

The second commission, The Home Care Commission (Hjemmehjælpskommissionen), sat down June 2012 by the Parliament. The Commission published its main report and 29 recommendations in June 2012 entitled Report from the Home Help Commission Home help for the Future – Elders resources at the center for a coherent service (*Fremtidens hjemmehjælp – ældres ressourcer i centrum for en sammenhængende indsats*).

Table 10: Home care - 29 recommendations organised in nine thematic areas

<p>I. Paradigmatic shift</p> <ul style="list-style-type: none"> <li>• Continue shift in municipalities toward the improvement of functional capacities to enable to remain independent of help as long as possible, and more compensatory and nursing measures for persons with large and complex care needs</li> </ul>
<p>II. Prevention</p> <ul style="list-style-type: none"> <li>• Increased focus on socially vulnerably elderly supported by more evidence</li> <li>• More targeted and flexible preventive home visits: increase age of compulsory visits from 75 to 80, offers to elderly in risk groups below 80, more use of screening tools to assess need for preventive measures, and introduce group based offers to supplement individual visits in persons' own homes</li> <li>• Improved preventive measures by implementation of existing effective tools for early detection of elderly and by developing competences on prevention among carers</li> </ul>
<p>III. Training and rehabilitation</p> <ul style="list-style-type: none"> <li>• Systematic documentation and dissemination on evidence-based knowledge about effects of rehabilitation</li> <li>• Systematic rehabilitation in home help including physical, psychological and social dimensions based on these principles: persons active participation, individual and flexible plan based on the persons need and resources, holistic view on the whole life situation of the person, goal-oriented, cross-disciplines and –sectors, coordination, planning, evidensbased and quality</li> <li>• Broad defitinition of the target group for rehabilitation, i.e. both citizens with time-limited measures and citizens with complex needs of long-time measures</li> <li>• Motivation and dialogue with the citizens and his/her family and frieds are important</li> <li>• Change rules to support municipalities in adopting a common and broad frame of understanding</li> <li>• Eliminate the current distinction between temporary and permanent home care</li> </ul>
<p>IV. Help to weak persons</p> <ul style="list-style-type: none"> <li>• Target compensatory help to weak persons which in a professional assessment is not seen as having the potential to enter rehabilitation or who have a need for help also after rehabilitation</li> <li>• Plan measures to weak persons with large and complex care needs on three quality parameters: coherent and coordinated measures, start with the persons own goals and resources with continuous follow-ups, and be ensuring professionally competent workers</li> </ul>
<p>V. Digital welfare</p> <ul style="list-style-type: none"> <li>• Relevant authorities continuously examine the possibilities and perspectives of using welfare technologies and digital solutions in the home help area</li> <li>• Citizens are at the starting point for use of welfare technology in home help, including user experienced quality in the development and implementation of technology, citizens who are alien to the technology are met with understanding and special attention, and that the municipalities assess the need for other solutions for citizens who cannot become secure with the technology or whose needs cannot be met by technology</li> <li>• Carers are professionally fit to master the technologies and to introduce these to citizens</li> <li>• Systematic collection of knowledge of municipalities' experiences with the development and implementation of welfare technology and digital solutions in the home help area</li> </ul>

<p>VI. Organisation and management</p> <ul style="list-style-type: none"><li>• Frequent and relevant follow-ups and dialogue between authority and delivery agency</li><li>• Less detailed regulation of time and single benefits and more flexibility and space to professionalism in the meeting between the person and the carer</li><li>• Organisation and management that supports rehabilitative measures with cross-disciplinary and coherent measures</li><li>• Payment model that gives economic incentives to agencies to deliver rehabilitative measures and to pursue higher quality, goal attainment and effects for citizens</li><li>• Cross-disciplinary visitation for elderly where the need for home care and need for aid, training and home nursing is assessed together</li><li>• Municipalities collaborate and coach carers in home care and home nursing</li><li>• Municipalities make a common action plan for all measures for elderly with complex needs and recipients of different services as home care, home nursing and training</li></ul>
<p>VII. Carers competences</p> <ul style="list-style-type: none"><li>• To ensure that future carers for both public and private sector delivery agencies have the necessary and relevant educational background to take on new tasks in home care</li></ul>
<p>VIII. The voluntary social efforts</p> <ul style="list-style-type: none"><li>• Secure a good framework at the local and national level for the voluntary social efforts for elderly</li><li>• Municipalities continuously try to engage associations, organisations, and other volunteers in measures towards elderly in their own homes</li></ul>
<p>IX. Documentation</p> <ul style="list-style-type: none"><li>• Municipalities ensure a high professional quality in documenting the measures for citizens, including a systematic description and follow-up on goals, measures and effects</li><li>• Municipalities use IT solutions that enables exchange of information between functions and occupational groups in municipalities and between these and hospitals and general practitioners</li><li>• National quality indicators that can function as a monitoring system for the quality of measures and that can enable citizens to compare quality across municipalities and delivery agencies</li></ul>

Source: HJEMMEHJÆLPSKOMMISSIONEN (2013).

The many recommendations from the Commissions have not been systematically picked up by the government or other political parties. Indeed recent developments have more been marked by the municipalities cutting various services to elderly – home care as well as institutional care – when pruning their budgets as not to be penalised by smaller central government subsidies.

Also it may be worthwhile, to examine closer the many recommendations made by the two commissions as they may prove insights also of interest to the situation in other countries, even if they are designated to the Danish system.

Care coordination is one of the issue recent reforms and discussions have centred on. The Home Care Commission, for example, suggested a holistic organisation of home care with the elderly having only one plan about home nursing, rehabilitation and training and practical help.

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## Annex – Key publications

### [Long term care]

LAURITZEN, Heidi Hesselberg, Rikke Nøhr BRUNNER, Pia THOMSEN, and Miriam WURST, *Ældres ressourcer og behov: status og udvikling på baggrund af ældredatabasen*, 2012, Copenhagen: SFI-The Danish National Institute of Social Research, retrieved from: <http://www.sfi>

*“The resources and need of elderly”*

This report describes the resources and needs of persons aged 67, 72, 77, 82 and 87. Data comes from three rounds of interviews in the Elderly database conducted in 1997, 2002 and 2007. The report provides a descriptive and an analytical part. The descriptive part consists of a number of separate analyzes of older people's health status, use of home care, housing, social networks and hobbies, examining, gender differences, differences between cohorts of older people in 1997 and 2007, and the differences between 67 - and 87 -year-old. The analyzes of gender differences among others, indicate that a higher proportion of men than women believe that they have good health and well-being, high levels of function and to a lesser extent receiving home. Despite women's lower self-assessed health situation, then there is a greater proportion of women who engage in leisure activities, and also makes it more often than men. Over time there has been a move towards that a larger proportion of elderly in 2007 reporting a good health and well-being, high levels of function and are to a lesser extent receiving home than in 1997. In 2007, cultivate a greater proportion of elderly also leisure activities and makes it more frequently than older in 1997. Cross-sectional analyzes indicate that a smaller share of 87-year-olds than 67-year-old believes that they have good health and well-being and a good level of functionality. This partly reflected in the fact that they increasingly receive home and that a higher proportion living in sheltered housing. The proportion who engage in leisure activities, decreases with increasing age, and the frequency also falls. The analytical part contains a number of analyzes of the factors that determines the elderly functioning and need for home. Overall, the results are in line with the results of the descriptive part of that older (67 - and 77 -year-olds ) in 2007, a higher level of functionality than the corresponding cohorts of 67 - and 77 -year-old in 1997. In addition, the analyzes of the elderly in 1997, good health and functioning, are less likely to have decreased functioning and receiving home 10 years later. In addition, men with a well-being in 1997 less likely to have a low functional in 2007. Physical activity reduces the likelihood of decreased functioning and need for home. Elderly cohabitation status also affects their level of functioning and need for home as cohabiting generally have a less likelihood of decreased functioning and receiving home care than older people living alone.

ROSTGAARD, Tine, Rikke BRUNNER, and Torben FRIDBERG, *Omsorg og livskvalitet i plejeboligen*, Copenhagen: SFI-The Danish National Institute of Social Research, retrieved from: <http://www.sfi.dk>

*“Care and quality of life in residential homes”*

This study shows how the caring efforts in a care home can contribute to the resident's quality of life. The authors use the ASCOT (Adult Social Care Outcomes Toolkit) method to quantitatively measure the care related quality of life. The study was conducted in 38 nursing homes through observations of residents and interviews with residents, care staff and relatives.

The Caring Conditional quality of life operationalized in ASCOT method within eight so-called quality of life domains: 1) Control over daily life, 2) Personal care and well-being, 3) Food and beverages, 4) Property, 5) Approach, 6) Activities, 7) Social contact, and 8) Dignity. The survey shows that most residents without health care would likely have large unmet needs in everyday life, especially compared to keep their home clean and neat, whereas a much greater extent is self-reliant in terms of domains activities and social contact. This means that the efforts that are being made in care homes, in particular, can help to lift the care-related quality of life for residents in relation to recoup the more basic needs, which include home care, personal care, food and beverage and security and to experience having control over his life. And apparently succeeds out in care homes to improve residents' quality of life in these areas: When we look at how the residents thrive with the help that is being provided, it is especially in relation to personal care, and to some extent also in relation to the dwelling and more generally dignity that their care-related quality of life is high. A significant proportion of the residents believe, however, that even with care have large unmet needs in terms of social contact and activities. That potential for improvement is greatest in these two domains, and it is especially here, care homes can improve performance. It is also worth noting that 1 per cent. of the residents have large unmet needs in relation to domains housing, food and beverage, security or control, or dignity, ie. to their needs in these domains do not get covered.



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