



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

Prevention and rehabilitation in the long-term care system

National Report Denmark

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1 Introduction

This report has been drafted with substantial contributions from the Danish National Expert Panel (NEP; see Annex). We would like to extend our sincere gratitude to all NEP members for their time and interest.

1.1 Background

The background to any study of long-term care for older people in Denmark is the major sea change in housing and care for older people that began in the 1980s. The Skaevinge Project (Wagner, 1997) fundamentally and radically shifted Denmark's entire approach to long-term care, and the principles have since been adopted in countries as culturally varied as Japan and Canada. At the centre was the dismissal of the concept of traditional nursing homes, where care and accommodation were provided as a package. With the separation of housing and care functions there came a raft of changes: rooms were converted into homes, older people retained their individuality and the notion of self-care became central, 24 hour care by inter-disciplinary teams was adopted and crucially, instead of pocket-money older people could now keep their pensions and make decisions about the kind of care they preferred. All developments since then have been based on these earlier initiatives.

1.2 Demographic starting point

After a period of stagnation in the 1980s, Danish life expectancy has been improving since the mid-90s, although it is still behind the EU average. In 1997 there were 792,229 people over the age of 65; by 2007 the number had increased by 6.1% to 843,895, representing 15.5% of the total population. In the same decade, life expectancy at 65 increased by approximately one year for women (to 84 years) and two years for men (to 81 years). Remaining *healthy* life years at 65 have increased significantly in the past decade, by 56% for women and 46% for men (Eurostat).

Projections indicate that the percentage of those over 65 is expected to rise to 25% by 2050. Despite the increase in healthy life years and improvements in services and technology, we are likely to see higher numbers of people dependent on long-term care (LTC), especially as the fastest growing sector of the population is the 'oldest old' (over age 80); by 2050 they are expected to constitute 10% of Denmark's total population (European Centre for Social Welfare Policy and Research, Draft report, 2009).

The implications of these trends for LTC planning are discussed in the section 'Governance and Financing'.

1.3 Organisation and Delivery of Prevention and Rehabilitation

Provision of health care in Denmark is a public task; over 85% of health care expenses are financed by public funds generated by taxation. In its 2008 publication, the Ministry of Health and Prevention describes how Danish health services can be categorised into 'primary health care' and 'hospital services'. Within primary health care, the 'practice sector' is made up of general practitioners (GPs), district nurses, specialists, dentists and professional therapists. The 'prevention/rehabilitation sector' offers a range of schemes aimed at health promotion, prevention of illness onset or deterioration, retraining and rehabilitation (Ministry of Health and Prevention, 2008). Both GPs and hospitals are involved in preventive

treatment. As will be seen below, health services have recently been decentralised to new regions and local authorities. Social Services fall under the remit of local authorities, and the overlap in the management and work settings of social and health service staff means that there is perhaps less demarcation between the two sectors and more opportunity for multi-disciplinary work than in other countries.

1.3.1 National reform of health services in 2007

Since 2007 prevention and rehabilitation services in Denmark have been undergoing a major change process in terms of organisation, management and delivery. A nationwide local government reform came into force on 1 January 2007. The aim was to provide a better basis for ensuring cohesive patient treatment, and simplified access to prevention, examination, treatment and care. Local authorities became the gateway to the public sector and thereby took on a considerably stronger role in health and social care. Five new regions became responsible for the health sector, i.e. hospitals, psychiatric treatment and the Danish Health Security. The regions provide a platform for planning and enhancing quality. Local authorities are at time of writing (2009) still in a phase of transition. They now play a more front-line role, as they have become responsible for all health promotion, prevention, training, care activities and rehabilitation not performed at hospitals. In particular with regard to retraining and rehabilitation, one of the overt reasons for assigning sole responsibility to local authorities was to reduce the occurrence of 'grey zones' when patients move from the secondary to the primary sector (Christensen/Hansen 2006: 43).

This new local government independence is founded upon the Danish welfare society, which is characterised by community services and strong local engagement. Increased freedom to steer services on a local level brings with it the need for accountability. A clear demarcation of responsibility between state, regions, local authorities and individual institutions is therefore essential.

In their report, which analyses the first year of the new local authority organisation, Hansen and Jørgensen (2008) describe two types of prevention responsibilities of local authorities: "The aim of prevention services targeted to the general population is to prevent illness, while prevention services to patients should contribute to preventing the further development of illness, and illness complications" (trans.). They allude to primary and secondary prevention, although the terms are not directly discussed. They find that authorities use different organisational models for health promotion, prevention and rehabilitation and that they are to varying degrees visible, profiled, prioritised and resourced in the different local authorities.

1.4 Political context – LTC policy

The stated aim of LTC is to make daily life easier, improve life quality and promote individuals' capacity for self-care. According to a recent joint European/Danish report on National Strategies for Social Protection and Social Inclusion, LTC policies in Denmark are based on continuity, employment of the citizen's own resources, choice and self-determination (European Commission and Danish Ministries of Welfare and Health and Prevention 2008).

The 2008 report states that organisation of health and care interventions for patients with chronic illnesses should be carried out in a multi-disciplinary, cross-sectoral and co-ordinated collaboration between hospitals, GPs and the local authority. In the course of a chronic illness a complex set of interventions will be required, including early diagnosis and follow-up and effective medical treatment. The GP should act as co-ordinator throughout the course of the chronic illness and should refer patients to local services for prevention and rehabilitation.

The report sets out a number of challenges to Denmark relevant to LTC:

- To maintain the current high level of social security while meeting the growing demands of an ageing population;
- To further improve the Danish health system's quality and effectiveness, hereunder in cancer treatment;
- To increase efforts to recruit health care staff and improve working conditions.

A note on terminology: those in receipt of long-term care are often referred to as being 'chronically ill', or 'suffering from chronic diseases/illnesses'. There is some inherent dichotomy between the notion of illness and disease, and the notion of self-care, self-determination, maintenance/improvement of capacities and recovery. Many people who need and receive long-term care would not consider themselves to be sick or ill. Care should therefore be taken to qualify the term 'chronically ill' when used as a catch-all for those in receipt of long-term care.

1.4.1 Recent developments in acute care policy

As part of the government's 2008-10 social care strategy, the existing law that allows all citizens to choose the hospital at which they wish to be treated has been extended. If they are not allocated a bed within one month, they can now instead choose to be treated at a private hospital at no cost to themselves. Although not specific to older people, this development exemplifies the growing commitment in Denmark to free choice and flexibility as fundamental rights of all citizens.

1.4.2 Recent LTC developments in home care

Home care, which can be either temporary or permanent, is granted following a needs assessment by one of a team of local authority case management officers, who are often nurses. Home help is granted irrespective of the older person's type of home, i.e. own home, serviced flat within a sheltered housing scheme or within a home for elderly people. In the last decade, older people have been afforded more flexible opportunities to plan the assistance they receive. They may choose private sector services, but the local authority must ensure that the services are carried out within the same time frame as the local authority services and that private assistance corresponds to the individual recipient's needs. In 2008

154,571 citizens (2.84% of the total population) were in receipt of long-term home help, and of these 26% chose to engage the services of private service providers (Statistics Denmark).

A recent further development to the home care rules means that LTC patients can now receive a cash payment, allowing them to employ helpers in the form of 'citizen-directed personal assistance'. The aim is to provide greater self-determination and flexibility. Citizens can choose to appoint an individual, an association or a company to employ the helpers they need.

1.4.3 Recent developments in intermediate care settings

Although the term 'intermediate care' is not defined in Danish healthcare terminology, there are to be found a range of initiatives and physical or organisational structures and settings that to a greater or lesser extent provide intermediate care for older people. One example is Tranehaven, Gentofte local authority's prevention and rehabilitation centre. Christensen and Hansen describe it as 'a special institution, a treatment institution that reminds one of a mini-hospital' (Christensen/Hansen, 2006: 44). Besides a range of health promotion, prevention, re-training and rehabilitation programmes, Tranehaven also has 83 beds for short stay treatment and respite care, with round-the-clock nursing care, doctors on the staff and highly specialised therapists. Cross-sector collaboration is vital to such an institution as Tranehaven, and from their position between the local community services and hospital services, the staff have established good relationships with GPs, and have key contact persons among the hospital staff, local nursing homes and sheltered housing and local authority care teams (ibid.).

Acute care beds in the community are increasingly used as instead of hospital admission, where an older person whose condition does not demand hospital treatment, but rather care and observation, can stay for a temporary period in their own neighbourhood. Although these beds fall within local authority jurisdiction, the Region pays for the person's stay, since the provision is offered as a substitute for hospital admission. In their report on specialised care outside of hospital, Hansen et al. (2004) set out various examples of Danish and international projects and settings in which acute care needs can be handled without hospital admission, either in the patient's own home or in an acute ward at a local nursing home. They point out that hospital admission can lead to complications in older people's health and capacity that may be avoided by local or home-based treatment. Prevention of hospital admission could thus in itself be considered as a prevention strategy. Local authority readiness to undertake specialised care for older people as an alternative to hospital admission rests on staff competence, access to expertise in the event of complications and a structure to support immediate assessment and regular observation in acute situations. The report concludes that local authorities are to a large extent equipped to provide such care to those already in receipt of home care, but not to the same extent for those who currently are not receiving home care.

1.4.4 Recent LTC developments in institutional care

The term 'institutional care' may have different meanings or interpretations in different countries. Table 1 shows numbers of people living in different categories of housing/care settings for older people. The source database, Statistics Denmark, provides information in both Danish and English.

Table 1 Persons in Denmark living in different types of dwellings for the elderly by age and type of measure

2008	*Nursing homes	*Protected dwellings	*Nursing dwellings (2006-)	*General dwellings for elderly persons (2006-)	*Other dwellings for elderly persons
65-66 years	129	50	480	863	287
67-74 years	903	222	3,142	4,772	1,321
75-79 years	1,139	234	4,013	4,756	1,274
80-84 years	1,841	293	6,681	6,030	1,564
85-89 years	2,419	476	8,169	5,578	1,468
90 years and more	2,868	431	8,128	3,578	1,039
Totals	9,229	1,706	30,613	25,577	6,953

Source: Statistics Denmark <http://www.statistikbanken.dk/statbank5a/default.asp?w=1344>. Sourced 070809.

Note: Some municipalities report large deviations between dwellings from year to year and the compilation is consequently not reliable. The number of dwellings and the number of persons cannot readily be compared, since they are compiled differently. *) A note on terminology: The Denmark's Statistics database provides a translation of the following five categories of accommodation for older people: 'Nursing homes' and 'Protected dwellings' refer to institutions where older people live in their own rooms/apartments with some shared facilities. All nursing homes have 24-hour staff as do 2 out of 3 protected dwellings. 'Nursing dwellings' refers to more modern institutions which also have staff and shared facilities, and can be said to be the modern replacement for the traditional nursing home. 'General dwellings for elderly persons' refers to housing that is designed/adapted so that it is suitable for older persons but which does not have staff or shared facilities. 'Other dwellings for elderly persons' refers to housing which is case managed by the local authority as suitable for older people, but this type of accommodation is not generally counted.

2 Prevention and rehabilitation

2.1 Prevention policies and strategies – including within LTC

Over the last 10-15 years, preventive health has been given an increasingly high priority in Denmark. This is principally due to recognition of the dominance of lifestyle related diseases such as diabetes, cancer and cardiovascular diseases. Since 2002 policies and initiatives either supported or put forward by the government have formed part of the national public health strategy *Healthy throughout Life* (Ministry of the Interior and Health, 2003). The strategy stresses the responsibility of the individual, but also underlines that the individual must be able to make well-informed choices. The strategy enhances the role of the civil society – social networks, the workplace, private organisations, etc. and emphasises that lifestyle cannot be changed without regard for the social context in which people live.

In line with this increased focus on prevention, the government appointed in 2008 a new national prevention and promotion commission, who launched their strategy, *We can live longer and healthier* in April 2009. The report details 52 specific recommendations to improve prevention and health promotion, including for older people with chronic conditions (Commission on Prevention, 2009). Central themes include user-participation and self-determination, the postponement of the need for public care help and thereby, hopefully, increased savings in care and treatment costs.

Rehabilitation for older people falls under the jurisdiction of local authorities and can take place in the person's home, in the local community or at a rehabilitation centre. Treatment is often of several weeks' duration and can be in the form of individual or group training. As Hansen states in his evaluation report on the first year of local authority reform (2008): "Rehabilitation is not a singular concept. There is often no clear distinction between retraining of functions particular to the individual, and support in the form of help to self-help, which can contribute to maintenance of or improvement in the accomplishment of a range of daily activities" (trans.). Hansen goes on to say in his report on the effect of one local authority's rehabilitation services for older people, that the form and content of rehabilitation vary greatly, and can include one-to-one training in daily activities or classes in strength or balance training. The analysis shows that effects are greater when the rehabilitation is undertaken at regular and frequent intervals and arguably the younger participants experienced better effect. He points to the lack of evidence-based research on the subject and recommends further research be undertaken.

2.2 Prevention and rehabilitation services at new 'health centres'

In line with the new national drive for improved prevention and rehabilitation services, many local authorities have, since 2006, begun to establish 'health centres'. The general concept is to set up an organisational unit that offers patients who have been referred by their GPs targeted health promotional, preventative and rehabilitative support, training, guidance and/or treatment, co-ordinated and delivered by a multi-disciplinary team. Within this umbrella concept, local authorities are free to create their own centre model, and consequently centres vary greatly in terms of target groups, aims and range of services. Some are general centres for all citizens, some focus on rehabilitation and re-training after hospital discharge, while others have health promotion and prevention as their aim, or are targeted at those with chronic illnesses, including older people.

All health centres have in common the need for strong partnership and joint working between GPs, hospitals, patient associations and training and exercise providers. Early evidence from evaluation (Hansen/Jørgensen, 2008) indicates that GPs have not referred as many patients as expected, which is thought to be due to lack of knowledge about the centres, lack of continuity in the services offered by the centres or lack of routine in the referral process. In some local authorities the communication and joint working between the practice sector and the local authority, in relation to patient education and rehabilitation, has been seen to have improved.

2.3 Preventative home visits to over 75s

All local authorities have been required by law since 1998 to offer two annual preventive home visits to all citizens aged 75 years or older (Law no. 1117, 1 Jan 2007). The overarching aim is to help older people to better use their own resources in order to maintain their independence for as long as possible. Closely related is the aim of health promotion, early detection of signs of illness, advice, guidance and sign-posting. Visits are usually carried out by district nurses, but an obligatory health check is not included, and GPs are rarely directly involved.

The beneficial effect of in-home assessment of elderly people on disability prevention or delay claimed in a number of randomised trials remains controversial. A three-year, large-scale Danish study which aimed to investigate whether education of home visitors and GPs in routine primary care improved the functional ability in home-dwelling older people, suggested that such training programmes will prevent functional decline in women, but not in men (Vass et al., 2006).

'Walk and talk', Odense local authority

Type/scope: Pilot project

Target group: Citizens in two neighbourhoods aged over 75 and in receipt of preventive home visits twice annually.

Background/aims: To combine preventive home visits with a health promotion/preventive activity, with the aim to increase physical activity, detect needs for for example rehabilitation or falls prevention, encourage older people to join with others in walking groups and/or set up their own, thereby broadening their social network and involve them in the rich tradition of clubs and associations in Denmark.

Content/method: In spring-summer 2009 home visitors became trained as exercise consultants for older people. The home visit takes the form of a walk, where health and social issues are discussed along the way and signs of tiredness, dementia, etc are observed.

Results/evidence: The success criteria were achieved: of 25 people offered a walk-and-talk, 10 said yes, of which 8 requested another walk-and-talk at the next visit. 15 people declined to take part. Qualitative evidence – feedback from participants – showed general satisfaction. Two volunteers from the participants agreed to organise walks for older people.

Challenges: Collaboration with the local older people's committee and Ældresagen, the association for older people was difficult to establish, and a longer preparation time is recommended. Written information to citizens should be optimised and different methods of communicating about the project should be used and on different occasions leading up to the start.

2.4 Prevention and rehabilitation within institutional care

An initial search produced little research and very few projects that could be said to be specifically targeted to improving prevention or rehabilitation with institutional care, but wider searches need to be conducted.

Named 'good practice project' – prevention of problems related to medication

Type: Project

Background: Every year in Denmark there are around 158,000 admissions to hospital because of incorrect use of medicine. Two out of three older people take 3 types of medicine per day and up to 15% take more than ten different types of medicine over the course of a year. Evidence-based studies document that nursing home residents experience many medicine-related problems: inappropriate choice of medicine, too high dosage, medicine interactions and risk of side effects. Risk medicines include anti-depressives, sedatives and antibiotics. The risk of inadvertent incidences increases with the number of medicines taken.

Scope: Lyngby-Taarbæk local authority nursing home and rehab centre in collaboration with local pharmacies aim to quality assure medicine dosage and administering to those taking more than 5 types of medicine a day, those who get medicine from different doctors simultaneously and those whose symptoms are suspected of being caused by incorrect use of medicine.

Aim: To contribute to quality improvements in medicine handling, dosage and administering among residents of a nursing home and those receiving home care.

Content/methods: Through dialogue developed a new care and treatment directive and better documentation of inadvertent incidences.

Results: A fall in inadvertent incidences and far fewer notes in health inspectors' reports. Residents report better satisfaction and well-being with regard to their medicine, while workers report improved evaluation of residents' symptoms. Particularly positive results were noted in the collaboration between the nursing home and pharmacists.

Source: www.godsocialpraksis.dk

2.4.1 Dementia

According to recently published international research, the number of people with Alzheimer's disease and dementia in Europe may be higher than previously reported (Reynish et al, 2009). Reynish et al. found that while dementia prevalence rates for all men and for women up to age 85 largely confirmed

previous findings, rates for women over 85 had previously been underreported, and for those over 95 the rate may be as high as 50%. This would suggest that figures for dementia and Alzheimer's disease in Denmark are closer to 78,500 and not the 56,000 seen in the most recent figures from 2008, and should be expected to increase in the coming decades with the increase in longevity.

“Dementia is a complex condition. There is no single, straightforward cause, and no way of definitely preventing it. No curative treatment is yet available” (Dementia in Europe Yearbook, 2008: 123). Medical treatment can only postpone symptoms for a period of weeks or months. It will be many years before results of tests on medicine to halt the development of the illness, vaccination and treatment with stem cells will be available (On Dementia, 2009). Because dementia is a progressive, degenerative illness of the brain, total rehabilitation, understood as a return to previous functioning, is not possible for people with dementia. However, much can be done to maintain life quality, and the sense of control over one's life and functions (REF). In Denmark dementia rehabilitation is concerned with promotion of the individual resources, self-determination and self-care. These take different forms at the different stages of dementia (Dementia in Europe Yearbook, 2008). Below is a brief overview of some services and interventions in Denmark, set out under the early, middle and advanced stages of the disease.

DAISY project (Danish Alzheimers Study of Interventions)

Type: A major scientific joint study between National Board for Social Services and H:S Memory Clinic, Copenhagen University Hospital.

Aim: to survey the support needs of those recently diagnosed with early-stage dementia and their relatives.

Scope: This broad-sweeping project will map out the support needs for those recently diagnosed with dementia in the early phase and their families.

Content/method: Data was collected between 2003-7 and sub-projects investigated support and advice, economic aspects of health, the need for social activities/networks, and legal themes.

Results: TO DO.

www.videnscenterfordemens.dk/daisy

“In the early stage it is important to support a person's independence, normal activities and way of life, to support functional capacity, to maintain meaningful roles and functions and to find appropriate compensatory strategies for those capacities that are already affected by the disease” (ibid.: 32). Dementia cafes can be found in many towns and cities in Denmark, run by either the local authority or the Alzheimer Association. Aarhus local authority has a dementia school for individuals with dementia and their families. In some towns the Alzheimer Association visits people at home to give advice. However, services are more prevalent in towns than in the countryside, and people in smaller communities may not be as well served.

“In the middle stage it is important to support the abilities and resources the person still has, and to create possibilities for success and a sense of achievement in order to support a person's identity” (ibid.: 31). Many people with middle-stage dementia live at home and receive comprehensive support from the local authority in the form of practical help, psycho-social support and counselling, and are offered activities at local centres, including working with life histories and physical activity. Referrals can be

made to church-based support groups, the local council for older people or the Alzheimers Association, which offer care relief for carers of people with dementia. A recent development is the provision by some local authorities of gardening activities, at either an allotment for older people or at a nursing home garden.

Robot Seal, at various local authorities

Type: Project/initiative

Scope: In collaboration with the Centre for Robot Technology in Odense, a number of local authorities have acquired a Japanese-developed robot seal pup at a cost of 7,000 euro for use in dementia care. The 'pet' is given a name, looks like a seal pup and moves and reacts to touch. Patients with dementia are encouraged to relate to the robot as they might to a pet, given that most pets are not permitted in the majority of care home settings.

Aim: The aim is to use a robot 'pet' to help residents to socialize, relax, feel soothed and calm, and lift their sense of well-being.

Results: Early results show that quality of life and general levels of well-being can be improved, although some residents were at first sceptical. **Source:** <http://www.teknologisk.dk/projekter/24936>.

"In the advanced stage it is essential to provide support for mental and physical capacities as well as for the ability to interact" (ibid.: 32). Most people with advanced dementia live in nursing homes. It is important that they can avail of the same opportunities as for people at other stages of the illness, but sometimes staff shortages, high turnover of staff and lack of financial resources can restrict their participation.

SPIDO – Socio-pedagogic practice in daily care

Type: Socio-pedagogic development and training project

Background: Previous experience with socio-pedagogic methods in a National Board of Social Services project 2004-6 showed that it is possible significantly to reduce and prevent use of force over patients with dementia. The then Minister of Social Services earmarked a grant to continuing professional development (CPD) for workers which led to this project.

Scope: A new approach to treatment and handling of patients with dementia, who are among the most vulnerable LTC patients.

Aim: To reduce and avoid the use of force when treating patients with dementia.

Content/Method: The training programme has run from 2007 and is due to complete at end 2009.

Results: The first evaluation emphasizes that workers have a greater awareness of work processes and prevention/handling of conflict situations, together with a greater willingness to use the skills the patient has learned and to employ to a greater extent creative solutions in their daily care.

2.5 Cross-sectoral prevention and rehabilitation

There is in general much evidence to suggest that the future development of health care services will demand more co-operation between staff from different organisations, disciplines and levels of responsibility. Jointly managed and performed services are becoming more prevalent in Denmark, and in contrast to other countries, many staff already work in multi-disciplinary settings. For example, home nurses often work side by side in the same office as home care workers, although they belong to different teams.

Multi-disciplinary working is increasingly demanded and expected, both within hospitals, and between different care settings. Yet, a range of Danish research papers over the past decade point a range of challenges in this area. In *Shared Care – collaboration and conflict between local authority, GP and hospital*, Seemann/Antoft (2002) write that despite the development of cross-sectoral relations in the health sector, the inter-organisational structures and relationships are still underdeveloped, sporadic, cumbersome and time-consuming. The joint-working culture is often characterised by lack of consensus agreements, conflicts, prejudice and unfulfilled expectations. The article '*The fragmented healthcare sector*' (Seemann 2004) is based on 35 in-depth interviews with key staff at regional (the pre-2006 smaller regions) and local authority level and among GPs. (Findings yet to be analysed.)

Challenges in cross-sectoral work:

The pilot project 'Rehabilitation in daily living' mentioned later in this report involved joint working that demanded a new and complicated management and reporting structure:

- Home trainers (released from their home care teams to take part in the project) and home nurses were led by the district leader
- The district leader referred to the nursing manager
- Case assessment officers referred to the manager of the assessment office and worked in a different setting
- Therapists referred to the retraining centre manager
- Managers of nurses, assessment officers and therapists were jointly responsible for solving problems which the district leader, home nurses, assessment officers and therapists themselves could not solve.
- The project relied heavily on referrals from GPs to case assessment officers, which were less forthcoming than expected.

The initial feedback from participants reflected the fact that inter-disciplinary work places greater demands on leadership and increases the need for effective communication by all stakeholders, which can increase levels of bureaucracy.

Source: Danish national centre for social research (2008)

Integrated Health Care - This FP7 project has launched research for better ways to ensure continuity in clinical care for elderly rehabilitation patients with the frequent chronic conditions stroke, COPD and heart failure as a reaction to the problems of a fragmented health care sector as focused by WHO. The mission of the project is to document the benefits of Integrated Homecare (IHC) combining effective home rehabilitation of patients with economic savings for society.

A medical technological evaluation undertaken in 2005 of 'home training' for stroke patients by hospital-based teams (Larsen, 2005) sought to describe the cross-sectoral and multi-disciplinary nature of this service. 'Home training' is understood as a special rehabilitation process involving early discharge from hospital, re-training in the home setting, which encompasses psycho-social needs, draws in family and home care workers and is co-ordinated by outreach hospital staff. The focus of the rehabilitation is far removed from hospital-based re-training, in that it includes motor exercises, ADL training and identification of suitable aids and alterations to the physical living environment. Unlike traditional hospital-based rehabilitation, up to 25% of the hospital therapists' time is spent on informing the patient, family, local authority therapists and homecare workers, who will take over when the hospital team have finished. A meta-analysis of literature showed that home training can reduce a period of hospitalisation by 11 days. Home training as opposed to hospital rehabilitation reduces the risk of negative rehabilitation effect (death or institutionalisation) by 41%. However, although this and other studies show that home rehabilitation saves money and means better rehabilitation for patients in the long run, recent developments indicate that local authorities look to short term and keep as much rehabilitation as possible under their jurisdiction for fear of incurring additional expenditure (Larsen, 2009).

In their review article on the value of rehabilitation programmes by outreach hospital teams as follow-up after discharge for patients with chronic illnesses, Jørgensen and Henriksen (2005) give evidence from Danish and international research of reductions in length of hospital stay and frequency of readmission, and increases in patient satisfaction, self-assessed health and IADL functional capacity. Although there is a long tradition of follow-up rehabilitation in outpatients units, the article highlights the value of outreach teams conducting rehabilitation in the home for continuity between hospital and community care and its effect on increased motivation to regain capacity.

2.6 Prevention and assistive technology

This section is still being researched. See the example above on the use of a robot seal pup in dementia care.

2.7 Falls prevention

Reducing the incidence of falls among older people is a public health priority in many countries. In Denmark approximately 30% of people over 65 fall each year. Between 20% and 30% of those suffer injuries that reduce mobility and independence and increase the risk of premature death. Fall rates among institution residents are much higher than among community-dwellers (Skelton/Todd, 2004). There is a growing body of evidence indicating that falls-prevention programmes that include muscle strengthening and balance-training exercises can significantly reduce the incidence of falls (Yardley et al., 2006) and are linked to fewer hospital bed days and a higher quality of life. The 2003 Cochrane review concluded that multidisciplinary, multifactorial screening and intervention programmes were likely to be beneficial in prevention of falls (Gillespie et al., 2003). However a large-scale Danish study (Vind et al., 2009) re-

cently found no preventive effect of a programme of multifactorial fall prevention on fall rates, number of fallers, or injuries caused by falls. They recommend more research to establish which sort of fall prevention is more efficient in the community and, when taking feasibility, acceptability, and cost into account, which subgroups may benefit from a more intensive intervention.

Training course for older people in prevention of balance and falls-related problems

Aim: Increase knowledge of prevention of falls. To try out two models of training older people.

Target group: Older home-based residents who are referred to falls and balance training at the Geriatric Day Clinic at Roskilde Hospital.

Content:

- A training programme for older people who have been diagnosed as having falling/balance problems at the Geriatric Day Clinic. Six sessions of 3 x 2 hours teaching for a group of 10 participants, where the involvement of participants is given a high focus.
- 2 Courses arranged for local older people's associations, pensioners clubs, etc. Ten sessions of 2 hours' duration for larger groups (25-50) with some participant involvement.

Results: To do.

In Denmark it is recommended that, for every contact with an accident and emergency ward or hospitalisation as a result of a fall, the risk of falling is assessed and a plan of action drawn up (The National Board of Health, 2006). People assessed as having no elevated risk of future falls but who have a low-energy fracture should be referred to an assessment to determine whether osteoporosis is present and to subsequent treatment if warranted. If the basic assessment leads to the suspicion that the fall was caused by a disease of a specific organ, the patient should be referred to a specialist physician for further assessment. Rehabilitation is recommended which should comprise multifactorial adapted interventions that may include a combination of treating relevant health problems, optimising pharmaceutical treatment, exercise training (training in balance, strength, gait and walking), vitamin supplements, use of hip protectors and modifying environmental (dwelling-related) risk factors. Exercise training is the cornerstone of any type of rehabilitation of patients who have experienced a fall. Continuity and quality are important, and patients must be encouraged to participate actively in treatment. This can be supported by educating patients and by disseminating patient-oriented material (Commission on Prevention, 2008).

2.6 Prevention and rehabilitation within home care

Preventative home visits to people aged 75+, case manager's assessment visits and the regular contact between care staff and older people can more effectively be used to detect and take action on the likelihood of, for example, the occurrence of falls. This is in line with the other areas of focus, i.e. detection of signs of dementia, physical inactivity, insufficient nutrition, etc. (Commission on Prevention, 2008). Competence development in care staff with regard to both the falls prevention strategies and individual risk factors can increase attention to falls prevention.

Home trainers – Rehabilitation for Daily Living, Fredericia local authority 2008-9

Type/Scope: Pilot project within a larger project 'As long as possible in one's own life' [trans.].

Aim: To postpone and/or reduce the need for compensatory aid and support by offering intensive rehabilitation to older people in their own homes.

Target group: Home care recipients over 65.

Content/Method: An interdisciplinary treatment team, consisting of assessment case officers, physiotherapists, occupational therapists and home nurses, drew up one joint rehabilitation plan for each citizen. Care staff carried out the work in the role of 'home trainers'.

Results/Evidence: Some home care workers maintained that rehabilitation was already integral to their work, but the project also showed that there is a difference between home training and home care, and that the home trainers often did things for the citizens that the citizens could almost certainly do for themselves. The evaluation showed positive results, where some participants no longer receive home care and others receive less than before.

Challenges: One caveat is the short duration of the pilot (3 months), with fewer participating citizens than expected and the results are not based on stringent empirical evidence but on interviews with four participants. Joint working proved to be a major challenge. Please see under the relevant section in this report for further discussion about joint working in this project.

Source: Danish national centre for social research (2008)

Home help is seen as helping citizens to self-care, i.e. as supplementary assistance for tasks that a recipient is temporarily or permanently unable to do or has severe difficulty in doing alone. Assistance is planned in close cooperation with the recipient, and either supports the recipient in maintaining or recovering a physical or mental functional level or remedy special social problems.

The assistance should aim at activating the citizen, and its chief objective should be to enable recipients to manage on their own or - if this proves impossible - to include the recipient in performing as many

tasks as possible. Often a written contract is drawn up, between the citizen and the local authority or private sector provider.

2.7 Prevention within dental care

Dental care is a specific area of LTC where more can be achieved within prevention and rehabilitation. A regulatory guide regarding local authority and regional dental care provision (National Board of Health, 2006) states that 'local authorities should provide preventive and treatment based dental care to those over 18 who, due to ... physical/mental disability, have difficulty in availing of general dental services. It is the duty of the local authority to provide information about their dental care services' [trans.] (ibid.: 35).

It was the intention of the now 14 year old law regarding dental care that services should be prioritised and more attention given to multi-disciplinary working. But there is evidence to suggest that both those in receipt of dental care and care staff do not prioritise daily dental hygiene/dental care and the spirit of the law is not evidenced enough in daily care practice (Schou et al, 1996; Ekstrand et al 1998 cited in Ekstrand/Esmark 2009, pg. 16). The fact that there often are barriers between older people and staff in relation to oral care – which by both parties is considered a private concern – could result in the reduced priority of oral hygiene (Schou et al, 1996 cited in Ekstrand/Esmark 2009, pg. 17). Care staff should be trained in dental care and hygiene, but the basic and follow-up training they receive on the subject is often less than adequate or not routinely included in training programmes.

It is generally accepted that particular medicines can cause dryness in the mouth related to reduced saliva secretion. This puts many older people at increased risk of cavities, which can develop very quickly. The report states that this risk should be recognised and taken into account in care interventions (National Board of Health, 2006, pg. 39). It has been recommended (by a Danish researcher in dental care – unpublished) that when such medicine is prescribed, the patient's dentist should automatically be informed. A high fluoride content toothpaste is available on prescription for those at particular risk of developing cavities, but it seldom recommended.

3 Good practice discourse

In 2006 the National Board of Social Services set up a publically accessible database 'Good Social Practice' (www.godsocialpraksis.dk). The database registers examples of initiatives from across local authorities which an expert group deems to demonstrate good practice. Its purpose is to disseminate knowledge and as a development tool for local authority planning. Voluntary good practice champions were recruited – by spring 2009 there were 74 – whose role is to find examples of good practice and to disseminate and spread information on good practice to local authorities.

Under the heading 'Older People' the majority of examples focus on management, training and procedural initiatives which will either be of economic or staff welfare benefit. They appear to be evaluated

less often from the perspective of the value to older people, except as indirect outcomes. While no examples specific to prevention and rehabilitation for older people within LTC were found, a few of the projects touched on initiatives that could be said to indirectly contribute to secondary prevention work.

Named ‘good practice’ example: Prevention through increased training of home workers

Type/Scope: Project

Aim: To reduce the growing need for home help among residents whose functional capacities are failing. Home care workers find that they often need more time for their home visits, more frequent visits and more hands, which increases the workload for their team. By collaborating with occupational therapists, the hope is that this increased need will be reduced.

Content/Method: Occupational therapists supervise and guide home care staff in their work in people’s homes by focusing on maintenance training and support of activities of daily living (ADLs). This cross-sectoral collaboration also includes case assessment officers, who are encouraged to take account of maintenance training when they visit residents.

Results/Evidence: To do.

4 Special topics

4.1 Education and training

In-service training for health care staff is well established in Denmark. An evaluation of a training course for staff conducting preventative home visits for those over 75 (Thorgaard/Hougaard, 2008) concluded that the aim of the course – to train staff to better spot early signs of dementia – was achieved. The vast majority of participants developed their knowledge of signs of dementia and their competence in spotting signs and taking further action.

A three year study of an educational programme for healthcare providers in routine primary care showed improved functional ability in older people living at home but did not reduce nursing home admissions or mortality (Vass et al., 2005).

4.2 Quality assurance

The Danish Institute for Quality and Accreditation in Healthcare (IKAS) has recently developed the Danish Healthcare Quality Programme for the entire healthcare system. It aim to include all Danish publicly financed healthcare services and to operate on a cross sectoral basis. The Programme is a result of a collaboration entered between central government and the regions. Local authorities, private hospitals

and pharmacies have signed agreements to be part of the Programme. Accreditation is the central focus. In 2008 a national nurses' strike delayed the implementation of the model, which will now first come into effect in autumn 2009.

Quality in elderly care was a 3-year national project (2005-7) whose aim was to improve quality in provision of elderly care, both for those living at home and in care institutions. Central to the project was the sub-project *Development of methods in elderly care* which strived to create and implement a new methodology under the themes 'values', 'communication and information' and 'flexibility'.

Quality in Elderly Care, 2005-8

Type/Scope: Evidence-based project

Aim: To determine what characterises quality in care for older people at home and in care units for the perspective of older people, care staff and case assessment officers.

Target group: Older people in receipt of home care or living within care institutions.

Content/Method: Two studies were undertaken. The first study, 'Concepts of quality in elderly care – themes, roles and relations' [trans.], aimed to throw light on what those involved elderly care considered important in quality, barriers and expectations. The second study, 'Good quality in elderly care, determined by older people, care staff and case assessment officers' [trans.], highlighted the three groups' views on quality.

Results: To do.

A national social care quality reform process is currently underway to assess and improve quality in the care sector for older people, both for staff and recipients of care. Some key initiatives relevant to this report include:

- One permanent contact person for every older person in LTC and a reduction in the number of different home helpers that cares for an individual person.
- The most modern and up-to-date facilities and technologies.
- Better learning between local authorities and other stakeholders in care. A reporting system will be piloted where care staff, citizens and families can report errors and inadvertent incidences.
- Accreditation of learning and training of care staff.
- From 2010 the current local authority service strategies will be superseded by quality contracts. The contract will be between the citizen and the authority and will set out clear and achievable goals for each of the care services and sectors involved in the person's care.
- Increased choice of aids and accommodation conversion/adaptation.

User satisfaction surveys will be carried out to monitor quality, which will also serve to highlight organisations that have developed good practice.

4.3 Involvement of older people

User involvement is a relatively new concept in LTC for older people and is given only brief mention in the joint EU and national report on strategies for social protection and social inclusion (2008). However, the concept of user involvement in LTC has been inscribed in social service law since 1998. Care planning and treatment should be carried out in collaboration with, and based on the needs and wishes of the individual care recipient.

Since 1996 it has been a legal requirement for local authorities to elect Senior Citizens Councils. Before this, such councils had been established on a voluntary basis but only in some areas. The National Association of Senior Citizens Councils (NASCC) is a voluntary organisation, consisting of a council from each of the 98 local authorities. All local authority residents aged 60+ are eligible to stand for election and vote. The work of the NASCC comprises advice and guidance, information sharing, running courses and contributing to decision-making at local and national level.

Resident involvement in case management, Vesthimmerland Local Authority

Type/Scope: Project

Aim: To establish resident involvement and to highlight residents' resources in case management, to demonstrate compliance with the rule of law on user involvement.

Target group: Older people in receipt of home care.

Content/Method: Case assessment officers have involved older people in case management in the field of older people's care. By early intervention they focused on the possibility of the older people contributing to assessment of cases and to clearly document their contributions. In addition, older people's own resources were highlighted.

Results: To do

4.4 Supporting carers

By law, local authorities have a duty to offer care relief/substitution and respite care for carers of those with reduced capacity, for example people with dementia. Care relief/substitution takes place in the older person's home whereas respite care is offered in the form of day, night or round the clock accommodation in a nursing home or other care setting for older people.

No specific links were found to support for carers in relation to prevention and rehabilitation. This may point to a lack of research or focus on the role of carers within prevention and rehabilitation. Those who choose to take on the formally recognised role of carer of their terminally ill relative, often a son/daughter, can apply to take paid leave of absence from their job to take on this palliative care role (Law of 1 January 2005 regarding: "... care remuneration in relation to care of terminally ill close relatives" [trans.]).

4.5 Ethnic minorities

In 2006 a fund was earmarked to encourage the development of targeted interventions for older people of other ethnic backgrounds than Danish. The aims of the fund, to which all local authorities can apply, were to:

- Prevent and relieve social and health problems among older people from ethnic minorities
- Promote dialogue between older people from ethnic minorities and their relatives and the local authority older people's care services
- Encourage and increase this groups participation in local preventive activities
- Improve services for older people from ethnic minorities with dementia and their relatives.

Ten projects were funded, spanning from preventive interventions to the establishment of activities at local clubs and associations. The last project will be completed in October 2009 and the success of the fund will be evaluated.

5 Governance and financing

5.1 Financing health and social care

A basic principle of the Danish healthcare system is that all citizens must have equal access to health services, including free access to hospital treatment and maternity care. Health services are predominantly financed through taxation, so individual citizens' financial situation, labour market situation and other conditions play no role in their access to health services. Local authorities are responsible for home nursing offered to citizens free of charge, and social services to older people in the form of personal or practical assistance, transport to rehabilitation appointments, meals-on-wheels, etc.

Hospital treatment of non-emergency cases requires referral from a GP, who assumes a gatekeeper function. The principle of the Lowest Effective Care and Treatment Level was introduced in an attempt to minimize costs. In this way, efforts are made by GPs to complete the treatment of as many as possible in the practice sector before referring them to hospital treatment or treatment by a specialist.

In 2005 health expenditure was comprised of 84% public and 16% private expenditure – mainly for pharmaceuticals and dental care. In 2005, Danish health care expenditures constituted 9.4% of GDP (REF). Between 2005-7 the number of patients treated in hospitals increased by 2.6%, due to a commitment to reducing waiting lists, a financial injection from the government and focused improvements in the cardiovascular and cancer fields.

5.2 Financing LTC

Denmark spends on average 2.7% of GDP on LTC for older people; 27% of this on institutional care and 73% on in-kind home care (European Centre, Draft report, 2009). All older people resident in Denmark have direct access to a range of services, should temporary or permanent physical or mental impairment prevent them from handling tasks on their own. Individual offers of LTC for older people are allocated on application and based on an assessment by a local authority case manager in collaboration with therapists and home nurses. The local authorities are responsible for providing the support for older people.

Legislation allows local authorities to charge citizens for the actual expenses for materials, and may include staff expenses when determining payment for meal services. Thus, user charges only account for a diminutive part of total health care expenses for older people.

Better and more flexible home help was a specific target of the 2006-8 LTC policy. Local authorities could apply to a central fund to carry out projects under three themes:

- Increased activity – more time for home helpers at home with individual older persons
- Digitalisation – to free up human resources so that home helpers can spend more time with older people, and to increase flexibility and continuity
- More choice and flexibility – to improve quality and effectiveness of care.

5.3 Future challenges to the financing of LTC

A major challenge for Denmark and many other EU countries is that the number of older people in need of care is growing, while there are fewer adults of working age to provide and finance this care. The Danish welfare state is stretched in its attempts to recruit and retain an adequate workforce that will ensure essential welfare needs are met and at the same time secure continued high levels of service. The future economic viability of the care sector rests on the urgent development of resource-saving interventions, to generate further knowledge about the most effective and efficient methods and to exchange research and results.

The population's gradually rising share of older people and mean life expectancy will put considerable pressure on public finances in the coming decades; one reason being that costs of LTC, the National Health Service and public transfer payments will rise steeply. Public individual costs of LTC and the National Health Service are forecast to increase gradually by 2.7% of GNP until 2050 as a consequence of demographic development (REF).

Public expenditure for health and LTC is rising because older people on average account for the highest age-related costs and the size of this group will be increasing relatively steeply in the coming decades. Weighing the demographic development against age-distributed costs produces a highly mechanical forecast of trends in costs for health and LTC. However, several Danish and international analyses have revealed that the years leading up to the individual person's death are the most costs-intensive in terms of expenditure on the health sector, care and accommodation. Thus, the development in age-related costs must be adjusted to allow for the effect of people's improved health as seen in increasing life expectancy. As a supplement to the growth in resources, new technology, etc., new work procedures and the resultant constant rationalisations in the public sector may help improve service.

The local government reform of 2007 was intended to encourage collaboration and multi-disciplinary working between different stakeholders, thereby ensuring more efficient use of resources, and greater focus on prevention at the local level. Additionally, it is intended to contribute to greater coherence between the administrative levels. The rules on free choice, which have led to transparency in the use of resources, and the fact that local LTC is exposed to competition from private providers, are also intended to contribute to more efficient task solving. Hence, these initiatives may help ensure economic sustainability in the care of older people.

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