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

Governance and financing of long-term care

National Report Denmark

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Table of contents

1 Key contextual factors 3

2 The governance and financing of long-term care services for older people 4

3 Key barriers to joint working 8

3.1 Structural 8

3.2 Procedural 8

3.3 Financial 9

3.4 Professional 9

3.5 Issues of status and legitimacy 9

4 Key enablers 10

4.1 Shared vision 10

4.2 Clarity of roles and responsibilities 10

5 The funding of long-term care services 11

6 Financial sustainability 11

7 Good practice 12

7.1 Telemedicine 14

8 Ongoing tensions 14

9 Embedding good practice in everyday practice 15

10 References 16

1 Key contextual factors

The background to how long-term care for older people in Denmark is governed is the major sea change in housing and care for older people that began in the 1980s. Denmark had long upheld the tenets of the so-called 'northern social-democratic welfare regime' (Esping-Andersen, 1990). But it was the results achieved by an action research project at local authority level in the nineties that brought about radical and permanent changes to Denmark's approach to long-term care (Wagner, 1997, WHO report 2009). At the centre was the dismissal of the concept of traditional nursing homes, where care and accommodation were provided as individual packages. With the separation of housing and care functions there came a raft of changes, including 24 hour care by inter-disciplinary teams and a drive towards self-determination, where older people could now keep their pensions and make choices about the kind of care they preferred. Developments in the structure and national administration of long-term care continue to be influenced by this national shift in thinking that was brought about by a bottom-up approach. One of the many last consequences is that there is no longer a concept called 'institutionalised care' in Denmark. Even very frail people who live under one roof have their own apartments and receive 'home care'. Hence in this report all reference to the living situation of older people will refer to 'older people's housing' and not 'institutionalised care'.

1. The Danish welfare system is characterized by universalism and primary tax financed provision. Around 85% of health care expenses are financed by public funds which are generated by taxes. The responsibility for running the public health service is decentralised to five regions and 98 local authorities, whereas the state is in charge of legislation, national guidelines, supervision, monitoring, general planning and the overall framework of the health economy. In terms of long-term care for older people, this means that local authorities and regions, while administering provision, must adhere to regulations and direction set at a national level (Ministry of Health and Prevention, 2008).

2. Unlike in other countries, such as the UK, in Denmark in the primary sector there is less demarcation between healthcare and social care, since health professionals often work in the same physical setting as social care workers, and increasingly in multidisciplinary teams. There are however ongoing issues between the primary and secondary sectors which are discussed in this report.

3. Choice and self-determination are not merely buzzwords in Denmark. Although there is a strong commitment to publicly funded, comprehensive services and the welfare state, a mix of public and private provision, offering consumers ever greater choice, is becoming more prevalent and supported at governance level. The independent (or voluntary) sector is not, however, a major provider.

2 The governance and financing of long-term care services for older people

The governance and financing of Danish health care services, hereunder LTC, takes place across national, regional and local levels. Law and regulations are decided at national level, while provision is divided between what is perceived as two sectors. Regional authorities are responsible for acute and specialised care, including hospitals. Local authorities are responsible for the primary sector, including prevention, rehabilitation and long term care, social care and home care. General practitioners (GPs) stand between the two sectors: they are perceived to be part of the primary sector while regulated by the regions (Campbell and Wagner, 2009).

Current governance and financing is based on the nationwide local government reform of 2007. The aim was to provide a better basis for ensuring cohesive patient treatment, and simplified access to prevention, examination, treatment and care. The health care service is organised in such a way that responsibility for provision of services lies with the lowest possible administrative level. Services can thus be provided as close to the users as possible.

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 became the gateway to the public sector and thereby took on a frontline role in both health and social care. One of the overt reasons for assigning sole responsibility to local authorities for, for example, all prevention and rehabilitation services, was to reduce the occurrence of 'grey zones' where patients move from the secondary to the primary sector (Christensen/Hansen 2006: 43). Proximity to citizens gives local authorities opportunities to follow and affect citizens' health. Moreover, local authorities could establish a holistic, cross-sectoral and coherent prevention and rehabilitation system, involving a broad range of health concepts in an integrated and localised range of services.

In the regions health care is financed by four kinds of subsidies: a block grant from the state, a state activity-related subsidy, a local basic contribution and a local activity related contribution. The state block grant constitutes the most significant element of financing – approx. 75%. In order to give the regions equal opportunities to provide health care services, the subsidy is distributed by a number of objective criteria that reflect expenditure needs (e.g. demography and social structure of each region). Furthermore, part of the state financing of the regions will be a state activity-related subsidy. The activity pool may constitute up to 5% of the health care expenditure of the regions. The purpose of the pool is to encourage the regions to increase the activity level at the hospitals.

Local authorities must contribute to financing health care. Since 2007 they have acquired a more important role within health care, as they are now responsible for local health care tasks (preventive treatment, care and rehabilitation). The purpose of the local contributions is to encourage local authorities to initiate efficient preventive measures for their citizens with regard to health issues. Local financing consists partly of a basic contribution and partly of an activity-related contribution. Together they constitute approx. 20% of total financing of health care in the regions. The basic contribution is determined by the regions. The maximum limit is fixed by statute. The local authorities (min. 2/3 of the local authorities in the region) are able to veto a region's proposal to increase the contribution in excess of

the price and wage development. The local basic contribution is initially fixed at approx. €134 per inhabitant.

The activity-related contribution depends on how much the citizens use the regional health services. It will primarily reflect the number of hospitalisations and out-patient treatments at hospitals as well as the number of services from general practitioners. In this way the local authorities that succeed in reducing the need for hospitalisation, etc. through efficient measures within preventive treatment and care will be rewarded. As a part of the activity-related contribution to the regions, the regions have to redistribute the contributions to the hospitals. For 2007, in accordance with the agreement between the government and Danish Regions concerning the economy of the regions, 50% of the hospital budgets depended on activity-related contribution.

Free and equal access?

The Danish health care system is based on a principle of free and equal access for all citizens. Thus, the vast majority of health services in Denmark are free of charge for users. However, it should be noted that health insurance is included in income tax, which is one of the highest in the world. Furthermore, the long-held principle of equal access is increasingly challenged by private health insurance and private hospitals. It can be argued that the government's commitment to further developments in this direction weakens the power of the public system of healthcare. Dental care, foot care and psychologists' services must be paid for, and this has consequences for older people's health if they cannot avail of care due to lack of personal resources.

Legislation allows local authorities to charge citizens only for permanent help concerning personal care and practical assistance in the home. They may not charge labour costs of providing personal and practical assistance, but may charge citizens for the actual expenses for raw material and other materials. However, they may include staff expenses when determining payments for meal services, to an agreed ceiling. Thus, user charges account for only a diminutive element of total health care expenses for older people. Residents in older people's housing pay monthly rent corresponding to the costs of running the housing estate (instalments on loans and interest). They can be eligible for income-related support to reduce rent costs. The principle of local self-government means that the local authority determines the service level and allocates resources for the area in accordance with the overall political objectives on service levels. Denmark has no centrally-specified national standards for the quality of services for older people. Legislation defines the overall objectives of social policy and rights to old-age care.

Deinstitutionalised care

Denmark is perhaps the country in Europe that has progressed furthest with desinstitutionalisation of older people. A basic principle of Denmark's LTC policy is that the type of accommodation should not dictate the kind of care provided. Individual needs should guide such decisions. Consequently, Denmark has not built any conventional nursing homes for institutional accommodation since 1987 (Wagner 1997). The trend has been towards subsidised housing for older people in the form of non-profit housing, including individual apartments with care facilities and associated care staff. Unlike conventional nursing homes, housing areas are separated from the service areas.

As a general rule, the local authority has the right of referral to non-profit homes for older people, but may in special cases transfer this right to another body, e.g. independent institutions. Recent years have

seen increasing focus on the treatment of chronically ill patients whom the health sector is unable to accommodate, e.g. terminally ill cancer patients. A range of hospitals have set up palliative wards to accommodate terminal patients. Outreach teams have been set up to support the patients and their relatives when the patient wants to spend the final phase in the home. Finally, several private hospices have been set up to accommodate terminal patients. Costs of referred patients are payable by the local authorities, which have agreements with private hospitals.

Provision for carers

People caring for a close relative at home can claim compensation for lost wages (care allowance). The local authority decides on payment of care allowance. They may grant a care allowance only if a medical doctor assesses hospital treatment to be futile. In addition, the doctor must agree that the dying person can and should be cared for in the home. The patient must agree on establishing the care scheme. The local authority must also provide the possibility of relief or respite care for spouses or other close relatives caring for a person with physical or mental impairment (Law of 01.01.2005 regarding: "… care remuneration in relation to care of terminally ill close relatives"). Relief is performed in the home while respite care takes place outside the home, e.g. in the form of offers of day, night or 24-hour stays at older people's housing or serviced apartments.

In relation to support for dementia patients and their carers, Denmark offers a wide range of opportunities, and there are few who would say they are not informed. Most local authorities have a team of dementia coordinators who act as the first point of contact after diagnosis. They coordinate support from other organisations, e.g. the Alzheimer's Association or relief care run by churches or other voluntary sector organisations, and refer the carer to support groups and a much-used telephone hotline.

In recent years there has been an increasing awareness of, and attention given to health inequalities. There is political agreement that there is a need to respond better to the fact that those with fewest resources in society, often those with a different ethnic background than Danish, generally have poorer health status and fewer remaining healthy years than the general population. A number of projects have focused on improving prevention measures for those from minority ethnic groups (Ministry of Social Welfare, Ministry for Health and Prevention (2008).

The Migrant Health Clinic at Odense University Hospital – the only one of its kind in Denmark – was established in May 2008 after a growing recognition of the existence of a significant group of patients with different ethnic backgrounds who have less access to prevention and treatment at the same high level as other Danish patients. The Clinic's work and experience has been the subject of widespread interest from the Health Protection Agency, political parties, the media and from GPs, social workers and local authorities. The clinic is.

Migrants and refugees represent a distinct group who have become "eternal" patients with severe and complex ranges of symptom including unusual pain conditions, post-traumatic stress, anxiety disorders, diabetes, obesity, etc. Treatment is complicated by language barriers, poor networks and low body awareness. These patients typically attend endless numbers of consultations in the primary sector, private practice specialists, and various hospital departments without coordination or attempts at definitive diagnosis. Furthermore it is increasingly recognised that war trauma can have delayed somatic effects.

The Clinic's main task is to make assure that these groups of patients get early professional treatment and care, clarification on their situation and answers to their questions. Beyond these clinical tasks the aim is to systematically collect and process experiences about disease patterns, survey results and treatment in this patient population and thereby develop guidelines that can support other hospital departments and GPs in the study and treatment of this group of patients.

Free choice and personal budgets

National-policy interest in the conditions of older people has been growing in recent years. In 2002, the Danish parliament passed a number of legislative initiatives (the seniors' package) whose overall objective was to give citizens more free choice.

Since 1993, citizens in need of hospital treatment have been able to choose which hospital they wish to be treated in. Freedom of choice was introduced to meet a desire from patients for greater self-determination. At the same time it was expected that it would even out the differences in waiting times across counties. If a citizen is judged to need treatment on a specialist level, s/he has a further choice between hospital departments which offer treatment on a highly specialised level. Citizens may also choose among private hospitals or clinics in Denmark or abroad if the waiting time for treatment exceeds one month and the chosen hospital has an agreement with the regions' association regarding the offer of treatment. Citizens' option to be treated at another local authority's hospital has created a certain amount of competition among local authorities.

Free choice of housing for older people came into force in 2002, and free choice of personal and practical help providers in 2003. The intention was to dismantle the monopoly on service provision. All older people in need of and eligible for the range of older people's housing on offer are entitled to choose such housing freely within the local authority area as well as across local authorities. However, the local authority of the area in which residence is taken up must also assess the citizen concerned to be in need of such accommodation (double eligibility assessment).

The free choice of personal and practical help provider means that the local authority must ensure older people are given a choice between providers. They can either enter into an agreement with all providers wishing to provide personal and practical help and meeting local price and quality requirements (the approval model). Or a contract may be drawn up with a number of qualified providers (the tender model). The home help recipient may opt personally to appoint someone to perform the tasks, but this person must be approved by and enter into a contract with the local authority. The local authority is responsible for the home help whether or not it is provided by a local or private provider. The choice of provider has no influence on the service level or the extent of home help. In 2008 there were fewer than two private providers for domestic aid in one third of the local authorities, indicating that incentives are restricted (Lee et al, 2010).

A government programme in 2005 earmarked substantial funding for the implementation of an older people's housing guarantee, so that eligible citizens have to wait no more than two months for an apartment, and for the setup of an application pool for better and more flexible home help in the local authority.

It is now enshrined in the Danish social service law § 95 and 96 that all disabled or chronically ill older people are entitled to payment of a cash amount or a voucher – much like a personal budget - in order to choose who is to perform home help tasks, when they are to be performed and how. They become the home helper's employer. However it is thought that few older, chronically ill people have availed of this provision.

3 Key barriers to joint working

3.1 Structural

Seaman (2003) writes that: "new ways of cooperation and collaboration over the boundaries in health care cannot lead to success if we ignore a) informal cooperation emerged organically through daily routine, b) incentives and privileges for the professional groups in health care, and c) to involve the professionals in the development process." Denmark has been debating and deliberating on 'the collaboration agenda' since the 1970s. Successive governments have identified and analysed the same barriers to cross-sectoral cooperation, leading Seaman to suggest that changes to practice and division of tasks cannot be carried through administratively. 'Management' tends to control instead of to innovate.

3.2 Procedural

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.

Shared care, hospital-based home care, integrated care, extended hospital care, etc. imply new patterns of cooperation and new divisions of tasks among workers, institutions and sectors. This is a challenge to the various stakeholders' ability and willingness to cooperate, and threatening well-established positions is unavoidable. Both Danish and international studies document that even though there is general agreement about the need for integration, ideological and cultural differences can obstruct cooperation and communication.

Seaman (2003) mentions a number of myths that need to be dispelled for successful integration:

- The myth that collaboration is hindered because the hospital doctors sovereignly decide when treatment of an admitted patient is to be ended.
- The myth that it is possible generally to determine what is a hospital task and what is a local authority task, which leads to mutual accusations of failure to deal with individual tasks.

- The myth of patients who are discharged from hospital to older people's specialist housing without looking at other possibilities, despite of the fact that these may be better for the patient.
- The myth that the hospital is always the most expensive solution and therefore must be avoided.

This is not to suggest that there is no, or failing collaboration. There is co-ordination of provision between different sections of the local authority (delivering different kinds of home care and other services). There is also coordination between home nurses/social and health assistants and GPs and between home nurses, GPs and specialists from the hospital delivering home care. Some local authorities have case managers to manage the transition between hospital and home; in others the assessment officers handle this. Further research is recommended to evaluate the quality and effectiveness of this coordination.

3.3 Financial

Unlike, for example, in the UK, where health services and social care are funded under two distinct systems, Denmark's health and social care is more uniformly structured (see elsewhere in this report) and geared towards enabling jointly coordinated provision.

3.4 Professional

Those agents in control of the insecurity in a system have the biggest proportional influence. A role which in the Danish health services continues to be filled by doctors, and it is to be expected that they will defend their dominant position (Seaman, 2003). It is the individual patient's doctor who assumes the gatekeeper function and has responsibility for choosing a health pathway for his/her patient. The doctor must treat the patient regardless of the costs but is obliged to act in accordance with the principle of the Lowest Effective Care and Treatment Level. Abbreviated as LEON in Danish, this policy was introduced in an attempt to minimise costs. In this way, efforts are made to complete the treatment of as many as possible in the practice sector before referring them to hospital treatment or treatment by a specialist, etc.

Required expertise and discretionary power of nurses and physiotherapists and occupational therapists have been legally defined and the individual professional is authorised by the health authorities. Descriptions of specific job profiles for these professions are developed by the local authorities and include practical and instrumental care as well as leadership, assessment, supervision, development and education of patients. Also informal carers as well as formal education of students within the professions and vocational training and their descriptions of job profiles for social and health helpers and assistants are developed by the local authorities.

3.5 Issues of status and legitimacy

In Denmark there is not such a great discrepancy in salaries as in some other countries. This may contribute to fewer issues regarding status between, for example, home care workers and the professionally educated staff groups they work with. Salary structures are generally publically available, and follow strict scales regulated by governing bodies and trade unions. Furthermore, a homecare worker with the lowest level of qualification can, in principle, continue along this educational pathway all the way to being qualified as a nurse. Embedded in the work culture in Denmark is a flat, or at least not steep, hier-

archical structure. Decisions come about generally through negotiation aimed at reaching consensus by all parties.

There is a serious issue however, regarding a general lack of qualified care staff. The care units attached to older people's housing and hospitals can employ non-qualified staff on short-term contracts, for example university students who take on a side-job.

4 Key enablers

4.1 Shared vision

All health service agreements must go before the health co-ordination committee for approval by the National Board of Health (Danish Commission on Prevention, 2009). The committee is made up of representatives from the regions, local authorities and the practice sector. Besides these, the regions and local authorities can come to voluntary agreements independent of the health co-ordination committee.

4.2 Clarity of roles and responsibilities

Collaboration and joint responsibilities between regions and local authorities are clearly set out in a number of administrative tasks and regulations. A health co-ordination committee oversees collaboration. Detailed health contracts are agreed and joint working contracts regarding admission and discharge, medical aids, rehabilitation, etc. An example is SAM:BO – which is a new (post-2007 reform) contract between hospitals, local authorities and GPs in the Region of Southern Denmark. The major change is that hospitals must now be in dialogue with the local authority as soon as a patient is admitted, to enable thorough preparation for discharge. The aim is to alleviate potential issues for staff, make the process smoother for the patient and to encourage more and better joint working.

Since 2007 local authorities have set up Health Centres. The general concept is an organisational unit, usually led by senior nurses or physiotherapists, 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, that may include all or some of the following: nurses, physiotherapists, occupational therapists, psychologists, doctors, social workers, dieticians. All health centres have in common the need for strong partnership and joint working between GPs, hospitals, patient associations and training and exercise providers. The stated aims are to increase cross-sectoral working, improve quality, increase recruitment and improve continuity for patients. 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.

5 The funding of long-term care services

Total expenditure on LTC in DK in 2007 was 2% of GNP (Eurostat). In 2008 long term care amounted to approximately 20% of the total health care expenditures. 9% of the long term expenditures were spent on home care and 11% on care related to older people's housing. In 2008 15.5% of the population was aged 65 and over, and 4.1% was 80 and over. The stark reality of the future pressure on LTC services is illustrated by the estimated increase in these figures to 23.3% / 7.8% in 2030 and 24% / 10.3% in 2050 (StatBank Denmark).

In Denmark, LTC (here including home care and older and disabled people's housing) is currently staffed by about 88,000 full time employees. If we compare this to the Netherlands, where the corresponding total is about 165,000 for a three-fold population, this means that there are approximately 50% more staff per capita in Denmark. Explanations include fewer Danish working hours per year and the large proportion of women in Denmark employed outside the home, thus reducing informal care (Lee et al, 2010).

A fixed budget is politically set for each individual local authority. In order to calculate prices in relation to the tender, personal care budgets and payment per type of service provided were introduced. Price setting only comprises part of services delivered by home care and excludes services in older people's housing. Price setting only relates to practical performance i.e. excludes assessments and other services related to organising home care services. As a minimum prices must be calculated for personal care (within and outside normal working hours), meals-on wheels and domestic care (including serving of meals, laundry and cleaning). Prices are calculated by including direct expenses, administration and overhead. Calculation is based on a very detailed description of each specific function but still resulting in prices which differ greatly between local authorities (Lee et al, 2010).

Recent years have seen a shift from direct financing of LTC to the creation of pools to which organisations can apply for funding. Some private funds have ample resources, for example 'Trygfonden' which is a fund associated with a large insurance company.

The National Board of Health have just announced (March 2010) the creation of a reference group for chronic illness with the stated aim to improve coordination of provision across sectors and increase patient education and self-determination. Based on the finance law of 2009 and the ongoing quality reform approximately 79 million euro has been set aside for 2010-2012 to improve services for patients with chronic illness. A Chronic Illness Team and a Steering Group for Chronic Illness have also been established to support and administer this new funding injection (National Board of Health, 2010).

6 Financial sustainability

In Denmark families are not liable to maintain older family members. All citizens are entitled to a public funded basic age-related pension. The pension age is gradually being raised from 65 to 67. As a supplement to the basis pension there are income-based (labour market negotiated) and private individually

funded pension schemes. 18% of the population above the age of 65 is considered at risk of poverty (Lee et al, 2010 - EURHOMAP database).

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, while the current regulations, etc. remain unchanged. Today accounting for 9% of GNP, 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. (Ministry of Interior and Health, Ministry of Social Affairs, 2005)

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 long-term care. 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 and nursing homes. Thus, the development in age-related costs also allows for the effect of people's improved health as seen in increasing life expectancy. Mechanical forecasts should not been interpreted as expressions of unchanged service levels. Thus, the calculations have not allowed for the fact that, 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. Further, mechanical forecasts are not an expression of concretely prioritised future development in costs.

The new 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 expected to contribute to more efficient task solving.

There is political commitment in Denmark to maintaining an overarching economically responsible policy with regard to the health sector, which accounts for a significant part of overall public spending. There is wide agreement that the health of the population should remain high on the agenda. This is reflected in recent the underpinning of this wish in real terms, where the health sector received a substantial increase in funding to improve medicine and treatment in the hospital sector. Coupled with this commitment is that higher demands are placed on health professionals in terms of effectiveness and productivity. Up-to-date, reliable documentation and a reduction in bureaucracy are also stated aims.

One major challenge to the continued sustainability of the health sector is the challenge to attract a sufficient and qualified workforce. It is essential that unnecessary administration and bureaucracy, for example, double registration, are reduced and at the same time that supervision of productivity and quality control of central indicators are improved (Ministry of Social Welfare, Ministry for Health and Prevention, 2008).

7 Good practice

In 2008 the government and local authorities agreed a series of principles that characterise good practice in decentralised administration and governance (Ministry of Social Welfare, Ministry for Health and

Prevention, 2008). A quality reform of the public sector has thus been initiated, which aims to continually renew and develop quality, including conditions for both those in receipt of LTC and staff in the care sector. The quality reform includes the following initiatives that relate to LTC for older people:

Attractive workplaces, including better frameworks for recruitment and retention of staff, good leadership and development of staff competencies.

- *Fewer different helpers* in the home and one permanent contact person.
- *Modernised buildings, facilities and technology*, especially time-saving technology in the older people's sector.
- *Better learning between local authorities and care sectors:* trials will be run to test and develop a system where care staff, residents and relatives can report mistakes and incidents, in order to improve learning across local authority boundaries and sectors.
- *Accreditation:* from 2009 an accreditation system will be trialed at older people's housing, including ongoing assessment of competences. It is hoped that the model will eventually be adopted in other areas of the care sector.
- *Quality contracts:* In 2010 the current local authority service register will be superseded by quality contracts with the citizen, where clear targets for services will be agreed.
- *More free choice* of aids and layout of accommodation.

The Danish Healthcare Quality Programme (DDKM) is a method to generate persistent quality development across the entire healthcare sector in Denmark. The DDKM provides for standards of good quality and of methods to measure and control it.

The objectives of the DDKM are to:

- avoid errors causing loss of lives, quality of life and resources
- ensure that knowledge achieved via research and experience is utilised in all branches of the healthcare sector
- document performance
- achieve the same high quality across geographical boundaries and sectors
- generate coherence in citizens' pathways across sectors – e.g. in the transition from hospital to local healthcare
- render quality within the healthcare sector more visible
- avoid that all institutions must invent their own quality assurance system
- continuously strive towards excellence.

The DDKM aims at including all Danish publicly financed healthcare services and seeks to operate on a cross-sectoral basis. The programme is a result of a collaboration entered between central government and the regions, thereby covering the public healthcare sector in full. Local authorities, private hospitals, and pharmacies have also signed agreements on being part of the Programme. The Programme also reaches out internationally. Accreditation standards must be approved by the international accreditation organisation ISQua, the International Society for Quality in Healthcare.

The national survey of admitted patients' experiences (LUP, 2009) highlighted both some key areas of good practice and some outstanding issues:

- Almost 90% responded very positively/positively to how they were met and treated on admission and 85% felt satisfied at discharge.
- Inclusion of the patient's (83%) and carer's/family's (78%) wishes and knowledge scored high.
- 84% responded very positively or positively to the co-ordination between the ward and the local authority home nurse/home care staff, while 80% were very positive/positive towards the information received from their GP.
- Lower scores were achieved for waiting times to be received onto the ward (50%) and for receipt of written information (47%).

7.1 Telemedicine

In their article on trends in integrated care (2002), Gröne and Garcia-Barbero state that the key to integration of services lies in technologies facilitating exchange of information. Telemedicine can be defined as the movement of medical information over distances. Clinical telemedicine is conducting clinical functions, as well as movement of medical information over distances (Jest 2010). In Denmark telemedicine is increasingly tested, piloted and rolled out in healthcare, including in LTC, where for example COPD can be self-monitored and reported by the patient from home. Telemedicine may improve the integration of health and social services and perform them closer to the patient, changing the locus of treatment to the patient's home. A Danish team has recently drawn up a new model for assessment of telemedicine (MAST) to be used as a basis for decision making in EU on the use of telemedicine applications (Kidholm et al, 2010). The model uses a multi-disciplinary process to summarise and evaluate information about medical, social, economic and ethical issues in a systematic, unbiased, robust manner. It also includes an assessment of the transferability of results found in the scientific literature and results from new empirical studies.

The technology is ready, but the administration and funding of it requires more investment to yield medium and long-term results.

8 Ongoing tensions

A range of studies (including the Danish Welfare Commissions report, 2005 and OECD, 2008) indicate that the continued change in the population make-up, developments in technology and the increasing number of treatment options can be expected to contribute to an increase in hospital sector costs as a percentage of GDP.

International comparisons (including OECD's economic survey, 2008) show that there is a very wide access to public social services in Denmark. However, one of the current challenges is to reduce the long waiting times in being allocated care accommodation. Future tensions include maintaining a balance between continued financial sustainability of the care sector without compromising quality or reducing service levels to those most in need of help. Recruitment and retention of qualified staff is a further major challenge. Moreover, national finance policies need to take account of the growing number of older people and the decreasing number of adults of working age. In order for the health and social care sectors to remain financially sustainable, there is therefore an urgent need to develop resource and

time-saving working methods and to increase knowledge about, and share experience of the most effective methods.

Current concerns in relation to Danish home care are:

- As those with chronic conditions live longer, pressure is put on services. A focus on cost-effectiveness highlights the need for developing shared care between the secondary and primary sectors, and for most services to be placed in the primary sector. Shared care arrangements demands better coordination. There is a demand for both horizontal and vertical substitution (e.g. tasks being transferred from specialist (secondary sector) to generalists (primary sector) and from medical doctors to nurses and from nurses to assistants). Coordinated pathways between hospital services and primary care and social services are being developed, e.g. outgoing hospital based team in relation to Stroke, COPD, Heart Failure and palliative care (www.integratedhomecare.eu).
- The financial systems used in different sectors create barriers for sharing of services across sectors. For example, specialised treatments and rehabilitation define the responsibility as lying with the hospital, resulting in a financial barrier for specialists working in the secondary sector to provide services in the home of the patient or for the home care service to provide specialist care (e.g. peritoneal-dialysis) in the home of the patient. In principle financial barriers between the health sectors should be solved locally by direct agreement between a local authority or groups of local authorities and a region. However, as the barrier is the same for all hospitals and local authorities, a national solution would be recommended.
- With LTC placed primarily in the primary sector, there is a trend towards using the home of the patient as the main arena for providing health care, and there is a higher degree of focus on supporting self-care arrangements for the patient and family.
- There are problems in recruitment and retention of home care staff, resulting in the use of unskilled labour.
- A growing demand for regulation and documentation results in a greater man hours spent in fulfilling these tasks and more bureaucracy (Lee et al, 2010).

9 Embedding good practice in everyday practice

There is a growing awareness in Denmark that good practice should be disseminated faster and better, so that others can benefit from what works. As part of the current quality reform, the government in co-operation with the regions will support a more systematic exchange of experiences in the quality network. Ongoing results in productivity and quality will be published so that hospitals can learn from each other. The National Indicator Project is another example of systematisation of good practice recording and dissemination, and is a joint project of the central government health authority, hospital administrators and GPs' clinics. The aim is to maintain and develop treatment quality at Danish hospitals.

10 References

Campbell, L. & Wagner, L. (2009) 'Draft report on prevention and rehabilitation for older people in long-term care in Denmark, INTERLINKS work package 3', National report of INTERLINKS. Odense: University of Southern Denmark (unpublished).

Esping-Andersen, G. (1990) *The three worlds of welfare capitalism*. Princeton, NJ: Princeton University Press.

Christensen, M./Hansen, E.B. (2006) 'The future role of local authorities in health services' [trans. 'Kommunernes fredtidige opgaver på sundhedsområdet'], Report, Forum for Quality and Development in the Public Sector (FOKUS).

Danish Commission on Prevention (2009) *We can live longer and healthier – Recommendations from the Commission on Prevention for a strengthened prevention strategy* [trans. Vi kan leve længere og sundere – Forebyggelseskommissions anbefalinger for en styrket forebyggende indsats].

Gröne O, Garcia-Barbero M, (2002) *Trends in Integrated Care: Reflections on Conceptual Issues*. World Health Organization, Copenhagen. EUR/02/5037864

Jest, P, (2010) 'Can the challenges facing the health service be solved by innovative application of technology?' Innoevent 2010, Odense University Hospital and Littlebelt Academy of Professional Higher Education, unpublished slide presentation.

Kidholm, K., Bowes, A., Dyrehauge, S., Ekeland, A.G., Flottorp, S.A., Jensen, L.K., Pedersen, C.D., Rasmussen, J. (2010) *The MAST Manual – a model for assessment of telemedicine*, MethoTelemed, Medcom – The Danish Health Data Network and Norwegian Centre for Telemedicine. www.telemed.no/methotelemed

Lee, A., Petersen, K.H., Larsen T. (2010) *Summary Report on Danish Home Care Services*. Under publication for EURHOMAP 2010.

Ministry of Health and Prevention (2008) *Healthcare in Denmark.*

Ministry of the Interior and Health (2003) *Healthy throughout Life – the targets and strategies for public health policy of the Government of Denmark, 2002–2010.*

Ministry of the Interior and Health, Ministry of Social Affairs (2005) *Report on health and long-term care in Denmark.*

Ministry of Social Welfare, Ministry for Health and Prevention (2008) National report on strategies for social welfare and social inclusion 2008-2010 [trans: National rapport om strategier for social beskyttelse og social inklusion 2008 – 2010].

National Board of Health (2010) *Terms of Reference for the National Board of Health Reference Group for Chronic Illness.*

Seemann, J., Antoft, R. (2002) *Shared Care – collaboration and conflict between local authority, GP and hospital* [trans: Shared Care - samspil og konflikt mellem kommune, praksislæge og sygehus].

Seeman, J. (2003) 'Barriers between sectors in healthcare', pp 30-33 in: Jørgensen, S.J., Hendriksen, C., Falkesgaard, N. (Eds.) (2003) *The challenge of chronic diseases. Can we do better?* Workshop, Clinical Unit of Preventive Medicine and Health Promotion, Bispebjerg Hospital, Denmark.

Wagner, L. (1997) 'Long-term Care in the Danish Health Care System', *Health Care Management: State of the Art Reviews – June 1997*, Philadelphia: Hanely & Belfus.

World Health Organization (2009) Denmark: 'Improving the health of older people reduces hospital costs. A compendium of primary care case studies – 38 case studies submitted by 29 countries across the 6 WHO regions', *Nursing and Midwifery, Human Resources for Health, WHO*.