DENMARK

Ministry of the Interior and Health
Ministry of Social Affairs and Gender Equality

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Questionnaire on health and long-term care for the elderly

1. ACCESS

1.1. Healthcare

1.1.1. Mechanisms for guaranteeing access

The Danish healthcare system is founded on the principle of free, equal access to healthcare, which means that all residents in Denmark have access to the services provided by the healthcare system.

The Danish healthcare system is managed by public sector authorities and financed through general taxation. The financial status, labour market affiliation and personal insurance of individual citizens have no influence on their access to public healthcare services.

The healthcare sector is divided into the primary healthcare sector and the secondary healthcare sector.

Secondary healthcare sector
This sector comprises hospitals, managed by the regional authorities. All residents in Denmark have access to free hospital treatment and to childbirth assistance. Non-acute treatment at a hospital requires referral from a general practitioner (GP) or a specialist practitioner.

Primary healthcare sector
The primary healthcare sector comprises services provided by health professionals, which are either funded by the national health service or provided by local authorities.

The national health service is a mandatory, tax-financed insurance scheme managed by regional authorities (counties). The scheme covers the cost of medical assistance (general practitioners and specialist prac-

titioners) and provides reimbursement of a proportion of fees for treatment by a number of health professionals in private practice: dentists, physiotherapists, chiropractors, psychologists and chiropodists. The reimbursement amounts to 25-60% of the fee charged by the health professional – the balance being paid by the patient.

In addition, the national health service provides reimbursement of prescription medicine. The reimbursement rate depends on the individual citizen's aggregate annual payment for medicine covered by the reimbursement scheme. No reimbursement is available if the total annual cost is less than DKK 515 (69 euros)[1]. The reimbursement rate increases in steps as follows: medicine costs between DKK 515 (69 euros) and DKK 1,240 (165 euros): 50%; medicine costs between DKK 1,240 (165 euros) and DKK 2,900 (387 euros): 75%; medicine costs in excess of DKK 2.900 (387 euros): 85%. Children under the age of 18 are always entitled to reimbursement of at least 50% of the price of medicine covered by the scheme.

A number of private health insurance schemes offer insured patients reimbursement of the proportion of costs they must pay themselves as well as the cost of treatment in private hospitals. Private health insurance is not as widely used in Denmark as in many other countries (see 3.1.1.)

In addition to reimbursement from the national health service, retired people may be eligible for supplementary reimbursement – a health supplement – in pursuance of the Social Pensions Act. The health supplement may be granted to cover the amounts people must pay themselves over and above the reimbursement sum paid by the national health service for medicine, dental care, physiotherapist treatment and treatment by chiropractors, psychologists and chiropodists. Eligibility for the health supplement and the size of the supplement depend on the beneficiary's income and assets.

The healthcare services provided by local authorities(municipalites) include nursing in service users' homes, preventive healthcare schemes for children and young people (local authority physicians and health visitors), dental care for children and special dental care (dental care offered to weak older people, who pay a maximum of DKK 300 p.a.for the service). Health services provided by local authorities are free of charge for citizens.

Local authorities must provide physical rehabilitation to temporarily weak older people with impaired functional capacity caused by a disease that has not required hospitalisation. In addition, local authorities must offer help and assistance for the maintenance of physical and mental capacity. The assistance offered is based on an individual assessment of needs and requirements and complies with the service level determined by the local authority.

[1] Exchange rate: DKK 750.00

At least twice a year local authorities must offer a preventive home visit to all citizens aged 75 or more. The purpose of these home visits is to give higher priority to preventive, health-promoting activities in relation to older people by focusing on their safety and well-being and by providing advice and guidance concerning relevant activities and support schemes. The philosophy governing the visits is to encourage older people to utilise their own resources better and consequently allow them to preserve their functional capacities as long as possible.

For many years focus has been on establishing coherent treatment processes for all citizens, though particularly for older people, since their needs for care and treatment typically involve both the primary and the secondary healthcare sector and are consequently the responsibility of both local and regional authorities. In 1994, a new chapter was introduced in Danish health legislation concerning joint planning and collaboration between the various players in the healthcare and associated sectors, particularly the social services sector. According to this legislation, local and regional authorities must collaborate and jointly plan their activities to ensure cohesion, quality and prevention.

1.1.2. Assessment

Waiting time
A number of waiting time indicators or benchmarks are in operation in Denmark. Denmark has chosen to focus on the actual waiting time rather than on the number of people waiting, since this approach is more relevant for individual patients. The number of 24-hour patients who wait for more than three months has remained relatively stable at 7% over the past ten years.

There is free, equal access to healthcare services for all citizens in Denmark. A 1997 study of social patterns in relation to the use of services shows the following:

Use of general practitioners: Men having completed long-cycle higher education, top executives and high-level wage-earners contact their general practitioner less frequently than the population on average. The only group clearly above average is men receiving incapacity pension.

Likewise, women having completed long-cycle higher education working in top positions contact their general practitioner less frequently than the population on average, while women receiving incapacity pension contact their general practitioner more frequently than the population on average.

Use of specialist practitioners: Women generally contact specialist practitioners more frequently than men. A total of 19% of men and 30% of women aged 20-66 contacted a specialist practitioner in 1997. The

frequency for men having completed higher education is above average. The same pattern applies to women.

Use of dentists: Studies carried out in 1980 and 1997 show a social imbalance in the use of dental services. Men and women who have completed higher education (including vocational education) use the services of dentists more frequently than others.

1.1.3. Challenges

Since the late 1980s the reduction of the waiting time for pre-planned treatment at a hospital has been considered the greatest political challenge in Denmark. Consequently, a number of initiatives have been launched to increase activity and reduce waiting time, including allocation of additional resources and initiation of experiments with new organisational structures.

In 1999 a three-year strategic plan for development of the hospital sector was adopted. The plan included a number of goals concerning the reduction of waiting time, for example that at least 85% of all patients must be offered preliminary examinations within four weeks of the date of referral. By the end of 2002, at least 85% of non-acute patients must be offered treatment within three months of the date of referral. In addition new organisational structures have been introduced in the hospital sector, the so called activity-based units, in which the activites in each county are merged inter large physical or organising units across the existing hospitals in order to obtain more quality and efficiency in treatment.

An important challenge to Denmark lies in ensuring effective and optimal use of health staff, since Denmark has a shortage of physicians and nurses in certain parts of the country.

A number of initiatives have been implemented to strengthen efforts relating to older patients with diseases in the field of internal medicine. Central and regional authorities have agreed that local policies must be formulated for the treatment of such older patients. By the end of 2002, regional authorites must prepare clinical guidelines for chronic pulmonary diseases and dementia. In addition, regional authorities must continue their efforts to establish alternatives to hospitalisation and to assess patients as potential recipients of relevant services at an early stage.

1.1.4. Planned policy changes

The Danish government has set aside DKK 1.5 billion to reduce waiting time. The funds will only be released to hospitals if the hospitals are able to document increased activity.

From 1 July 2002, the free choice of hospital has been extended for patients who have waited for more than two months. Such patients will be entitled to treatment at private hospitals and hospitals in other countries wich whom the regional authorities have entered special agreements.

1.2 Long-term care

1.2.1. Access to long-term care

Admission
Danish eldercare is founded on the principle of free, equal access to care. This means that all residents in Denmark have direct access to various services if they are unable to cope on their own because of temporary or permanent impairment of physical or mental capacities. Older people (and people with disabilities) are allocated help and assistance on the basis of applications.

Local authorities are responsible for providing the various services to older people in compliance with legislative requirements. The services in question are outlined below.

The local authorities provide funding for the services through local taxes and block grants from the government.

Danish legislation only allows local authorities to demand payment for permanent practical assistance and personal care in people's homes to a very limited extent. Local authorities are not allowed to demand payment of expenses relating to staff providing personal care and practical assistance, but they are allowed to charge for products and materials used.

Note also that residents in ordinary housing for older people pay a monthly rent that covers the cost of operating the housing facilities. Residents in ordinary nursing homes pay a sum that by and large covers the cost of operating the nursing homes.

According to Danish legislation, local authorities determine the content and extent of the assistance offered (the service level) on the basis of local conditions, and they provide resources for the services in compliance with general political objectives concerning service levels.

Provision of home help
Local authorities must provide help and assistance for personal care and practical tasks in people's homes to the extent that the individual citizens are unable to cope on their own. Such personal and practical assistance is considered help to self-help, i.e. as supplementary help to tasks that the service recipients are temporarily or permanently unable to do or can only do with great difficulty alone. The help therefore involves an element of activation and its primary aim should be to enable recipients to manage on their own, or – if this is not possible – to contribute to the performance of as many tasks as possible.

Help for personal care and practical assistance are offered following a specific, individual assessment of the functional capacities of each individual recipient and his or her needs, as well as on the basis of the service level determined by the local authority. Home help may be offered either temporarily or permanently. The majority of older people who are offered home help are granted home help services on a permanent basis. Home help may be granted irrespective of where the older person in question lives: own home, residential care homes or sheltered housing for older people.

Effective from 1 July 2002, a change of legislation allows older people greater choice in terms of deciding how the help and assistance provided should be performed. All people who receive personal and/or practical assistance now have the general right to exchange the services allocated to them with other services they want. The exchange must be effected within the time framework set by the local authority for the original services granted (on the basis of an assessment of needs and requirements). Irrespective of such exchange of services, the local authority is still responsible for ensuring that each individual citizen receives the help and assistance covering his or her needs and requirements. The home helper must therefore make a professional assessment in each individual situation as to whether a person can reasonably opt out of the services originally planned to obtain other services instead.

Institutional care
A basic principle in Danish eldercare policy is that the housing facility in which an older person lives cannot be decisive as to what kind of care services he or she is entitled to. The provision of care services must exclusively be based on the older person's specific needs and requirements. For this reason, no traditional nursing homes have been built in Denmark since 1987. Instead, subsidised housing for older people has been constructed, including housing with care and nursing facilities and staff. As opposed to conventional nursing homes, this type of housing clearly separates housing facilities and service facilities, which means that specific service areas are at the disposal of residents.

Ordinary housing for older people and traditional nursing home facilities are available to older people (and people with disabilities) who need such facilities. Generally, local authorities have the right to allocate places in ordinary housing for older people, but may in certain cases transfer this right to others, for example independent institutions.

Support for informal care
People who look after close relatives in their own homes may be granted compensation for loss of earnings (care grant). A precondition for the granting of care grants is that a medical assessment has shown that treatment in hospital would be futile. The local authority decides whether such care grants should be paid.

Local authorities must also offer relief and respite care to spouses or other close relatives who look after a person with impaired physical or mental capacity. Relief is provided in the person's home, while respite care is provided outside the home, for example in the form of accommodation at a nursing home or care facility during the day or night, or both.

Welfare measures
Furthermore, local authorities may provide or finance services for older people with the purpose of activation or prevention. The local authorities decide where and how such services should be organised and implemented.

Denmark has a long-standing tradition of cooperation between the voluntary sector and the public sector/local authorities concerning preventive, activating and health-promoting activities. In many cases, local authorities leave it to some extent to voluntary organisations or associations to initiate activities or preventive services aimed at older people, the projects being financed by the local authority.

Services may include sports activities, tuition and lectures and for lonely older people friendly companion schemes.

1.2.2. Assessment

According to Danish legislation, local authorities must stipulate deadlines for decisions concerning allocation of help and assistance for which applications have been submitted. Table 1 shows average deadlines for a number of services in Denmark as a whole (average of deadlines reported by local authorities).

Average deadlines for selected services (Denmark as a whole):	Days
Deadline for decisions concerning personal assistance and care	6
Deadline for decisions concerning help with practical tasks in the applicant's home	8
Deadline for decisions concerning places at nursing homes/residential care home	26
Deadline for decision concerning allocation of a place in sheltered housing (excluding residential care homes)	30

Table 1: Average deadlines for selected services for older people (Denmark as a whole).
Source: National Social Appeals Board, Social Map of Denmark 2001 (2001)

As part of their service declaration or in some other way, many local authorities announce the waiting time citizens must expect in relation to applications for services for older people. Table 2 shows the average

waiting time to be expected in relation to a number of services (average for Denmark as a whole).[2]

Average waiting time for older people to be expected in relation to selected services (Denmark as a whole):	Days
Waiting time for personal assistance and care	4
Waiting time for help with practical tasks in applicant's home	10
Waiting time for help to maintain physical or mental capacity	14
Waiting time for help with a place at a nursing home or in sheltered housing	56

Table 2: Average waiting time to be expected in relation to selected services for older people (Denmark as a whole).
Source: National Social Appeals Board, Social Map of Denmark 2001 (2001)

1.2.3. Challenges

The principle of local government applied in Denmark means that, within the framework of national legislation, each local authority decides the service level in its geographical area, including criteria for the provision of services, and allocates the funds required to achieve the service level decided.

The demographic development represents the most important challenge in connection with older people's access to long-term care, i.e. in relation to the service level offered by individual local authorities.
The increase in the number of older people in the coming decades will – all other thing being equal – mean higher costs on eldercare and so on.

In the years until 2010 the increase in the number of older people needing care will be relatively modest. Please see answer to 3.2.4. and annex 1.

Please also see 3.1.1 and annex 1.

1.2.4. Planned policy changes

In the spring of 2002, the Danish parliament adopted new legislation introducing free choice in the relation to eldercare. The free choice of housing for older people and people with disabilities came into force on 1 July 2002, while the free choice of providers of personal and practical help and assistance will be effective as from 1 January 2003. With this

[2] The average waiting time for the country as a whole is based on an average calculated on the basis of information about projected waiting time supplied by local authorities that publicise information about waiting time. It should be noted that waiting times may be calculated in very different ways depending of, for example, registration methods and local administrative procedures.

new legislation, the Danish government wishes to eliminate the public sector's monopoly on the provision of services.

The free choice of housing means that older people and people with disabilities who need sheltered housing, a place in a residential care facility or a place in a nursing home are entitled to choose a facility outside the geographical area covered by their local authority. If they wish to cohabit with their spouse or partner, they are entitled to a housing unit that can accommodate two people.

The free choice of service provider implies that local authorities must ensure that older people insofar as possible have an opportunity to choose between several service providers. The local authority may either enter into agreements with all service providers wishing to offer personal and practical help and assistance in compliance with the price and quality requirements stipulated by the local authority, or it may invite tenders and subsequently award contracts to a pre-defined number of competent service providers (2-5 service providers).

It is also expected that increased competition in the field of eldercare will lead to rationalisation in the social sector. It is also expected that the possibility to to choose your own provider will give the citizens an experience of better quality. Please see the answer to 2.2.4.

2. QUALITY

2.1 Healthcare

2.1.1 Standards

No national quality standards for the Danish healthcare sector have been issued, but the Government and the regional authorities have decided to prepare such standards to implement an accreditation process for all Danish hospitals.

The Parliament recently adopted legislation concerning patients' right to choose a private or foreign hospital if treatment cannot be provided by Danish public-sector hospitals within a period of two months. In addition, maximum waiting times for the treatment of people with life-threatening cancer and certain conditions of coronary heart disease have been laid down.

Patients' rights are laid down in the Danish Patients' Rights Act, Act No. 482 of 1 July 1998, aimed at ensuring that patients' dignity, integrity and autonomy are respected. Another objective of the act is to protect the relationship of trust and confidence between patients and physicians.

2.1.2 Assessment

In recent years, a number of initiatives have been launched to measure and improve the quality of treatment provided by the Danish healthcare sector. One of these initiatives establishes clinical quality databases, i.e. registers of measurable indicators that illustrate efforts and results in relation to a limited group of patients.

Projects called the National Indicator Project and Good Departments of Internal Medicine have been launched, one purpose being to make it possible to compare the professional quality of various departments and hospitals and to ensure improved cohesion in patient processes.

Further, an experiment is being realised concerning quality declarations as tools to illustrate the quality of a hospital department.

Note again that the Danish Government and regional authorities have decided to prepare a set of national standards for quality measurement in the Danish healthcare sector to implement an accreditation process at all Danish hospitals (see the answer to question 2.1.1).

2.1.3 Promoting quality enhancements

As far as the first part of the question is concerned, please see the answers to questions 2.1.1 and 2.1.2.

Denmark focuses especially on ensuring that conditions are improved for older patients with diseases in the field of internal medicine through better organised hospitalisation processes, including better coordination between the healthcare and the care sectors.

2.1.4 Challenges

The main challenge at organisational and administrative levels is to create consensus and support for a nationwide Danish quality assessment model, including formulation of relevant, measurable indicators for quality in the Danish healthcare sector.

2.1.5 Planned policy changes

The largest single quality project calls for development and implementation of a nationwide Danish quality assessment model.

In addition to this project, other quality projects and initiatives will either continue or be developed (please see the answer to question 2.1.2).

2.2. Long-term care

2.2.1. Standards

Danish legislation outlines overall objecctives for social policy as well as rights in relation to eldercare.

The principle of local government applied in Denmark means that, within the framework of national legislation, each individual local authority decides the service level in its own geographical area and allocates the funds required to achieve the service level decided.

However, Danish legislation requires that local authorities prepare quality standards, including a description of the service level decided by the local authority.

The quality standards must describe the services available to citizens who need personal or practical help and assistance, physical rehabilitation or general physical exercise to be provided at the local level. Descriptions of the nature, scope and performance of help and assistance must be concise and must include quality objectives (operational objectives), which the local authority can subsequently use to evaluate performance and results.

The quality standards must be adopted by the local authority, which at least once a year must follow up on the quality and management of the services provided. The follow-up should be based on the operational objectives formulated in the quality standards, so that it is also a follow-up on political targets relating to the services provided by the local authority, including political targets for absenteeism and health and safety standards in service provider organisations.

If used correctly, local authority quality standards can ensure coherence between political decisions concerning service levels and the resources set aside for them, decisions concerning help and assistance, fundamental values governing the performance of services (including value-based management) and the help and assistance provided to individual citizens. Additionally, the quality standards ensure transparency as regards citizens' rights, and they give both users and citizens a good basis for evaluating the performance of local authorities and service providers.

2.2.2. Monitoring and promoting quality

No centrally formulated national quality standards exist concerning the quality of services provided to older people, and there are no statutory certification schemes in operation in Denmark.

A voluntary, private certification scheme called Certification of Quality Management and Development of Eldercare has been set up to monitor and develop the quality of services provided to older people through recognition. The certification scheme covers all services offered in the

field of eldercare. To obtain certification, providers of eldercare must meet certain standards in three key areas: management; objectives and services; and process and resource management. Having obtained certification, service providers are entitled to describe their services as 'quality-certified eldercare services' and to use a certification logo.

The employees effecting personal and practical care and assistance are to a great extent recruited from the basic social and health education and training programmes.

The basic social and healthcare helper education and training programme runs for 14 months, while the second part runs for 20 months and leads to a diploma as social and healthcare assistant. The programme alternates between school tuition and on-the-job training in regional and local authorities.

Effective from 1 January 2002, a reform of the education and training programmes aims at ensuring better professional awareness coupled with upgraded skills and competencies of students.

Various programmes of continuing education and training are available on an ongoing basis for people working in the social sector (social and healthcare staff, nurses, managers, etc).

2.2.3. Challenges

In connection with the introduction of the free choice of service providers, local authorities must formulate and publicise quality and price requirements applying both to public and private service providers (please see the answer to 1.2.4).

This requires that local authorities make a clear distinction between their function as a local authority and their function as a service provider.

Another precondition for ensuring the framework required to give citizens a free choice of service providers and to achieve healthy competition in the field of home care is that local authorities are able to isolate the costs of home help services and make them transparent.

It is also a crucial, all-important precondition for concluding contracts with providers of personal and practical services that local authorities prepare quality standards that very precisely describe the service level wanted. Quality standards contribute to ensuring that service providers know the service level and perform the services in compliance with decisions. This includes performance of services meeting the quality standards set by the local authority.

The free choice between public and private service providers also implies that both local authorities and service providers focus on citizens' perception of the quality provided. In future, all parties involved will

therefore need to be better informed about user satisfaction with the help and assistance provided – i.e. the perceived quality. Local authorities will need information about user satisfaction to ensure that service providers supply service of the quality agreed (see above). Information about user satisfaction will also impact on service providers, since service users will be able to choose providers on the basis of the service delivered.

Furthermore, it must be ensured that citizens have access to information enabling them to compare the quality of services supplied by various service providers in the market.

2.2.4. Planned policy changes

In connection with local authorities' obligation to prepare quality standards (see 2.2.1), the Ministry of Social Affairs will in the autumn of 2002 initiate a project focusing on follow up - practices in a number of local authorities as well as their use of quality standards in day-to-day operations. The aim of the project is to develop a general model for better practices, follow up - procedures and embedding of quality standards in local authorities, and to ensure widespread use of the model.

Another significant aspect is that with a view to supporting and promoting the free choice of providers of personal and practical help and assistance, the Danish Ministry of Social Affairs will establish a central database with the data needed to ensure a genuine free choice both for citizens and local authorities and to create a transparent market for service providers. The database must include all price and quality requirements formulated by local authorities for home help as well as the names of all service providers who have been approved to supply home help.

The target group for the database is local authorities, citizens, enterprises and other stakeholders who want to monitor the actual realisation of free choice in the field of home help. The database will be updated continuously so as to enable all stakeholders to see the price and quality criteria a local authority applies in relation to the approval of service providers, as well at the names of firms approved as providers of services.

Finally, it should be mentioned that comparable information about individual institutions and services in the field of eldercare must become more easily accessible to citizens so as to facilitate citizens' choice between various public services available and to compare the quality of services. The increase in comparable information to users will improve citizens' opportunity to participate in the evaluation and discussion of various services, since such information will ensure greater openness about the nature and scope of local authority services.

Various guidelines including guidelines concerning services for older people have been prepared to facilitate local authorities' efforts to make

comparable information available to citizens. These guidelines will be revised in 2002/2003.

3. SUSTAINABILITY

3.1. Healthcare

3.1.1 Healthcare/expenditure and financing

The table below illustrates developments in public health expenditures in Denmark in the period from 1990 to 2000. It shows public and private health expenditure as well as figures relating to insurance. Note that insurance figures are net figures, which means that the figures represent the profits and administrative costs of the insurance companies. Insurance company payments for treatment and other services are included in the private health expenditure figures.

About 80% of health expenditure is publicly financed. Insurance accounts for only a relatively small proportion of total health expenditure
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	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Public health expenditure	7,035	7,236	7,421	7,619	7,736	7,788	8,018	8,219	8,488	8,811	8,951
Private health expenditure	1,533	1,473	1,533	1,600	1,721	1,673	1,758	1,834	1,949	1,993	2,083
Insurance	209	213	190	183	179	170	183	192	208	228	229
Total health expenditure	8,778	8,922	**9,144**	**9,403**	**9,630**	**9.630**	**9,958**	**10,245**	**10,644**	**11,032**	**11,262**

***Table 3**. Total health expenditure 1999 – 2000 – prices in million euros. Source: Statistics Denmark*

Expenditure relating to people aged 65+
In 1999 about 54% of total health expenditure in Denmark could be broken down on age groups by means of various registers. Unfortunately, the registers far from cover the entire healthcare sector. Of the figures that can be broken down by age group, 36% is spent on citizens aged 65 or more.

Public-sector authorities, primarily regional authorities provide the majority of funding for the Danish healthcare sector. The regional authorities finance healthcare through taxation.

Funding through insurance is not as common in Denmark as in many other countries. Public/private co-financing or full private financing is seen in areas such as dental care, medicine purchase, physiotherapy and chiropractics.

3.1.2 Healthcare/expenditure trends

The development of demand and the political priorities at regional and central level are crucial for future growth in hospital sector expenditure. Demographic changes are expected to generate an increase in expenditure of a little less than 0.2% annually in the period up to 2010. In recent years, the increase in healthcare expenditure has been much higher than 0.2%.

3.1.3 Cost control mechanisms

The Danish healthcare sector obtains the majority of its funding from public-sector authorities, i.e. by central and regional authorities. User payment is not used as a cost control mechanism in the hospital sector, the reason being a political wish to ensure free and equal access to hospital treatment for all citizens.

Public healthcare expenditures are mainly controlled by means of financial agreements between central government and local authorities. Hospital expenditure is controlled by means of target and framework management, which has proved to be an effective method of budget control. The vast majority of regional authorities combine target and framework control with contract management.

In addition to taxation by regional authorities, health expenditures are to a certain extent controlled by means of block grants.

There is no control of the demand for general practitioners, since all citizens can consult their GP without being charged. However, the regional authorities are able to exercise a degree of budget control by regulating the number of practitioners allowed to work under the national health insurance system. Several regional authorities have introduced incentives to reduce the use of out-of-hours services.

Services provided by specialist practitioners, physiotherapists, chiropodists and psychologists are only available on the basis of a referral from their GP. The reimbursement provided by the national health insurance system of fees charged for treatment by dentists and chiropractors is not conditional upon a referral from a GP. In return, user charges are substantial.

As regards medicine, several initiatives have been taken to keep price increases and public drugs expenditure in check.

- A method has been introduced for calculation of national health insurance reimbursement of medicine, which means that calculations of reimbursement sums are based on average prices in Europe.

- The sale of over-the-counter medicine has been liberalised so that the products are no longer exclusively sold by pharmacies.

- A reimbursement system based on means criteria has been introduced.

- Pharmacies are required always to select the least expensive medication among products treating the same condition. This is called analogue substitution.

As mentioned above, all Danish citizens have free, equal access to treatment. Physicians must treat patients without regard to costs. To minimise costs, the principle of the 'lowest effective cost level' applies. This means that as many people as possible receive final treatment in the primary sector rather than being referred to treatment at a hospital, by a specialist practitioner, etc.

In 1999, the Parliament adopted the Public Health Programme 1999-2008. The programme focuses on three age groups in particular: children, young people and older people. The objective in relation to older people is that services offered to them must aim at maintaining their social, physical and mental capacities as long as possible.

A new health programme is being prepared, scheduled for completion by September 2002.

3.1.4 Healthcare/challenges

The most important political challenge in the Danish healthcare sector is to increase activity and minimise or eliminate waiting time while also keeping costs in check. Healthcare costs relating to older people will increase considerably concurrent with the increase in the proportion of older people in the population, and this fact constitutes a particular challenge. Consequently, special preventive measures are to ensure that an increased number of older people will be able to live longer without contracting chronic, costly diseases. For this reason cost-effective preventive activities will be given higher priority.

3.1.5 Planned policy changes

Funding for activities must be targeted at all levels so as to ensure that each individual unit has incentives to treat more patients. This means that an increasing proportion of healthcare expenditure must be linked to specific activities and that each performing unit receives a part of the funds available.

Benchmarking, yardstick competition and performance indicators will be used more systematically so as to ensure that individual hospitals, individual general practitioners and other providers of healthcare services will always be able to compare their own performance with that of the best performers.

Prevention and treatment methods will continue to be targeted at the group of older people suffering from long-term sickness. Since a growing proportion of the older population have enjoyed good health for a number of years and are subject to fewer physical and mental restrictions, the new government's health programme will also prioritise special health initiatives aimed at healthy older people.

3.2. Long-term care

3.2.1 Expenditure and financing

In 2001 the net operating costs of long-term care amounted to DKK 28.6 billion from age 67+.

In recent years, costs have successfully been maintained at by and large the same level (see the table below). Measured in price and wage level terms 2002, the slowly increasing costs are largely equal to the projected cost increase caused by demographic development.

	1993	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
DKK	23.8	24.1	23.1	23.8	24.0	24.3	24.2	24.3	24.6
Euro	3.17	3.21	3.08	3.17	3.20	3.24	3.23	3.24	3.28

Table 4: Public net operating costs of services for older people, billion kroner/euros (price and wage level 2002).
Source: Local authority accounts
Note. Exchange rate, euro/ DKK: 750
Note. There is a reduction in net operating costs from 1994 to 1995 which is caused by the introduction of house rent in connection to the compulsory pension payment to people living in nursing homes and sheltered houses.

Local authorities finance the costs through local taxes, block grants from the government and possibly equalisation amounts received from other local authorities. There are no specific funding mechanisms.

Total net operational costs on elder care rose by 1.5 billion DKK during the period 1995-2001 equal to an average increase of 1.1% in real terms. Expenditure is now upwards of 25% of total local authority expenditures on services.
The increase in expenditure to a certain extent reflects an increase in the number of older people. Average net operational costs in relation to the number of persons over 67 increased from 32,600 in 1995 to 34,700 in 2000. In relation to the number of persons over 80 average costs, however, were rather stable over the last few years.

Average net operational costs per older person varies considerably between local authorities. The spread is from a minimum of DKK 25,000 per older person over 65 in the least expensive local authority to a maximum of DKK 48,000 in the most expensive as far as average expenses per older person are concerned. Data hereon must however be subject to reservation.

A greater part of the differences are due to the fact that the composition of the group of older persons varies, including their demand for care and their age.

Just as local authority expenses on older people vary from one local authority to the next so does the composition of the benefits and the general services that the local authority offers to their older citizens. A survey carried out by the Ministry of Social Affairs shows that there is a certain discrepancy in the productivity between local authorities, which indicates that there is potential for higher efficiency in the local authorities that has low productivity to day.

3.2.2 Cost control mechanisms

No payment is charged from citizens in connection with long-term care. However, a part of people's old age pension is withheld if they live in a facility for older people (nursing home or sheltered housing).

The local authorities are charged with ensuring all necessary planning and control, including comparisons with other local authorities. The local authority budget and accounts system, the governmental statistics system as well as a number of research and analysis institutions support these activities.

Individual local and regional authorities also have to ensure all necessary coordination between the eldercare sector and the healthcare sector. This includes use of solutions in the interface between the two sectors that are optimal from a national economy point of view.

3.2.3. Challenges

The demographic development is the most important challenge as regards the viability of provisions concerning long-term care (see annex 1). Up to 2010, the number of older people will slowly grow, which is expected to entail a modest real growth in the cost of eldercare (see table 5 below).

		2002	2003	2004	2005	2006	2007	2008	2009	2010
DKK	Maximum	24.8	24.9	25.1	25.3	25.5	25.7	25.9	26.3	26.6
DKK	Minimum	24.7	24.6	24.7	24.8	24.8	24.9	25.0	25.2	25.5
Euro	Maximum	3.31	3.32	3.35	3.37	3.40	3.43	3.45	3.51	3.55
Euro	Minimum	3.29	3.28	3.29	3.31	3.31	3.32	3.33	3.36	3.40

Table 5: Estimate of net public operating costs of services to older people in a scenario of an unchanged service level, billion kroner/euros (price and wage level 2002).
Source: Calculations based on the population forecast issued by Denmark Statistics (maximum) and the DREAM population forecast issued by the Danish Ministry of Finance (minimum).
Note. Exchange rate euro/DKK: 750

After 2010 the number of older people and consequently the need for long-term care are expected to increase considerably faster than before.

Projections on developments in population show that, based on simplified estimates, the expenditure triggered off by the demographic development will reach its peak by 2040 when expenditue on services to older people is estimated to be approx. 48% higher than in 2002 corresponding to upwards of 40 billion DKK in 2001 prices.

The demographic development may trigger various problems in relation to the recruitment of qualified manpower in the field of eldercare.

To this should be added increased demand as a result of general welfare trends. However, it should be borne in mind that, in general, the health of older people will be better and that older people will be better able to cope with the changes that occur in connection with old age. This has not been taken into consideration in the projections of table 5.

Finally, the number of older people from ethnic minorities will increase in the years to come, which will add further challenges to the eldercare services provided by local authorities.

3.2.4. Planned policy changes

Since demographic development will put pressure on public finances in the future, a viable fiscal policy requires funds to be set aside for the future. Denmark will ensure this through massive surpluses on the government budget of 1.5-2.5% of GDP on average in the period up to 2010, whereby the national debt and consequently public sector interest payments will gradually be reduced. The gross national debt will thus be almost halved from a little less than 47% of GDP at the end of 2000 to 24.5% of GDP at the end of 2010. The consequent significant reduction in interest payments will enable Denmark to pay the additional expenditure required as a result of the rapid increase in the number of older people after 2010.

The period up to 2010 will be used to introduce new solutions to adapt efforts and initiatives in the field of eldercare to future requirements.

In June 2002, the Danish Parliament adopted an act on the free choice of providers of personal and practical help and care. The primary purpose of this act is to allow older people receiving personal and/or practical help a choice between several service providers. With this act, the government wishes to give older people needing help better opportunity to influence the quality of the services. At the same time, the new act challenges local authorities to control costs in the new scheme of free choice.

By enhancing transparency in resource use through the free choice of service provider, local authorities are expected to be in a better position to make the supply of eldercare services more efficient without jeopardising service quality. A productivity analysis made by the Ministry of Social Affairs in 2001 showed that the potential for improvement in local authorities is up to 40% of the current service output, assuming that all local authorities will reach the same level of productivity as the most productive local authorities.

Tables:

Table 1: Average deadlines for selected services for older people (Denmark as a whole)
Table 2: Average waiting time to be expected in relation to selected services for older people (Denmark as a whole).
Table 3. Total health expenditure 1999 – 2000 – figures in million euros.
Table 4: Public net operating costs of services for older people, billion kroner/euros (price and wage level 2002).
Table 5: Estimate of net public operating costs of services to older people in a scenario of an unchanged service level, billion kroner/euros (price and wage level 2002).

Annex 1:

Development in the proportion of older people in the population

	1/1 2002	1/1 2020	Change	
			Number	Per cent
18 – 64 years	3.396.844	3.408.346	11.502	0.3
65 – 74 years				
Men	193.882	298.008	104.126	53.7
Women	221.369	316.828	95.459	43.1
Total	415.251	614.836	199.585	48.1
75+ years				
Men	139.968	195.493	55.525	39.6
Women	239.365	273.124	33.759	14.1
Total	379.333	468.617	89.284	23.6
65+ years, total	794.584	1.083.453	288.869	36.4

Source: Danmarks Statistik (www.statistikbanken.dk)

Annex 2:

Local government

Local government in Denmark consist of 14 regional authorities (*amtskommuner*) and 275 primary local authorities (*primærkommuner*), including the two metropolitan areas of Copenhagen and Frederiksberg. Regional and local authorities are independent, politically controlled organisational units empowered to levy taxes individually. The bodies charged with local political management – regional, local or district councils – are elected every four years in ordinary elections.

Local authorities are responsible for planning and providing a broad spectrum of social services, including care for dependent older people, day-care facilities, rehabilitation, and job-activation for unemployed people not covered by unemployment insurance schemes. Local authorities also implement social security schemes including old-age pensions as well as decisions on award of anticipatory pension, sickness benefits and child allowance, the size of such cash benefits being determined by statute. Finally, local authorities pay cash assistance benefits under the social assistance scheme. The size of these benefits is also determined by statute.

Regional authorities are responsible for tasks and services requiring a larger population base and more specialised knowledge. Their primary responsibility is hospital management and – through the Health Care Reimbursement Scheme – the private practising healthcare sector. Regional healthcare expenditure accounts for about half of the regional authorities' total revenue. Their primary social responsibility in terms of expenditure is to provide suitable housing for people with severe physical or mental disabilities. Regional authorities advise local authorities on support and treatment of the most exposed groups in the community. They also advise citizens, for instance parents of disabled children.

In Copenhagen and Frederiksberg, regional and local authority responsibilities are merged into one authority.