ESPN Thematic Report on Challenges in long-term care

Denmark

2018

Jon Kvist
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European Social Policy Network (ESPN)

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Summary

Danish long-term care (LTC) aims to increase the quality of life of persons in need of care and to increase their ability to take care of themselves.

Denmark has perhaps the most universal LTC system in the world. In 2016 the following were the percentage shares of persons above 65 years of age covered by the system's four main elements:

1. 8.4 percent received a preventative home visit;
2. 1.0 percent undertook rehabilitation;
3. 13.1 percent received home help;
4. 7.2 percent resided in elderly homes.

LTC is organised and delivered by 98 municipalities and, for certain health benefits, by 5 regions.

LTC is financed through general taxation and generally provided free of charge. The main exception is food services where a user's charge cannot exceed EUR 7 per meal or EUR 467 per month.[1]

The trend towards the deinstitutionalisation of elderly care continues, most recently with a renewed emphasis on rehabilitative measures. Such measures have become a compulsory part of home help offered prior to the calculation of an elderly person's need for personal and practical home help.

However, incremental cuts have over the last few years resulted in significant reductions in the scope of LTC.

Population ageing in particular constitutes a formidable challenge for the system of LTC itself, as many LTC professionals are reaching retirement age, at the same time as demand is unlikely to decrease – despite success in improving elderly people's health and autonomy.

Major recent reforms include the 'dignity billion' and the national action plans for dementia and for the older medical patient. These plans are directed towards better-quality LTC by, for example, professionalising, integrating and coordinating multidisciplinary measures as well as better involvement of elderly people and their relatives.

The report suggests recommending an extension of the new socioeconomic investment model to the elderly population, in particular to rehabilitation measures.

Finally, Statistics Denmark publishes data on 23 indicators of relevance to elderly care that, together with data on the indicators in the new reform initiatives, provide a substantial list of information relevant to LTC.

[1] 100 euros equal 744.5455 DKK (monthly average, January 2018) (nationalbanken.dk).

1 Description of the main features of the country's long-term care system(s)

The dual goal of Danish long-term care (LTC) is to increase the quality of life of persons in need of care and to increase their ability to take care of themselves. The system is probably the most universal and comprehensive system in the world. Most LTC is provided by way of residence in institutional care, or special housing with nurses attached, or home help. Most of the system is organised and financed at the local level, where 98 municipalities adopt and deliver the bulk of LTC services. The regional level is responsible for primary health. There are no LTC policies at the central level, albeit national politicians agree on general regulation and often strike budget deals that set the economic conditions for local policies. Whereas national politicians define the principal elements in LTC, it is local politicians who define how much should be delivered, by whom, and under what conditions. Popularly speaking, this leads to 98 municipal versions of the Danish LTC system.

The LTC system consists of five elements:

1. preventative measures
2. rehabilitation
3. home help
4. homes for the elderly
5. other measures, including personal assistance and food services.

Municipalities offer the elderly a variety of **preventative measures**, including preventative **home visits** and activity offers. Depending on their age and life situation, elderly people are offered a preventative visit that focuses on their functional, psychological, medical, and social resources and challenges. Everyone above 75 years of age is offered a visit. The offer is also made to persons between 65 and 79 years of age who are in a special risk group because they, for example, have lost their spouse, are isolated or have been discharged from hospital. Finally, persons above 80 years are offered a visit on a yearly basis. As of 2016, municipalities can organise public arrangements as an alternative to individual visits for groups that normally decline home visits. In 2016, 93,424 persons received a preventative home visit, down from 122,794 in 2010 (Danmarks Statistik, 2018).

The scope and kind of **activity offers** differ between municipalities and include visit schemes, workshops, education, talks, and sports for the elderly. The offers can be delivered by municipalities themselves, by associations and organisations, and by citizens. Users should have equal responsibility and influence on offers, and if they include elderly people the local elderly council must be consulted. A food service may also be offered – that is, food prepared outside the home and brought to the elderly or to a local elderly centre.

Rehabilitation is part of the home help service. When a citizen applies for home help, the municipality must offer a rehabilitation programme prior to assessing the need for home help. The municipality must also offer rehabilitation to alleviate reduced physical function caused by illness, and maintenance training aimed at preventing loss of functional capacity or to maintain or improve such capacities. The aim of rehabilitation is to make citizens more autonomous and give them a greater sense of independence in everyday life. The goals of the rehabilitation programme are set jointly by the municipality and the elderly, and the programme must be holistic and cross-disciplinary. The programme can be delivered by private providers. The programme contains one or more of the following elements: physical training; a medication review; nutritional intervention; ADL training (training in activities of daily living); physical aids and changes of environment; and measures addressing loneliness. In 2016, 11,279 persons above 65 years undertook rehabilitation (Danmarks Statistik, 2018).

Home help is a central part of LTC and covers personal care, practical help and support, and food services. Personal care consists of help in maintaining personal hygiene, to get dressed, to get out of bed, and to eat. Practical help covers cleaning, laundering and shopping. Home help is given to persons who cannot undertake these activities themselves. The amount of home help is initially decided by a municipal case worker after a home visit and is later also informed by the result of the rehabilitation programme. Albeit municipalities have different practices, many municipalities differentiate between five levels of functionality, giving rights to varying amounts and types of home help. Claimants received an average of 5.8 hours of personal care and 0.7 hours of practical help on a weekly basis (Danmarks Statistik, 2018). In total 538,950 hours of home help weekly was delivered in 2016 (Danmarks Statistik, 2018). In total 146,214 persons were entitled to home help in 2016 (Danmarks Statistik, 2018).

Elderly people are offered a **choice** between at least two different providers of home help, one of which can be a municipal one. In 2016 35.7 percent of home help claimants chose a private provider (Danmarks Statistik, 2018). Besides the free choice of a provider the elderly are also entitled to appoint a person to carry out the tasks. This person must be approved by the municipality, which acts as employer, sets out the services to be provided, and ensures help is provided in case the person gets ill. The scheme also approves family members but is only relevant for persons under pensionable age.

Persons with special needs have a right to a place in a home for the elderly. Today there are **five types of homes for elderly**:

1. nursing homes *(plejehjemsboliger)* are institutions for the elderly with permanent staff and service areas;
2. sheltered housing *(beskyttede boliger)* are connected to institutions for the elderly, with some having permanent staff and service areas and others operating with emergency call arrangements etc.;
3. elderly housing *(plejeboliger)* consists of homes for the elderly with associated staff and service areas;
4. general elderly homes *(almene ældreboliger)* are designed to be suitable for the elderly and persons with disabilities but they do not have permanent staff or service areas;
5. private care accommodation *(friplejeboliger)* consists of rental accommodation for persons with extensive needs for service and care, with permanent staff and service areas outside the municipal sector.

Which accommodation the elderly person resides in will depend on their preferences and care needs; as well as on the local situation with regard to policies on, and vacancies in, nursing homes and in general elderly homes. The needs assessment takes into account physical, mental and social aspects, but not the age of the applicant. If the functional capacity of the elderly person is markedly reduced in their existing home and the latter cannot be made suitable, they may be granted a place in a home for the elderly.

After going on to a waiting list, elderly people must be offered a place in a **nursing home** *(plejehjem)* or in **elderly housing** *(plejebolig)* within two months. Elderly people who have been granted a place have the free choice of applying for a home in another municipality or in a specific institution. Elderly people who want to keep living with their spouse or partner must be offered a home suitable for two persons. The number of places in elderly care accommodation was 79,970 in 2016, slightly down from 82,059 in 2010 (Danmarks Statistik, 2018). The average duration of stay in a home for the elderly is 32 months (Sundheds- og Ældreministeriet, 2016). In 2013 the average age on entering an elderly home was 83.7 years (Sundheds- og Ældreministeriet, 2016). About 50 percent of residents in nursing homes had one or more chronic diseases and 42 percent in elderly homes had dementia (Sundheds- og Ældreministeriet, 2016).

In addition to the four core elements of LTC – preventative measures, rehabilitation, home help, and homes for the elderly – there are a number of **other LTC measures**. Municipalities offer **food services** both to persons in their own homes and in nursing homes. Although municipalities are allowed to ask for payment, most municipalities subsidise food services. Nursing homes may not charge more than EUR 467 monthly, and persons not living in a nursing home cannot be charged more than EUR 7 per meal.

The special **needs of relatives** are still largely neglected. This is the case even though relatives often undertake considerable caring responsibilities, e.g. close relatives of persons with dementia spend six hours per day on average on nursing and care (Sundheds- og Ældreministeriet, 2016). There is respite and flexible care leave of up to six months, which can be split and shared between people attached to the labour market, e.g. wage earners, self-employed people, and unemployed people, but not persons above pensionable age (Kvist, 2016). Most benefits-in-kind that support the relatives of care-dependent people are not run by public authorities but by voluntary organisations.

Municipalities are increasingly working towards involving relatives and voluntary organisations in LTC activities. Many municipalities have a policy that provides a framework for how relatives may be engaged in care activities (Sundheds- og Ældreministeriet, 2016). All municipalities involve voluntary organisations in organising, for example, activities for the elderly, such as walks and visits.

The important caring roles of voluntary organisations and of the relatives of care-dependent persons are increasingly recognised and various initiatives have been taken to strengthen their role.

The system is regulated nationally but delivered locally by the 98 municipalities. Five regions are responsible for primary health services.

Most LTC benefits are **free of charge**.

Most LTC benefits are **financed by general taxation** that is raised at both the local and state level.

Each year the municipalities determine **quality standards** for home help, rehabilitation, and training services: these are publicly available, and used in tenders and in audits. The purpose of quality standards is to ensure that citizens get professional, dignified and qualified treatment in the event that they need help and support. Municipal audits include at least one unannounced visit to nursing homes and care homes.

2 Analysis of the main long-term care challenges in the country and the way in which they are tackled

2.1.1 Assessment of the challenges in long-term care

How accessible and adequate is LTC? In the wake of the economic crisis, Parliament adopted stricter regulation of municipalities' finances, which in turn were even more prudently managed than required. As a result, there has been a de facto retrenchment in certain areas despite an absence of explicit policies at the central or local level. De facto retrenchment has also occurred to the extent that the level of provision has remained stable whilst the number of elderly people, especially those above 80 years, has gone up. The number of elderly people above 65 years of age rose from 902,859 persons in 2010 to 1,116,062 persons in 2018 (an increase of 23.6 percent). In the same period the number of persons above 80 years rose from 227,510 to 256,694, an increase of 12.8 percent.

The weekly number of home help hours has gone down. Total home help went down by 18 percent from 656,142 weekly hours in 2010 to 538,950 in 2016 – equal to 6 million fewer hours of home help annually (Danmarks Statistik, 2018). In particular practical help has gone down by 33 percent, from 135,970 hours in 2010 to 91,691 in 2016.

The number of persons receiving home help decreased by 12 percent, from 162,769 in 2011 to 142,865 in 2016 (Danmarks Statistik, 2018). This can only in part be ascribed to elderly people having generally better health and functional capacities.

The share of the elderly living in nursing homes and care accommodation is falling. From 2010 to 2016, for example, the share of the elderly above 75 years in institutional care fell from 15 percent to 12 percent. (Danmarks Statistik, 2017 NYT 37). The same decline can be noticed for other age groups.

There were 1,385 persons on a waiting list for nursing home and care accommodation in 2016, i.e. at a level that has remained stable since 2010 (Danmarks Statistik, 2018). The average waiting time varies between the 98 municipalities, ranging from 0 in 12 municipalities to 97 days in the municipality of Egedal (Danmarks Statistik, 2018). 33 municipalities have a shorter waiting period than 2 weeks, and 9 municipalities have a longer average waiting time than prescribed by the guarantee of 2 months.

In sum, access to LTC has become less universal with the gradual shift away from institutional care to home help that started in 1987 and with de facto cuts in home help in recent years. Policies in the pipeline (see assessment of policy reforms below) are likely to result in more resources in home help. However, as most LTC is provided free of charge and is not dependent on work record, social divisions have not emerged.

LTC is **challenged** by population ageing and changing demands. Population ageing means the elderly will make up a larger share of the population while children and young people will make up a smaller share. The average age of the population will increase from 41.3 years to 43.8 years by 2060 (Danmarks Statistik, 2017). Average life expectancy has continued to rise, from 74.5 years in 2000 to 79.0 years in 2017 for men and, similarly, from 79.2 to 82.9 for women (Danmarks Statistik, 2018HISB7). Albeit the health of the elderly has improved markedly, it is questionable whether this can totally offset a higher demand for LTC caused by population ageing.

When asked about the quality and stability of their home help, a large majority say they are satisfied or very satisfied. Between 83 and 86 percent said they were satisfied with personal and practical help given to them either in their own home or in a nursing home in 2015 (Danmarks Statistik, 2018). Similarly, 74-85 percent say they are satisfied or very satisfied with the timeliness, stability and uniformity of services (Danmarks Statistik, 2018). Between 65 and 75 percent are satisfied with the number of different helpers in the services provided (Danmarks Statistik, 2018).

The long-term **trends** toward more autonomy for elderly people and less institutionalisation of LTC are continuing by new means. The integration of rehabilitation in home help has markedly expanded the scope of **social investment** or active ageing. By developing, reinstating and maintaining functional capacities rehabilitation aims to allow the elderly as much autonomy as possible. In the 1990s, less institutionalisation was secured through more home help and less nursing homes. Since the late 1990s the same trend has seen the establishment of new forms of housing for the elderly. Hence traditional nursing homes are being phased out and replaced by **care homes**. The main difference between nursing homes and care homes concerns the setting of rent; in care homes the elderly have the status of tenants and can apply for housing allowances to meet part of the rent. From 2010 to 2016 the number of places in nursing homes fell from 8,761 to 4,425 and the number of places in care homes increased from 36,449 to 40,459 (Danmarks Statistik, 2016).

To ensure the quality of LTC and prevent abuse of individuals, municipalities are obliged to undertake **audits**.

As noted earlier, the special needs of relatives are not yet properly addressed; this is reflected in the policy recommendations of Carers in Denmark (2018), which include better legal recognition, rights for carers in various domains, establishment of an education for all carers and care consultants in municipalities and hospitals, and rights to practical and psychological help. Perhaps dementia and Alzheimer's disease are the two

areas where most progress has been achieved in addressing the needs of relatives. Hence, there has been an Alzheimer plan for some time and the national dementia action plan 2025 also contains elements of relevance to caring relatives.

The quality of health care for elderly people is also likely to increase as the Satspuljeaftale of 2016 introduced general practitioners attached to all elderly care institutions, a measure which in a pilot project was found to have positive effects (see Kvist, 2014).

The **employment challenge** is very real in Denmark. For LTC itself the challenge is dual: many LTC workers are retiring at the same time as the need for LTC increases (Sundheds- og Ældreministeriet, 2016). Together with a perception that new public management has been taken too far, there has for some years been a debate about how to turn 'cold hands' (i.e. management) into 'warm hands' (i.e. client-oriented work). One issue is how to reduce the share of management vis-à-vis the share of client-oriented workers. The second issue concerns how to enable client-oriented workers to spend time taking care of citizens rather than on red tape. A move towards more social investment in the elderly (in Danish: *genoptræning* and *vedligeholdelsestræning*) has been on the rise in recent years. This move towards more rehabilitation, especially in home help, has increased work satisfaction among workers in home help. Compared with other colleagues, staff providing rehabilitation on a daily basis are more satisfied with the educational and collegial support they receive, and they find their work to be more meaningful (Rostgaard and Matthiesen, 2016).

Since the extent of home help has gone down at the same time as the population is ageing, one might expect an insufficient provision of formal care, which in turn could hinder female labour market participation. However, when examining the employment rates of women of middle age, i.e. the group most susceptible to suffer from the reduced scope of formal care, one finds no such empirical support – either over time or compared with the situation in other countries.

As the employment challenge is central to LTC itself, local and central government has for some time attempted to recruit more young people to undertake an education in social and health care – either as a social and health nurse, which takes from 3 years and 10 months to 4 years and 7 months, or as a social and health assistant, which takes 2 years and 2 months. In particular, the social and health assistant track may assist persons who have a marginal place in the labour market to become LTC professionals.

A financial sustainability challenge accompanies population ageing. As described earlier, municipalities have made cuts in LTC even though this has not been an explicit policy.

Many initiatives are designed to address both the employment challenge and the financial sustainability challenge, including those on rehabilitation: see the next section.

2.1.2 Assessment of recent or planned reforms

Recent reforms and initiatives include the national action plan on dementia, the 'dignity billion' package, and the national action plan on the older medical patient.

Entitled 'A secure and dignified life with dementia', the **national action plan on dementia 2025** was launched in January 2017. To substantively improve measures for dealing with dementia and to reduce geographical differences, the plan has three aims over the period to 2025: 1) all (98) municipalities should be dementia-friendly; 2) more people should receive a timely and adequate diagnosis, with 80 percent having a specific dementia diagnosis; and 3) improved nursing and treatment should reduce the use of antipsychotic medicine among people with dementia by 50 percent. This has resulted in 23 initiatives linked to five focus areas: early detection and better quality in patient inquiry and treatment; better-quality nursing, care and rehabilitation; support and counselling for relatives of people with dementia; dementia-friendly communities and housing; and increased knowledge and competence levels.

The initiatives are financed by EUR 63.1 million from the Satspuljeforlig for 2016-2019 (Sundheds- og Ældreministeriet, 2017).[2] The initiatives are based on a thorough report and dialogues with relevant partners and experts (Sundheds- og Ældreministeriet, 2016).

Since 2016, municipalities have been obliged to formulate and adopt so-called dignity policies in dialogue with the local elderly council, relatives of the elderly, voluntary organisations, and management and staff within both public and private elderly care. Policy measures are backed by 1 billion Danish kroner each year (the '**dignity billion'**, equal to EUR 134.3 million) from the 2016 Budget (Regeringen et al. 2015) and adopted as law on 23 February 2016. Funds have been allocated to municipalities according to their demographic composition. Municipalities must formulate a dignity policy every four years (coinciding with the political cycle) and submit information to the central level, and on the municipal homepage, on how the extra money is spent. The policy must as a minimum address issues such as: the autonomy of elderly people; the quality, multi-disciplinarity and coherence of care; food and nutrition; and a dignified death.

The national action plan on the **older medical patient** from 2016 contains a series of initiatives grouped into eight focus areas: earlier detection and more timely measures; stronger trauma functions in municipalities; better qualification in municipal home nursing; stronger measures against over-booking of hospitals (extra money); more outreach functions and counselling, from hospitals to municipalities and general practitioners; more integrated measures; medicine reviews; and better digital collaboration about complex cases.

This plan is financed under the 2016 Budget with a total of EUR 108 million from 2016 to 2019, and subsequently EUR 33.6 million annually. After being adopted by a majority in Parliament the plan has been written up together with Danish Regions (DR) and Local Government Denmark (KL).

In the **national plan for health** from 2016, the second of eight goals is to strengthen measures for elderly persons and the chronically ill. The plan came out of the budget negotiations in 2016 between the government on one side and DR and KL on the other side.

Currently, the government, KL and DR are working together on proposals in relation to the treatment of patients that goes across sectors, designed to ensure that it is better integrated, close to citizens, cost efficient and of high quality (*Udvalg om det nære og sammenhængende sundhedsvæsen*, Committee on the integrated health system).

2.1.3 Policy recommendations

There is no easy money to save in elderly care without reducing the scope or quality of home help or homes for the elderly.

However, more effective and cost-efficient measures might include an even stronger emphasis on rehabilitation and social investments. This calls for evidence-backed interventions. In January 2018, the National Board of Social Services launched the socio-economic investment model (socioøkonomisk investeringsmodel, SØM), which can help municipalities and other actors assess the economic returns on social investment measures for persons of working age. In 2018, work on the SØM is aimed at extending it to children and youth. One policy recommendation could be to extend the SØM further to also encompass rehabilitation and social investment measures for the elderly. This could prove important for the further expansion of rehabilitation measures, and provide a bulwark against budget cuts.

[2] All Danish social security benefits are rounded down when they are paid out. The 'savings' from this practice enter a fund called the *Satspulje*. Each year the political parties agree, on a majority basis, how to use the resources in the fund; these have to be targeted in a broad sense at initiatives that may benefit the claimants of social security.

The idea of working toward measures that are more integrated, holistic and built on multi-disciplinarity, is well reflected in current reform thinking. However, plans may be good on paper, but if they are not backed by action, their potential may not materialise. Staff numbers in both social and health LTC functions have been cut in recent years, and their trade unions are warning that working conditions have become so dismal that they jeopardise the ability to undertake LTC work properly.

3 Analysis of the indicators available in the country for measuring long-term care

The government and KL have agreed to develop a more coherent documentation of municipal services which, as described above, includes the area of the elderly. Statistics Denmark has published documentation and statistics for 19 of the 23 indicators: see Table 1 below.

Table 1. Indicators in the national documentation relating to elderly people

Indicator (Danish)	English name	Definition	Source	Frequency
Kvaliteten af hjælpen	Quality of help	User satisfaction with practical help/personal help in own home/nursing home	Survey	Bi-annual
Hjælpens stabilitet	Stability of help	User satisfaction with the stability of help	Survey	Bi-annual
Antal forskellige hjælpere	Number of different helpers	User satisfaction with the number of helpers	Survey	Bi-annual
Kendskab til frit valg	Knowledge of free choice	Share of elderly people knowledgeable about their right to choose between public and private suppliers of home help	Survey	Bi-annual
Kenskab til fleksibel hjemmehjælp	Knowledge of flexible home help	Share of elderly knowledgeable about their right to choose between personal and practical help	Survey	Bi-annual
Det gennemsnitlige antal sygehusliggedage	Average number of hospital bed days (> 67 years)	The number of bed days per exit according to diagnosis	Register	Annual
Det gennemsnitlige antal genindlæggelser	Average number of hospital re-admissions	The number of hospital admissions taking place within 30 days of the last	Register	Annual
Antal visiterede og levered timers hjemmehjælp til borgere omfattet af frit valg (eget hjem)	Number of referred and delivered home help to citizens covered by free choice (own home)	Number of hours of, respectively, personal and practical help	Register	Annual
Antal visiterede timers hjemmehjælp for borgere i plejebolig/plejehjem	Number of referred hours of home help to citizens in nursing homes	Number of hours of, respectively, personal and practical help	Register	Annual
Antal modtagere af praktisk hjælp/personlig pleje, der er omfattet af frit	Number of recipients of practical help/personal care covered by free	Number of hours of, respectively, personal and practical help	Register	Annual

valg	choice (own home)			
Antal hhv. plejehjemspladser og plejeboliger	Number of places in, respectively, nursing homes and care homes	-	Part of social resource status	Annual
Antal ældre, der modtager genoptræning/træning	Number of elderly people in receipt of training and rehabilitation	Rehabilitation relating to alleviation of reduced physical functionality not treated as part of hospitalisation	Register	Annual
Antal gennemførte forebyggende hjemmebesøg	Number of preventative home visits	Number of visits and number of citizens receiving a visit	Register	Annual
Andel af hjemmehjælps-modtagere samt andel førstegangsvisiterede, der benytter en privat leverandør	Share of home help recipients, and share of first time referred, who use a private provider	-	Register	Annual
Antal hjemmehjælps-modtagere, der skifter leverandør	Number of home help recipients who change provider	-	Register	Annual
Antal ældre, der benytter frit boligtilbud til hhv. Plejebolig/plejehjem og ældrebolig	Number of elderly people who use free accommodation offer to nursing home/care home and elderly housing	Number of elderly people who have been on a waiting list for a specific accommodation, and the number of elderly people not making use of the right to choose accommodation	Register	Annual
Brugertidsprocent	User time percent	No specification of how to calculate this means it has not been published since 2010	Register	Annual
Antal hjemmehjælps-besøg, der gennemføres planmæssigt	Number of home help visits held as scheduled	No distinction between personal and practical help	Register	Annual
Den gennemsnitlige ventetid til plejebolig og plejehjemsplads	Average waiting time to access care accommodation and nursing home	Time from elderly people being granted the right to accommodation until an offer is made (excluding elderly people making use of the free choice of accommodation)	Register	Annual

The indicators that are lacking are: expenditure on home help; expenditure on nursing home/care accommodation; expenditure on support aids; and expenditure on training and rehabilitation.

The indicators are constructed in different ways. Most indicators are based on either annual municipal and other administrative register data or a bi-annual survey of the elderly.

The indicators may be used for different purposes. Take, for example, the concept of quality of LTC. This is a multi-dimensional concept that includes user perceptions, needs

assessments, policy inputs such as staffing, and outcomes such as effects on health. The quality of LTC could thus be examined using indicators on user satisfaction with LTC (i.e. quality, timeliness, conformity and stability), staffing (i.e. number of hours, staff education, and staff-elderly ratio), and effects on health (i.e. average numbers of, respectively, hospital bed days and hospital re-admissions).

The data periods vary between indicators but for many it is possible to establish time series from 2008 to 2016.

The data is publicly available online at Statistics Denmark (2018) and can in most cases be broken down to the level of regions and municipalities. The website also contains details concerning the indicators' definition, population covered, and the source of data. For an English description of the indicators – with a statistical presentation, statistical processing, relevance, accuracy and reliability, timeliness and punctuality, comparability, accessibility and clarity – please see Danmarks Statistik (2018c, Elderly - Indicators).

Population, labour market and other statistics are also available from Statistics Denmark.

Statistics on LTC professionals are available, but the time series was discontinued in 2015 (previously RES10, now RES14). As a result it will take some years before a new time series can be established.

To these general indicators that are made available through Statistics Denmark one may add the indicators that are part of the national action plans on dementia and the older medical patient, and those that relate to the national goals on health.

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