ESPN Thematic Report on Inequalities in access to healthcare

Denmark

2018

Jon Kvist
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Directorate-General for Employment, Social Affairs and Inclusion
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European Social Policy Network (ESPN)

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The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Summary / Highlights

Denmark has a universal, tax-financed public healthcare system with comprehensive coverage. Equal access to healthcare is the primary objectives of the system.

The level of unmet need in healthcare in general (1.1% in 2015) is lower than the EU-28 average (3.2%).

Though a public healthcare system, dental care is the exception to the rule, as patients pay 87% of dental care costs directly. The level of unmet need in dental care is, at 3.9%, higher than in healthcare generally and double that (7.8%) for persons in the first income quintile.

Supplementary private healthcare insurance, introduced in 2001, now covers 36.5% of the population (2014). The scheme covers those people whose employers have taken out insurance for their employees. The scheme does not cover the unemployed, the self-employed or persons in non-standard jobs, unless they have taken out insurance individually. Private healthcare insurance gives those insured expanded and faster access to healthcare.

The complementary non-profit association 'danmark' covers about 43% of the population (2018). It covers individuals who have joined on their own initiative, but does not admit persons with existing health problems. The scheme reimburses part of the out-of-pocket payments related to certain services and goods, like psychologists and spectacles.

Various measures have been introduced in recent years to improve healthcare for certain groups of patients and socio-economic groups. The efforts have concentrated particularly on healthcare for the elderly and on patients with chronic diseases and dementia. By improving the availability and comprehensiveness of healthcare services, this may reduce inequities in healthcare access.

The number of general practitioners is falling, resulting in less availability of primary care. The number of clinics fell by 5.9% from 2007 to 2017, and a further 5.8% may close in 2018 to avoid an on-going accreditation process. Because general practitioners work as gatekeepers, the inadequate supply of doctors may lead to later admission of patients to specialists and hospitals.

There are many national measures on health inequities according to regions and municipalities that play a prominent role in the regulation of healthcare nationally.

The report recommends:

- taking action to secure more general practitioners
- improving the working conditions of healthcare staff, especially in hospitals and long-term care
- improving the availability of mental healthcare services
- involving the relatives of patients to a larger degree
- continuing the improvement in the treatment of patients with complex and chronic problems.

Measures to address inequity that focus on local and regional differences are widely available and used in the national regulation of healthcare.

Measures to tackle inequities in access to healthcare that focus more on a person's socio-economic status could help identify, monitor and evaluate issues involving the availability and affordability of healthcare.

1 Description of the functioning of the country's healthcare system for access

Denmark runs a universal-coverage, tax-financed healthcare system. **Equal access to healthcare is its primary objective**. The **coverage of public health insurance is 100%** in Denmark, as it is in the other Nordic countries (Eurostat, 2018). The Danish healthcare service can be divided into two sectors: primary healthcare and the hospital sector.

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

In case of illness, the citizen normally first comes into contact with primary healthcare. Usually patients start by consulting their **general practitioner**, whose job it is to ensure that they are offered the treatment they need and are not treated at a more specialised level than necessary. Normally, it is necessary to be referred to both hospitals and specialists by a GP. General practitioners also refer patients to other health professionals working under agreement with the healthcare service and arrange for home nursing to be provided. De jure universal coverage is thus in practice modified by the GPs acting as 'gatekeepers' with regard to hospital treatment and treatment by specialists. Finally, a guarantee ensures that residents who are not examined or treated within 30 days of referral by their GP have the right to seek treatment at private or foreign hospitals. Lack of available healthcare may be compensated for in these ways.

On average, there are 6.0 GPs per 10,000 inhabitants. However, in the region of North Jutland there are only 5.2 and in the region of South Denmark there are 6.5 (Praktiserende Lægers Organisation, 2017a).

On average, 67% of GP lists are closed to new patients, up from 38% in 2014 (Praktiserende Lægers Organisation, 2017a). However, this masks regional differences: 80% of GP lists in North Jutland are closed to new patients, but only 57.3% in Mid Jutland. It also masks large local differences: 15 municipalities have more than 90% of their GP lists closed to new patients (including six municipalities where all GP lists are closed to new patients), whereas in five municipalities the figure is less than 10% (Praktiserende Lægers Organisation, 2017b).

A new factor putting pressure on both the availability and quality of GPs' work concerns an on-going accreditation process. As part of an agreement between GPs and the Danish Regions, all general practitioners must have their clinics accredited in line with the Danish Quality Model (*Den Danske Kvalitetsmodel*) by the end of 2018. However, a large number of GPs (200 as of 12 May 2018) have asked for permission to close their clinics by August 2019, in exchange for not having to go through the accreditation process in 2018. In the Copenhagen area alone, the potential closure of 92 clinics would result in 157,000 patients losing their doctor (Danmarks Radio, 2018).

The **hospital sector** deals with medical conditions that require more specialised treatment, equipment and intensive care. In principle, **everybody has the same access** to hospital treatment.

Like Denmark generally, the **healthcare sector is organised** at three political and administrative levels: the state at the national level, the five regions at the regional level and the 98 municipalities at the local level. The healthcare service is organised in such a way that responsibility for services provided by the health service lies with the lowest possible administrative level. Services can thus be provided as close to the users as possible. This decentralisation means that equal access in practice differs from region to region and from municipality to municipality.

At the **local level**, the 98 municipalities are responsible for home nursing, public healthcare, the school health service, child dental treatment, prevention and rehabilitation. The municipalities are also responsible for the majority of the social services, some of which have to do with the healthcare service, including homes for elderly people with care facilities and associated care staff.

At the **regional level**, five regions are responsible for running hospitals, as these require a larger population than that of the majority of the municipalities. The regions organise the health service for their citizens according to regional preferences and available facilities. Thus, the individual regions can adjust services within the financial and national legal limits according to needs at the different levels, e.g. the composition and number of staff and the procurement of the appropriate equipment, which in turn has an impact on the coverage and depth of coverage. The availability of hospital treatment may differ between regions. Residents have the right to seek treatment anywhere in Denmark if their home region does not provide a service that is delivered elsewhere.

At the **national level**, the central administration is run by Parliament, the Ministry of Health, the Danish Health Authority, the Danish Medicines Agency and the Danish Patient Safety Authority. They are responsible for the general regulation, planning and supervision of healthcare, i.e. for initiating, coordinating, monitoring and advising. Some of their main tasks are to establish the goals for a national health policy and to set guidelines for the running of healthcare services and support efforts to improve productivity and efficiency, e.g. through information and economic incentives.

The healthcare system is mainly **financed through general taxation**. Taxes are collected at the national level (state taxes) and at the local level (municipal taxes); the regions have no authority to collect taxes. The regions are mainly financed by the central government (75%) and secondarily by the municipalities. The municipalities are financed by their own taxes (71%) and through a central government grant (*bloktilskud*) and other schemes. The central government grant is adjusted for demographic and social factors.

Whether the level and structure of spending ensures an **adequately funded** healthcare system is **debatable**. The level of health spending is above the EU average both when measured on a per capita basis (EUR 3,494 in purchasing power parities in 2014) or as a share of gross domestic product (GDP) (10.4%) (Eurostat, 2018). In terms of the structure of Denmark's health spending, only long-term care stands out: at 2.8% of GDP, it is surpassed only by Sweden. However, like other institutions in the public sector, healthcare has been subject to a requirement to increase its productivity. From 1999 to 2007, the requirement was 1.5% annually; thereafter it was 2%. In 2018, the requirement was suspended, pending replacement with another model of regulation in 2019.

In terms of **affordability of health expenditure** and **depth of coverage**, most of the Danish healthcare services are free of charge, including treatment by GPs and hospitals. However, to varying degrees **user charges** are required for outpatient visits to psychologists, chiropractors and physiotherapists, as well as for dental care, prescriptions, hearing aids and cosmetic treatment. Patient's expenses may be fully or partly reimbursed by public or private means. Public reimbursement can be made by the municipality or the state (through its agency *Udbetaling Danmark*). Private reimbursement can be made by 'danmark' or a private health insurance scheme.

Patients can get **reimbursement for their spending on medicines** through three public schemes. First, the general allowance (*generelle tilskud*) depends on the annual amount of expenditure and whether it concerns children below 18 years or adults above that age. In 2018, expenses up to EUR 130 annually are not reimbursed for adults, but 60% is reimbursed for children. In the case of annual expenses of between EUR 130 and EUR 215, 60% is reimbursed for children and 50% for adults. For annual spending of between EUR 215 and EUR 463, 75% is reimbursed for both groups. And both groups have 85% reimbursed for annual expenses exceeding EUR 463. Second, on behalf of

patients, physicians may apply for increased reimbursement – an individual allowance (*individuelle tilskud*) if the patient is in need of more expensive medicine than the cheaper alternative – for example, the patient may be allergic to the cheaper medicine. The physician can apply for a full reimbursement if the patient is terminally ill. Third, the patient may apply to the municipality for the allowance for medicine (*enkeltydelser til medicin*) which is a discretionary allowance that depends on the person's assets, income, expenses and motivation. Medical expenses may also be reimbursed in part by 'danmark'.

Old-age pensioners (and disability pensioners on rules prior to the 2003 reform) may receive an additional health allowance (*helbredstillæg*) covering up to **85% of their expenses** for psychological treatment, chiropractic treatment, dental treatment, medicine, hearing aids and podiatry. To get the full allowance, their assets must be less than EUR 11,300 and the annual income that supplements their pension(s) must not be greater than EUR 2,750 (for a single person in 2018) or EUR 5,442 (for a couple). That entitles the person to 100% of the allowance. For every additional EUR 67 (single person) or EUR 134 (couple) of annual income, there is a 1% reduction in the allowance (which covers 85% of the expenses: thus a 1% reduction entails an allowance that is 99% of 85% of expenses). The pensioner may apply to the municipality for a personal supplement (*personligt tillæg*) to cover the payment not reimbursed by the health allowance.

Dental care is provided by municipalities free of charge for persons below 18 years of age, i.e. child dental care (*børnetandplejen*). To encourage young people to take up dental care, the fees have been set at a particularly low level for persons aged 18 to 25 years. Social assistance claimants can get the municipality to pay part of their dental care expenses up to a ceiling of EUR 1,340 (2018). First the claimant must pay a fee of EUR 80 and then (if the application is successful) 35% of the remaining expenses. The municipality pays the rest. For example, in the case of treatment costing EUR 1,340, the claimant would pay EUR 521 (i.e. EUR 80 + 35% of (EUR 1,340 minus EUR 80)) and the municipality would pay EUR 819 (EUR 1,340 minus EUR 521). For dental treatment that exceeds EUR 1,340, the dentist must apply to the municipality on behalf of the patient. Old-age pensioners and certain disability pensioners may be eligible for the health allowance (see above), which significantly reduces their expenses. However, by no means all dental care is covered by public subsidies. Around 85% of dental care expenditure, including orthodontic treatment, involves user co-payments, which may be covered in part or in full by 'danmark'.

Sygeforsikringen danmark ('danmark') is a voluntary healthcare insurance association which covers almost 2.5 million persons, equivalent to 43% of the whole population (Sygeforsikringen danmark, 2018). Its members pay a quarterly membership fee (children are free of charge) that varies according to their preferred level of coverage. Persons in the basis group *(Basis)* pay EUR 13 for a dormant membership allowing them to shift later to another group without a prior medical examination, a group that provides reimbursements. Persons in the basic group *(Gruppe 5 – grundlæggende dækning)* pay a fee of EUR 48, in return for which the patient receives subsidies on dental care, medicine and glasses; the fee is EUR 109 in the extended coverage group (Gruppe 1 – Den udvidede dækning), which – in addition to the aforementioned – gives subsidies for more dental care treatment, larger subsidies to pay for medicines and subsidies for operations after 1 year; and the fee is EUR 137 in the most comprehensive group (Gruppe 2 – Den mest omfattende dækning), which – in addition to the aforementioned – gives subsidies for specialist doctors, laboratory tests, and full medicine costs, irrespective of whether these are covered in part by public means. In these ways, 'danmark' compensates fully or in part for members' out-of-pocket payments for dentists, psychologists, medicine and more. The company is owned by its members and pays out more than 90% of membership fees in subsidies to its members.

However, However, not everybody can become a member of 'danmark'. Indeed, to become a member of 'danmark' the applicant must not be over 60 years of age, must be

completely healthy at the time of entry and not suffer from any recurring illness or physical problem (such as chronic or recurrent back pain or a missing limb), must not have been on medication in the preceding 12 months, and must have permanent residence in Denmark (or be temporarily resident abroad) (Sygeforsikringen danmark, 2018). There is thus inequity between the healthy and the non-healthy and between those that can afford the coverage (and remember to pay the quarterly fees) and those that cannot.

There are also private healthcare insurance schemes (*sundhedsforsikringer*) that give members the opportunity to receive faster treatment at private hospitals and clinics, and to see specialist doctors. The quality of care should be the same as in public hospitals. These schemes are mostly related to employer schemes, although individuals can also sign up. In the latter case, there is a waiting period of 6 months before members can get treatment. Private health insurance does not cover sickness or symptoms that people had before they took out the insurance. In 2016, 1.86 million persons were covered by one or more private health insurance schemes (Pension & Forsikring, 2018).

Most complementary voluntary insurance for expenses not covered by the public healthcare system – besides medicine, physiotherapists and dental care (as described earlier), spectacles, psychologists and other items – is provided by the non-profit health insurance association 'danmark'. Most supplementary health insurance providing expanded and faster access to private healthcare providers is granted as part of an employment contract. Although 38% of the population has these types of complementary or supplementary coverage, they only involve a small part of total health expenditure.

Nevertheless, it is plausible that the interaction between public and private healthcare has led to both positive and negative outcomes. On the positive side, free choice of treatment across regions and, after 30 days, private and foreign treatment may lead to shorter waiting lists in public healthcare. Negative outcomes may include worse quality and availability of public healthcare if doctors leave the public sector to work in the private sector. In a longer time perspective, it could also be that private healthcare insurance for insiders reduces their willingness to finance the universal public healthcare system, leading to a dual healthcare system.

Unfortunately, there are few studies examining the effects of public-private interactions in healthcare; but two studies by the association of insurers and private pension funds are described in the next section.

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

The universal, comprehensive public healthcare system translates into relatively few inequities in access to healthcare (but surprisingly not into similarly low inequity in health outcomes). Whereas all registered Danish residents are entitled to a comprehensive package of health services, this is not the case for two numerically small groups: non-residents only receive acute care; while irregular migrants and visitors can get care provided by a voluntary, privately funded initiative of Danish doctors that is supported by the Danish Red Cross and Danish Refugee Aid.

Most publicly financed services are free of charge at the point of use. Hence, a household's out-of-pocket payments (13.8%) and voluntary schemes (2%) are both lower than the EU average. By contrast, the proportion of government outlays (84.2%) is considerably higher than in the EU. Part of the out-of-pocket payments can be reimbursed by public means from municipalities and from private healthcare insurance. The public reimbursements are likely to reduce inequities in access to healthcare, and private reimbursements are likely to increase such inequities. However, as discussed below, this may lead to a black-and-white picture of the effects of the Danish public-private mix in healthcare on inequities in access to healthcare.

Although access is equal and mainly provided free of charge, waiting times and distance reduce the take-up of healthcare and result in **unmet need**. However, the share of people with self-declared unmet need for healthcare services due to financial barriers, waiting times or travelling distance (1.2% in 2015) is considerable lower than in the EU-28 (3.2%) (Eurostat, 2018).

There are differences in the scope of unmet needs across areas. Because dental care has predominantly financial barriers (in the form of user payments), it may be an area with a large share of unmet need. Indeed, the level of **unmet need for dental care** (3.9% in 2015) is higher than for healthcare in general. Nevertheless, the Danish level of unmet need in dental care is lower than in the EU-28 (4.5%) (Eurostat, 2018). However, this is due rather to considerably lower unmet need among the elderly (1.5% of those aged 65 and over in 2015) than to unmet need among those of working age (4.7% of those aged 16-64), which is actually at the level of the EU-28 (4.6%). Because Denmark is known for having a Nordic welfare model, with low inequality, it is surprising that a large share of low-income groups (7.8% of persons in the first income quintile in 2015) report unmet need – not far off the EU-28 average (8.3%) and considerably higher than for the Danish population on average. And there are two policy developments that mean there is no sign of this declining in the short to medium term. First, the level of subsidies for preventive and basic dental care is likely to fall, as the area was cut by EUR 40 million in 2003, and in spring 2018 the Danish Regions and the Dental Association (*Tandlægeforeningen*) could not agree on a new scheme of subsidies, resulting in a collapse of the system and in Parliament passing a special law regulating the field until a new model is put in place (planned for 2019). Since social assistance and other minimum income benefits have been cut since the last year for which data are available (2015), the number of people with unmet needs is probably increasing. In sum, preventive and basic dental care is likely to become less available and less affordable, in particular for persons on social assistance.

The level of spending and the emphasis on new public management, with a requirement for increased activities in order to avoid a 2% budget cut, have been associated in national debates with two questions on the availability and affordability of healthcare. Indeed, it has been widely debated over the past few years whether automatic cost reductions, often translated into demand for increased activities, can be based on increased productivity in the healthcare sector, which is labour intensive. If not, then cost reductions simply mean that fewer people have to do more, affecting the quality of services. A recent survey shows that three out of four nurses think the productivity requirement is adversely affecting the quality of treatment and care (Dansk Sygeplejeråd, 2017). The increase in activities and worsening working conditions have led many healthcare professionals in hospitals and long-term care to reconsider their working lives – and have probably also led to fewer students choosing a career in healthcare. In turn, this leads to problems involving the availability of healthcare.

Leading health economists, the Association of Danish Patients, the trade unions of doctors and of nurses, and many more actors finally managed to influence the parliamentary parties, so that the 2% annual cut was abolished as part of the 2018 Budget agreement between the liberal-conservative coalition government and the Danish People's Party on 4 October 2017. A new model of regulation will be in place from 2019, but it is too early to say how this may affect the adequacy of healthcare funding.

Private health insurance primarily covers persons in employment. Critics of private health insurance would argue that it leads to a dualisation of coverage between high- and low-income groups in the labour market. However, the association of insurance companies and pension funds, Insurance & Pension Denmark (*Pension & Forsikring*), argues on the basis of two of their analytical reports that the coverage is not polarised and that there are significant advantages to private schemes supplementing public ones (Pension & Forsikring, 2008; Pension & Forsikring, 2010).

Since its analyses find that there is no significant difference between private sector employees with healthcare insurance and those without, Insurance & Pension Denmark

argues that there is no A team or B team with regard to health in the labour market. Similarly, the association argues that private healthcare insurance increases labour supply, because many doctors and nurses work both full time in the public sector and part time in the private sector. Due to lack of more recent analysis, it is not possible to say whether these findings (based on data from the early 2000s) hold true today.

In any case, it is certain that those who are in employment and covered by private health insurance have expanded access to a range of services and faster access to treatment than do those not in employment. Hence, unemployed and retired persons have less access to private healthcare than do employed persons. Moreover, within the group in employment, coverage does not include the self-employed or persons in non-standard employment (except for those few individuals who may have taken out private health insurance). There are no initiatives in the pipeline to extend the coverage of private health insurance to these groups.

In certain healthcare areas the problems of access and inequities relate not to the availability and affordability of services, but rather to opposition to their use. Most worryingly has been the **low vaccination rates** of children, which are below the EU average. However, recent national data show a positive development, as 96% of children born in 2016 were vaccinated in 2016 or 2017 – up from 92% for earlier cohorts (Lægemiddelindustriforeningen, 2018).

The healthcare sector is under **pressure** from several quarters. The number of patients is increasing because of demographics; care needs are changing due to the greater number of elderly people and longer longevity; and there has been a rise in the number of chronic patients and patients with complex needs (i.e. patients with more than one disease). This increases both the number of healthcare patients and the number of needs that these patients have.

This starts with a visit to the **general practitioner**. However, this is becoming more difficult, as the number of GPs is falling at the same time as the number of patients is rising, and also as care needs increase as the population ages. In particular, this has led to two types of problems related to the availability of GPs. First, many places in the country are experiencing gaps in coverage, as GPs who cease their activities are not being replaced by new GPs. Second, because of the huge demand for general practitioners, many of them have closed their lists to new patients. As a result, many patients either have to find a general practitioner further away from home or else have to choose one of the regional clinics, where they will not always be seen by the same doctor.

The annual number of **doctor's consultations** (4.4 in 2015) is lower than the EU average and decreased over the previous 3 years (4.7 in 2012) (Eurostat, 2018). However, GPs are extremely busy. They have about 24 face-to-face meetings a day with patients, compared to 13 in Finland and 14 in Sweden (findings from QUALICOPC, reported in Praktiserende Lægers Organisation, 2017a). Unlike in Sweden or Finland, visits to Danish GPs are not subject to user charges. Put differently, affordable services may put pressure on the quality of services when measured by the time spent with patients.

In recent years, there have been several healthcare initiatives for different socio-economic and patient groups, such as children, young adults, vulnerable groups, chronic patients and cancer patients. Recent reforms and initiatives also include the National Action Plan on Dementia 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 on dementia and to reduce geographical differences, the plan has three aims in the run-up to 2025: 1) All 98 municipalities should be dementia friendly, 2) more people should be diagnosed in a timely and adequate way, and 80% should have a specific dementia diagnosis, and 3) improved nursing and treatment should reduce the use of antipsychotic medicine among people with dementia by 50%. 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 the relatives of people with dementia; dementia-friendly communities and housing; and increased knowledge and competence levels. The initiatives are financed to the tune of EUR 63.1 million from the Satspuljeforlig for 2016-2019 (Sundheds- og Ældreministeriet, 2016a.[1] The initiatives are based on a thorough report and dialogues with relevant partners and experts (Sundheds- og Ældreministeriet, 2016a).

Several measures have been adopted to increase healthcare for the elderly. 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 for 2016 between the government on one side and the Danish Regions and Local Government on the other side (Regeringen, Danske Regioner and Kommunernes Landsforening, 2016). The National Plan for Health can also be seen as a way of using levels of inequity and trends in health across regions and municipalities to inform policy making locally and regionally. Hence the eight goals contain about 30 indicators, with scores for regions. For example, it can be seen that the number of acute hospital admissions for type 2 diabetes patients is above average but is moving in the right direction in the Capital Region; and is below average but is moving in the wrong direction in the Zealand Region (Regeringen, Danske Regioner and Kommunernes Landsforening, 2016).

The National Action Plan on the **Older Medical Patient** from 2016 contains a series of initiatives grouped into eight focus areas: earlier detection and timely measures; stronger trauma functions of the municipalities; better qualifications in municipal home nursing; stronger measures against overbooking 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 on complex cases (Sundheds- og Ældreministeriet, 2016b). The plan is financed by the 2016 Budget, with EUR 108 million from 2016-2019 and subsequently EUR 33.6 million annually. After being adopted by a majority in Parliament, the plan has been formulated together with Danish Regions and Local Government Denmark. Several of the initiatives may reduce inequities in access to healthcare by improving access to health for a vulnerable group and by decreasing inequities in access for different groups of the elderly – especially inequities between those elderly with and without complex care needs.

There have also been initiatives on mental care, with more money flowing into psychiatry. However, there is a lack of psychiatrists and other mental healthcare professionals which means that there are long waiting lists for mental care and treatment (Danske Patienter, 2018).

There have been a few recently adopted measures concerning regional-local interaction in healthcare which may have an impact on inequities in healthcare. **Regions and municipalities are trying to cooperate better and to integrate** their benefits. Hospitals make increased use of outreach teams after hospital discharge. Municipal units have been established at hospitals to facilitate follow-up care after hospital discharge. If these measures are successful, fewer patients (mostly from exposed or vulnerable groups) will be lost in the system and thus inequity will decline.

Currently, the Government, Local Government Denmark and Danish Regions are working together in a **committee** on proposals that support the treatment of patients and that cut across sectors, are better integrated, are close to citizens, cost efficient and of high quality (*Udvalg om det nære og sammenhængende sundhedsvæsen*, Committee on the integrated health system).

[1] 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 how to use the money in the fund; this money has to be broadly targeted at initiatives that benefit the claimants of social security.

The recommendations of this report partly echo those of the Danish Association of Patients (*Danske Patienter*), which suggests more action for the mentally ill, the relatives of patients and patients with multiple diseases (Danske Patienter, 2018). In addition, this report also recommends general initiatives that may help to improve the working conditions of healthcare staff, especially in hospitals and long-term care, in order to attract and retain professionals. Such initiatives may take many forms, including new regulation of healthcare and better funding.

3 Discussion of the measurement of inequalities in access to healthcare in the country

In Danish public health policy, it is common practice to compare health inequities across regions and, increasingly, across municipalities. For example, the National Action Plan has about 30 indicators on the eight goals where scores for regions and municipalities can be compared. International indicators on inequalities that can be broken down into subnational areas will be welcomed.

However, to make Eurostat (or any other international measurement of inequality) more relevant for national research and policy, two aspects could be addressed:

- **More timely information**: the Eurostat data, e.g. European Core Health Indicators (ECHI), are generally out of date, e.g. 2014 data in May 2018.

- **Reconsideration of geographical units**: the Danish regional and local units do not correspond to the EU NUTS system and require some adjustments to ensure that the measures are relevant to both research and policy.

Moreover, there is considerably less measurement of inequalities in access to healthcare along non-geographical dimensions in Denmark. An international push for more social gradients could indeed improve knowledge on where inequities are particularly pertinent and in need of policy adjustments. The World Health Organization has a list of over 600 indicators on health inequalities, from which those indicators can be chosen that are most relevant for EU countries.

The national and Eurostat measures of private health insurance coverage are not the same.

The Danish and ECHI indicators on the coverage of private health insurance could also be improved to better examine their coverage of the labour market, e.g. coverage rate of persons in employment. At the moment, coverage rates are provided as a percentage share of the population.

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