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THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN DENMARK

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1. The long-term care system

1.1 Overview

Philosophy and objectives

In general social care systems in European member states can be grouped into three categories:

- the state responsibility model,
- the family care model, and
- the subsidiary model.

The state responsibility model is characteristic of the Scandinavian countries and therefore also for Denmark (CESEP, 2007). From the point of view of the population, personal care in particular is primarily the task of the state (municipality). Nevertheless, a great share of help with practical tasks (gardening, financial tasks, etc.) is provided by members of the family, too. In Denmark, long-term care falls under social care and is the responsibility of the local councils, as regards both provision and financing. The rules on long-term care are part of the Consolidation Act on Social Services (CASS). Local authorities provide care for the elderly based on the general principle of free and equal access to the assistance offered. They finance the costs of long-term care through local taxes and block grants from the state.

Denmark's overall objective for long-term care policy calls for services to be based on the older person's wants and needs (Government of Denmark NAP, 2003, p. 40). As far as possible, this approach should ensure continuity in older persons' lives even if they become ill and infirm. Older persons in need of personal assistance and care are to be offered help. Assistance is considered help for recipients to help themselves, i.e. supplementary assistance for tasks the recipient is unable to perform him- or herself. Furthermore, assistance aims at helping recipients to remain active, with the starting point being enabling the recipient, to the greatest extent possible, perform as many tasks as possible (Government of Denmark NSR, 2006, p. 41).

Available services

The various forms of long-term care services offered under Danish legislation include care in conventional nursing homes (care homes), in modern close-care accommodation (subsidised housing for older persons with care facilities and associated care staff) and at home. In modern close-care accommodation, housing areas are separated from care service areas. Residents have to pay monthly rent corresponding to the costs of running the housing estate, but they have access to benefits depending on income.

Home help can be granted as temporary or permanent assistance. Temporary assistance may be chargeable (free only for persons with the lowest income), but permanent personal and practical assistance is free. Nevertheless, local councils may charge payments for expenses that are not staff expenses (for example, laundry coins and meal arrangements).

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Eligibility criteria

Any person who is lawfully resident in Denmark is entitled to assistance under the CASS. They are eligible to receive personal care and help with practical tasks, irrespective of age, income or wealth. There are no minimum requirements in terms of impairments to receive personal and practical help. After an individual assessment, the help needed is to be provided, even if the required time for help is less than two hours per week.

Funding

Permanent home help is free of charge, while temporary home help has to be financed by the recipients, and clients in nursing homes have to pay rent depending on income. The costs are generally not high. Long-term care as a part of social assistance is financed by local taxes and block grants from the state.

Beneficiaries

In 2007 around 206,600 persons received personal and practical help. This was 3.8% of the population. Among the beneficiaries, 87% were 65 years old and older. The share of the oldest old (80+) was 56%. Most of the recipients live in their own home (80%), while 20% live in nursing homes or nursing dwellings. Around 44% of persons living in their own home receive help solely with practical tasks.

1.2 Assessment of needs

The municipal council is responsible for offering personal care and assistance or support for necessary practical work at home. The assistance is to be offered to persons who are unable to carry out such activities due to temporary or permanent impairment of physical or mental functions or special social problems (CASS, ch. 16, section 83(1) and (2)). The latter can be used as a definition of the need for care.

Personal and practical assistance is granted following a concrete and individual assessment of the recipient's functional abilities and needs based on the local council's adopted service level. Denmark has adopted a comprehensive system of assessment and client management for elderly persons living in the community. Since 1996, everyone aged 75 and older has been entitled to at least two 'preventive' visits annually from a case manager employed by the municipality in order to evaluate individual needs and assist with planning for independent living. The Danish Ministry of Social Affairs tasked the municipalities with organising preventive home visits to older persons, but did not specify the guidelines on how to carry out the visits. Thus, there was wide variation among the municipalities in how the law was managed and implemented (Vass et al., 2007). In general, assessments have to be multidimensional and have to comprise all aspects of the individual's well-being, i.e. functional ability, welfare, life content, home conditions and possibilities of self-determination, but also include a review of medication, rehabilitative support, visitation and referral to specialists or other health care professionals if needed. For the assessment of functional impairments, the Barthel index is used.

In 2007, visits were primarily carried out by district nurses, but several other primary care professionals, e.g. occupational therapists, physiotherapists and social workers, were also engaged in the scheme. In a survey regarding the quality of care carried out by Rostgaard (2008) in 14 municipalities in Denmark in 2006-07, care assessors were also interviewed. All the care assessors interviewed had obtained a formal assessment qualification, usually consisting of a two-week course in assessment. They had on average been working within the care sector for 3.7 years, mostly as home carers before working with assessment.

Clients needing formal care are further assessed by a home-care manager, and the resulting care plan ends up as a contractual specification for the services needed. There are no pre-defined

categories of dependency, but the applicant will be classified along a continuum of dependency according to his/her specific needs. If the client disagrees with the allocation of services, the allocation decision can be appealed. The municipal council is to consider applications for assistance on a case-by-case basis, subject to an assessment of the assistance needed for the tasks that the applicant is unable to perform. In assessing the need for assistance, the municipal council must consider all applications for assistance from the applicant (CASS, ch. 16, section 88(1)). The assistance should be adapted from time to time to the specific needs of the recipient (CASS, ch. 16, section 88(2)).

The municipal council is to prepare a plan containing information about the functions covered by the assistance, the object of the assistance and the period during which assistance is to be provided. The plan must be completed in cooperation with the applicant and returned to the applicant in connection with the decision (CASS, ch. 16, section 89(2)). For nursing home residents, the plan should also include information about the overall programme for the care and attendance to be provided to the applicant.

1.3 Available long-term care services

General

All forms of long-term care services are available free of charge, including nursing homes, personal home care and practical help. Personal home help and practical help are to be provided for individuals in need of care living either in their own home or in nursing dwellings or special dwellings for the elderly. Since 2002, people have been entitled to choose either a private or public provider of practical assistance and from 2003 also among providers of personal care. In 2007, around 63% of municipalities provided a free choice of practical assistance and 41% of personal care providers (Rostgaard, 2007).

What services?

Denmark, more than any other EU country, has given explicit policy priority to community care over residential care, to promote older persons living in their own homes. Therefore, relatively few older persons are in long-term care institutions compared with other EU countries. Since the law on dwellings for older persons of 1987, no new nursing homes have been constructed, and instead a varied range of dwellings adapted for older persons has been developed. Those in need of care who are living in their own home or in special dwellings for the elderly are eligible to receive home nursing, home care and practical help. Home nursing refers to the medically necessary treatments (e.g. injections and wound care) provided by professional nurses in the home, usually as prescribed by a physician. Health services include health promotion and rehabilitation services. Home help refers to personal care services (i.e. assistance with activities of daily living, ADL) and domestic tasks (e.g. shopping, meal preparation and cleaning) provided by a range of paraprofessionals, along with personal care workers, homemakers and housekeepers (Brodsky et al., 2003). Additional measures to help enable care recipients to remain active are also included.

Although informal caregiving by relatives is not common, help for family caregivers is to be supported by the local authorities. Substitute or respite care is offered as well as cash allowances for palliative care. Under specific circumstances the carer of a closely connected person can be employed by the municipality for up to six months.

Who is eligible?

All citizens in Denmark are entitled to receive social services, irrespective of age, income, assets, living arrangements or the potential of informal carers. The assistance is to be provided on the basis of the recipient's particular needs and conditions and in consultation with the

individual recipient. Eligibility for social care is decided by a special municipal service. There are no minimal requirements to receive benefits from the local community. Long-term care needs are assessed by home-care managers. As noted above, a special scheme exists for the assessment and management of elderly persons living in the community: those aged 75 and older receive two preventive visits a year from a municipal case manager, who evaluates their needs and helps them plan for independent living. The assessments are mainly performed by nurses with input from home-helpers but the opinions of family doctors may be requested, occupational therapists may do home visits and physical therapists may suggest training. Home-help workers and nurses coordinate their services and the home-care team monitors the process (WHO, 2007).

1.4 Management and organisation

In Denmark, the government is responsible for the legislation concerning social services and assistance, but the local authorities are responsible for providing social services and for their performance. As long-term care is part of social assistance, the provision of personal care and help with practical tasks is organised and managed by the local authorities. The local council in the local authority is the body obliged to offer home-care services as well as places in nursing homes, nursing dwellings or other accommodation for the elderly. Nevertheless, they are not necessarily the provider of the required services.

Since 2003, the elderly have been entitled to choose freely between private and municipal providers of services and the local authorities are obliged to establish a framework for enabling private providers to enter the market for personal and practical assistance. According to the local government act, the local council must decide whether services should be tendered and, if so, which ones (Council of Europe, 2008). The local council will lay down the framework for the providers selected to offer the services. The prices are determined on the basis of the local authority provider's average long-term costs. The local authority must always impose quality requirements. The quality standards and price requirements for both public and private services must be adopted by the local authority, which follows up on the quality and management of the services provided at least once a year. The quality standards must describe the services available at the local level to persons in need of assistance, physical rehabilitation or general physical exercise in order to ensure transparency and to enable the users to evaluate the performance of providers. Local authorities must make a clear distinction between their function as a local authority and their function as service providers and have to isolate the costs for home-help services and make them transparent.

The local council is responsible for capacity planning and monitoring. The local authority must supervise the performance of the provision of personal and practical assistance to elderly persons. In cases where private providers perform local authority tasks, the local council is also responsible for supervising the provider performing the task. As part of supervision, the local council must carry out inspection visits in care homes and similar dwellings at least twice a year and prepare an inspection report. One of the visits must be unannounced.

1.5 Integration of long-term care

In general, health care and long-term care are public responsibilities. Whereas long-term care financing and provision are the responsibilities of the local municipality, health services are financed, planned and operated by the regions. To ensure efficient and effective caregiving and to coordinate health and long-term care a case management system has been introduced. Case management is a comprehensive and systematic process of assessing, planning, arranging, coordinating and monitoring multiple long-term care, services for the individual client across time, settings and disciplines (Brodsky et al., 2003). Home nursing and personal care services

are provided by home nurses. Practical help is provided by home-help workers, housekeepers and volunteers. All service teams work closely together to coordinate their services, and ongoing care is regularly monitored by the home-care team. Back-up consultations from the medical side of the system are often provided by hospital-based geriatricians or geriatric teams, particularly when home-care clients present complex problems or institutional placement is indicated. Although health and social care appear to be fairly well integrated, problems occur at the interface between regionally administrated hospitals and municipally administrated social-care services.

2. Funding

The total public, net expenditure on long-term care was €4.33 billion (DKK 32.3 billion) in 2003 (Ministry of the Interior and Health, and Ministry of Social Affairs, 2005, see also Table 1). Eurostat (2008) provides information based on the system of health accounts: in 2005 around €4.055 billion was spent on long-term care in Denmark. This was 1.95% of GDP. Most of this amount was spent on home care (€4.044 billion), with only €11.2 million spent on nursing homes. The lion's share of social service costs is financed by local taxes, although the municipalities receive additional reimbursement by means of block grants, equalisation grants and temporary subsidies from the national government to promote the selective expansion of services. For example, since 2003, the Danish parliament has earmarked a total of €18.4 million (DKK 137 million) for dementia initiatives (Council of Europe, 2008, p. 109).

User fees (for products and materials used in connection with permanent home-help services) and rents (for institutional and housing services) are levied, but play only a minor role in the social service funding scheme. Figures on the average amount of such payments do not exist (Council of Europe, 2008, p. 108).

3. Demand and supply of long-term care

According to the CASS, all needs for personal care or help with practical tasks are covered by the municipalities without minimum requirements. Local authorities have developed a wide range of services aimed at helping the elderly in need of care to help themselves. This includes assistance with cleaning, shopping, washing, preparing meals, and personal hygiene and care. Individuals who are in need of care and help not receiving any assistance from the municipalities are rare. Thus, the number of persons receiving practical and personal help may also be an indicator of the demand of care.

The public sector is the major provider of long-term and home care for older persons, but the government favours the development of competitive private agencies. Additionally, volunteer work is supported (Council of Europe, 2008). The objective is to broaden the volunteer profile by integrating volunteer work into the senior citizen's daily life regardless of the volunteer's age, profession or ethnic background (Jarden and Jarden, 2002). Persons in need of care have the free choice of providers of home-care services and the choice of several kinds of residential accommodation. The free choice of nursing homes will be introduced soon.

3.1 Need for long-term care

In 2007 some 5.5 million persons lived in Demark.[1] Around 15%, that is to say 844,000 inhabitants, were 65 years old and older, and around 4% were 80 years old and older (225,000 persons). Like other European countries it is expected that the share of the elderly will increase

[1] This refers to the midyear population in 2007.

markedly in the future. In 2050 a quarter of the population is expected to be 65 years old and older (Figure 1). The share of the oldest old (80+) will rise from 4% to 9.7% by 2050. As the need for care is strongly related to age, it can be expected that the need for care will also increase.

The need for care depends also on the living situation of the elderly. Single persons have a greater possibility of needing help from outside the household than persons living with a partner. Whereas the 'young old' often have a partner (two-thirds of those aged 65 to 69 have a partner), the share of persons living alone rises sharply with age. Around 72% of those aged 85 to 89 are single (Figure 2). As particularly the number of the oldest old will increase, further developments in the need for care will be highly dynamic.

In general, it is hard to quantify the number of persons in 'need of care'. But in Denmark all individuals in need of care are entitled to receive personal care and help with practical tasks provided by the municipalities without minimum requirements. To ensure that all persons in need of care can receive the help required, the preventive home visits were introduced, through which every person aged 75 and older not receiving permanent home help are entitled to receive two preventive home visits per year. A case manager employed by the municipality visits the elderly (75+) to evaluate their individual needs and to draw up an individual care plan. Yet not all of the elderly (75+) agree to be visited by a case manager. In 2007, 30% of preventive home visits were refused, with completed preventive home visits being carried out for 45% of cases.

After an assessment, the required amount and kind of help (as stated in the assessment report) will be provided, independent of the living situation of the individuals in need of care or the potential help by partners living in the same household. Furthermore, Danish ageing policy is based on the idea that the type of housing should not decide the care and services available but rather the individual's needs should solely determine the level of care needed and provided (Council of Europe, 2008). Thus, the help is to be provided irrespective of the living arrangement of the recipient either in his/her own home or in a nursing home or nursing dwelling. Therefore, the number of persons receiving permanent home help can be used to obtain an idea of the number of those in need of care. In 2007 around 206,600 persons received permanent home help.

The Ageing Working Group (AWG) carried out a new estimation of the development of long-term care expenditure in the EU (EC/EPC, 2009). To estimate the fraction of the elderly population who may need long-term care services, they used disability rates (the inability to perform one or more ADLs). According to this estimation the number of dependent persons amounted to 164,000 in 2007 and will rise to 327,000 by 2050 in Denmark. The estimations by the AWG are lower than the number of persons who received permanent home help in 2007.

3.2 Role of informal and formal care in the long-term care system

Denmark has made the choice of formal care over informal care. Public authorities play a significant role in the provision of all kinds of long-term care and as a consequence the family's contribution to providing especially personal care for older persons is regarded as negligible (Leeson, 2004).

3.3 Demand and supply of informal care

Information about the demand for informal care as well as informal caregiving activities and the characteristics of informal caregivers is rare (Kröger, 2005). Leeson (1999) carried out a survey elucidating the situation of older persons aged 60 years and older in rural and urban areas in Denmark. In this study less than 1% of the elderly interviewed received personal help from family members or other members of their social networks (as cited in Leeson, 2004). Another

study has found that up to 60% of Danish older persons receive some form of help from relatives, friends and neighbours, but that this is rarely the sole source of care (Hansen and Platz, 1995, as cited in Stuart and Weinrich, 2001). If this figure is true (60% of those aged 65 and older), then around half a million persons received informal help from a relative or friend in 2007.

If older persons receive help, then it takes the form of assistance around the home and garden, mostly provided by children (64% in urban and 75% in rural areas), spouses (20–13%) or other family members (12%). Children mostly help with repairs or transportation, while the spouse usually helps with cleaning, shopping and gardening.

In general, family members do not regard themselves as caregivers to a large extent; they see themselves as having a socially supportive role in relation to their older family members and the practical tasks with which they may help are seen as a natural part of this supportive rather than caregiving role. Lewinter (1999) analysed the division of care work between the family members and home help services. She points out that basic cleaning and personal care are the responsibility of the home help while other tasks are shared with the family members according to the individual situation. For the most part, family members help the elderly remain socially active and included in the family or social networks (as cited in Leeson, 2004).

Whereas informal personal caregiving is not common in Denmark, the government supports family caregivers with specific measures that are fixed by law. The municipal council offers substitute or respite services to spouses, parents or other close relatives caring for a person with impaired physical or mental functions (CASS, ch. 16, section 84(1)). The municipality has to employ closely connected persons who are attached to the labour market, and who wish to care for a relative with substantial and permanent impairments of physical or mental functions in the person's home if specific conditions are fulfilled. The carer may be employed for up to a continuous period of six months and receive a monthly salary of DKK 16,556. Furthermore, a person caring for a closely connected person who wishes to die in his/her own home is entitled to a constant care allowance, which amounts to 1.5 times of the sickness benefits to which the recipient is entitled.

3.4 Demand and supply of formal care

Demand

One of the main aims of the social services for the elderly is to ensure that the elderly can stay in their own home as long as possible and avoid institutionalisation. Thus, a large share of the recipients of permanent home help (206,600 in total) lives in their own home: around 165,700 persons in 2007. Some 41,000 individuals received permanent home help in nursing homes or nursing dwellings (Table 2). Whereas those living in nursing homes receive personal care as well as help with practical tasks, individuals living in their own home can receive personal care alone or help with practical tasks or both types of services. Around 44% of recipients living in their own home receive help solely with housework and 12% solely with personal care (Table 3).

Following the governmental structural reform that took place in 2007, there has been information about the gender of care recipients, but only for 92 of the 98 new municipalities. According to this information, around 69% of the recipients are women, and among the elderly recipients they represent around 72% (in 2008).

Recipients of permanent home help by age group

Although the assistance is provided irrespective of the age of the recipients, the 'need for care' occurs more often as individuals grow older. Thus, a great share of those receiving permanent

home help was 65 years old and older. In 2007, 179,000 of the elderly received permanent home help, among whom 116,000 were the oldest old (80+) (Table 4). As a result, around 21% of the elderly in Denmark received long-term care in 2007. Individuals in need of care not receiving home help or nursing care in an institution are rare. This comfortable situation can be traced back to the fact that (among other things) every municipality has the obligation to offer each citizen who has turned 75 years old and lives in his/her own home without personal or practical help at least two preventive home visits every year. The visits are carried out by community nurses, who evaluate the needs of the elderly and arrange the necessary help. In 2007 around 178,000 home visits were completed, but some 117,000 were refused by the elderly.

In total around 3.8% of the population received practical and personal care by the municipalities in 2007, but the share of dependent persons increased sharply with age (Table 5). The share of persons receiving permanent home help amounted to less than 5% until the retirement age (65), but rose to 21% at ages 75 to 79, up to 37% at ages 80 to 84, up to 60% at ages 85 to 89 and up to 83% at age 90 and older.

Compared with the share of beneficiaries of the long-term care insurance funds in Germany, a higher percentage of persons in need of care received permanent home help in the single age groups in Denmark. This can be traced back to the fact that in Germany only those with substantial impairments in ADLs (the minimum being impairments in two activities) and additionally in at least one instrumental activity of daily life (IADL) are entitled to receive benefits. In Denmark the eligibility criteria are more comprehensive (without minimum requirements). While a total of 21% of the elderly (aged 65+) received permanent home help in Denmark in 2007, only around 2% received personal care and 12% received both personal care and help with practical tasks. Thus, if we compare only those individuals who received both personal care and help with practical tasks in Denmark with the recipients in Germany, then the figures are similar (particularly for the older age groups).

Recipients of permanent home help by duration of help

The broad definition of the ‘need for assistance’ led to a high percentage of persons receiving less than two hours of permanent help per week. In 2007 around 50% of the elderly received up to two hours of help, around 11% between two hours and less than four hours of help, and another 11% between four hours and eight hours of help (Table 6). There is a clear distinction in the duration of help provided between individuals living in their own home and those living in a nursing home or a nursing dwelling. Recipients living in their own home received on average fewer hours of help than residents in nursing homes: 62% received less than two hours of help per week and another 13% between two and four hours, while half of those living in nursing homes received 20 hours or more of care. Almost all beneficiaries receiving help solely with housework at home got less than two hours help per week (98% all ages, 99% of the elderly).

Only a small share of individuals living in their own home needed intensive or highly intensive help. Around 3% of the elderly received more than 20 hours of help. The figure is a little bit higher for persons receiving both kinds of care (personal and practical help). The proportion of persons in need of intensive care among total recipients increased with age. Among recipients aged 90 and older 22% needed intensive care.

Persons living in nursing homes and nursing dwellings

Besides the statistics for recipients of permanent home help, the statistics for clients in nursing homes and special dwellings for the elderly provide information about the characteristics of clients differentiated by accommodation. The two sets of statistics are not fully comparable, but the latter provides additional information.

According to the client statistics around 12,200 persons lived in nursing homes, 2,200 in protected dwellings and 31,100 in nursing dwellings in 2007 (Table 7). Thus, the number of clients living in institutions or dwellings with around-the-clock services provided by permanent staff was a little bit higher than the number of recipients of permanent home help in nursing homes and nursing dwellings.

Residents in nursing homes were on average older than those living in nursing dwellings: the share aged 90 and older living in nursing homes was 28%, but amounted to 24% in nursing dwellings (Table 8). Nevertheless, nearly all clients were 65 years old and older (95% and 93% respectively) in both kinds of accommodation. Therefore, 1.6% of the population aged 65 years and older lived in nursing homes (and protected dwellings), and around 3.4% in nursing dwellings.

The number of persons living in special dwellings for the elderly amounted to 39,500 in 2007, among whom 32,700 were aged 65 years and older (in general and other dwellings for the elderly combined). As the number of the elderly (65+) receiving permanent home help at home (including in dwellings for the elderly) was 141,500 in 2007, the number of recipients living in their own home (not including those in special dwellings for the elderly) can be estimated at around 100,000, which equates to 57% of all elderly recipients.

Recipients living in their own home or in general dwellings are on average younger than those living in nursing homes or nursing dwellings. The share aged 90 and older, at 11%, is much lower than the share in nursing homes.

But at the same time, the individuals in nursing homes do not always fulfil the common definition of being in need of care. A study carried out by Ikegami et al. (1997) analyses the share of low-care cases in nursing homes. In Denmark, 43% of the persons studied who were living in nursing homes in Copenhagen were classified as low-care cases. Still, the data stem from 1992 and in the meantime the situation may have changed owing to the deinstitutionalisation strategy.

Temporary home help

Temporary home help is provided to persons in special living situations, for example after hospitalisation. Temporary home help is not part of long-term caregiving, but the figures are mentioned here to provide a complete picture of home help. In 2007 around 17,500 individuals received temporary home help for one period, and an additional 4,300 for two periods or more. Three out of four persons receiving temporary help were at retirement age (65+).

Supply

Nursing homes

As permanent home help is given strict priority over caregiving in nursing homes, no new nursing homes have been constructed since 1987 (Strandberg-Larsen et al., 2007). Thus, nursing homes are in the process of being phased out. Various forms of service-enriched housing are being developed in their place with the active support of the municipal and national governments. The goal is to create non-institutional but supportive living arrangements for the elderly with varying levels of functioning. Such housing is often located near and linked with existing nursing homes, sheltered accommodation, day-care homes or day centres and/or community centres to maximise the use of personnel and facilities, as well as to ensure convenient access to home help, home nursing and other community services (Brodsky et al., 2003).

As with home-care services, it is the municipalities that determine whether a citizen requires a form of help that cannot be given in the private home. If a citizen is offered residential

accommodation she or he can decide among the different alternatives within the municipality or even more to another. In cases where a person wishes his/her spouse, cohabiting or registered partner to remain part of the household, the accommodation offered must be suitable for two persons. If the recipient dies, the surviving spouse or partner will be entitled to stay on. On 1 January 2009, a care home guarantee was introduced, so that citizens eligible for nursing homes will have to wait no more than two months for a place to stay.

In 2006 there were around 91,000 places in homes suitable for the elderly, of which 45,000 included around-the-clock services from permanent staff. Around 15,400 places were provided in nursing homes in 2006 (Table 9). The number of places in nursing homes has declined markedly in recent decades. In 1987 around 49,000 places in nursing homes existed, while in 2001 the figure was 27,600 and in 2006 it was 15,400. In 2007 and 2008 a further reduction in places in nursing homes could be seen. Meanwhile, the number of dwellings for the elderly increased from 3,300 in 1987, to 37,900 in 2001 and 58,300 in 2006. This development reflects the changes in housing policy for the elderly.

Besides caregiving in nursing or private homes, there is caregiving in day-care centres. In 2006 there were around 29,500 places in day-care centres and day-care homes for the elderly.

Home-care services

Until the new law on 'greater choice of provider' introduced in 2002, local municipalities were the only providers of home care for the elderly. The new law aims at securing for elderly persons who receive home-care services the freedom to choose among different providers, the option of changing the help they receive from time to time and the possibility of moving to another municipality (with the entitlement). The municipalities have to calculate a unit price for home services and to invite private providers to compete for delivery. Private 'for profit' providers of home care are gaining an increasing share of the market – some 600 private providers existed in 2006, but they are mainly in the field of practical assistance, so the share of the total number of hours worked has remain below 5% (Goul Andersen and Carstensen, 2009). Free choice is popular and user satisfaction is slightly higher among those using private suppliers. Private providers can also compete by offering additional services for payment – an opportunity that municipalities do not have. But this has remained quite limited.

Public and private home-care services provide personal care as well as help with practical tasks. Often (public) home-care services also provide nursing home care. In 2006 some 1.1 million hours of assistance were provided by home-care services (Table 10). The greatest share of hours was provided for the combination of personal and practical assistance, around 0.93 million hours. Whereas the share of elderly persons (40% of recipients) receiving solely practical help amounted to 44%, the number of hours provided amounted to just 60,500. Thus, the average hours per week provided to individuals receiving just practical help was only 0.7 in 2006. On average the number of care hours per week amounted to 5.4 hours for all persons receiving permanent home help. For those receiving both personal and practical help, the number of hours provided on average, at 9.24, was much higher. The time spent on caregiving and help was higher for the oldest old, who received both kinds of help (9.6 hours). Owing to financial pressures, municipalities had reduced the hours of help provided solely for practical tasks. In 1999 more than 12% of the hours of assistance given was just for help with housework, compared with only 5% in 2006. A shift towards the provision of a combination of help also took place. The share of hours provided for both (personal and practical assistance) increased from 77% in 1999 to 84% in 2006.

Employees engaged in measures for the elderly

In total, 100,000 persons were employed in measures for elderly persons in 2006 (full-time equivalent, see Table 10). Around half of them were home-helpers, social and health workers

(45,300) and more than a quarter were social and health assistants (26,300). Only 6.4% were engaged in nursing and another 2.5% in managerial nursing. Those employed in catering, cooking, kitchen help and cleaning amounted to 8,500 full-time equivalents, which represents 4.5% of the employees. In addition were those engaged in physiotherapy and pedagogical work, (around) 4,800 persons.

Between 2001 and 2006, the number of employees increased by 4.5% (4,300 full-time employees) driven by the ageing of the population (Statistics Denmark, 2009). Most of the additional employees were home-helpers and social workers (2,900), but also the number of employees in physiotherapy and pedagogical work showed dynamic expansion.

4. Long-term care policy

4.1 Policy goals

The Danish welfare state has three primary characteristics: universalism, primarily tax-financed provision and single string provision. While the national government has developed the legislative framework for social and health policies, the regional authorities are responsible for health-care services and the local authorities are in charge of most of the services close to the citizens, including long-term care to the elderly. The local self-government provides the foundation of the Danish welfare society. The goal is to provide care services to everyone in need of care, generally free of charge, independent of income, age or potential family caregivers. The objective is to help people to help themselves, i.e. local authorities provide services as supplementary assistance for tasks the person is unable to perform him- or herself (CASS, ch. 16, section 83). The local authority's decision about the level of care services provided must be based on an overall assessment of the applicant and must relate to the individual's specific needs. The assistance is to be adapted from time to time in line with the actual needs of the recipient.

4.2 Integration policy

Following the administrative reform in Denmark in 2007, the primary care sector is financed by the regions and local authorities. Medical assistance and hospital treatment are free of charge for patients, and between 25% and 60% of the costs of specialist health services (provided by dentists, psychologists, chiropractors and physiotherapists) are also covered (European Commission, 2009). Local authorities are responsible for home nursing (offered free of charge on doctor's orders), and as of January 2007 also for some rehabilitation and health promotion and prevention. The secondary care sector, consisting of hospitals (including psychiatric treatment), is operated by the five new regions. The local authorities are responsible for providing the various forms of long-term care services. Denmark has the aim of integrating health and social care. The integrated health and social services implies that the services are provided to all elderly persons by integrated teams of home-helpers, home nurses, etc. (Colmorten et al., 2003). Therefore, Denmark has introduced a case management system. Each elderly person in need of support has a case manager in the municipality, who is the individual counsellor of the older person applying for support. The case manager coordinates the efforts and cancels them when the elderly is hospitalised, on vacation or visiting relatives. Home nursing services, personal home-care services and practical home-care workers cooperate and coordinate their services. Many local authorities cooperate on measures of prevention and rehabilitation for the elderly, with the goal of enabling older persons to remain in their homes for as long as possible. In addition, practical and personal assistance is supplied by local authorities, which employ physiotherapists or occupational therapists.

As regards the discharge of older persons from hospital, there are no regulations or standards to ensure coordination, although in some counties (before the local government reform) the hospitals and municipalities reached their own agreements on coordination. Even though health and social care appears to be fairly well integrated at the municipal level, problems have persisted in coordinating the activities of the municipalities and the counties/regions (Colmorten et al., 2003). The bulk of such problems in terms of integration occur at the interface between the regionally administered hospital system and the municipally administered health and social care services.

4.3 Recent reforms and the current policy debate

The local government reform, which entered into force on 1 January 2007, established 98 new, large local authorities (previously 275) and five regions (previously 16 counties). The reform laid down the framework for strengthening local self-government. Principles for good, decentralised management were agreed by the central government and the local authorities. The principles underline the rights and duties of the local councils to take responsibility for determining and prioritising the service level and for ensuring the quality of task management.

As regards major reforms, the Danish government has submitted a proposal for a reform to ensure the renewal and development of the quality of care in old age (Council of Europe, 2008). The reform means that the provision of care must be even more flexible than today and focus more closely on the individual needs of the elderly. One way to achieve this is to spread positive experience more quickly and invest in a better physical infrastructure. The government's preventive initiatives have to be seen in this context. The objective is for as many people as possible to have good conditions for a healthy, well-functioning and high-quality life. These conditions will help to postpone the need for public assistance.

The reform initiative on the quality of care also includes the intention to reduce the number of different assistants visiting the individual citizen. The aim is for recipients of home-help services to be entitled to a permanent contact person who must be close to the citizen. Furthermore, the local council's contract with the citizen must include clear and measurable objectives for the services, including home care. The idea is for citizens to receive clear information about the service level they can expect in the individual local-authority service areas (Council of Europe, 2008).

As part of the quality strategy, a quality fund is to be established, some of which will be allocated to improving the physical infrastructure and introducing new technology, in particular labour-saving technology for old age care (Government of Denmark NSR, 2008). Additionally, an accreditation model will be tested that systematically supports staff work with quality development through ongoing learning by providing the opportunity to use experts as sounding boards.

Besides the quality reform, the reduction of long waiting times for places in nursing homes or special dwellings for the elderly currently constitute a challenge. A care-home guarantee was introduced with effect from 1 January 2009, under which older persons with special needs for a dwelling in social housing or a care-home place must receive an offer of such accommodation at least two months after being accepted on the waiting list.

Another challenge is to increase the information about the possibility of free choice. As of 1 January 2003, persons in need of care have been entitled to choose among various home help providers (Ministry of the Interior and Health, and Ministry of Social Affairs, 2005). People are often unaware of these options, however. Individuals with a comprehensive and permanent need for help because of reduced physical or mental functional capacity can obtain a cash subsidy to hire their own assistants, through citizen-managed personal assistance (CASS, ch. 16, 95ff). The

rules in this area have recently been changed to increase self-determination and flexibility in the schemes. Both citizens and case managers must have the necessary knowledge about the new option.

4.4 Critical appraisal of the long-term care system

The demographic development of the proportionally increasing number of elderly persons among the total population in Denmark is expected to pose serious challenges for municipalities. To reduce the financial costs of care for the elderly, health and social authorities are attempting to place more and more emphasis on self-care, and effective preventive and health-promoting activities. The government and the local authorities are agreeing to focus on the positive resource network that relatives represent for older and disabled persons. The local authorities must therefore be aware of including the relatives and other relevant persons with a view to allowing them to assume responsibility (Government of Denmark NSR, 2008). However, it seems likely that patient co-payments and contracting services to private non-profit agencies will become increasingly popular tools for reducing costs and raising revenue in the future (Strandberg-Larsen et al., 2007).

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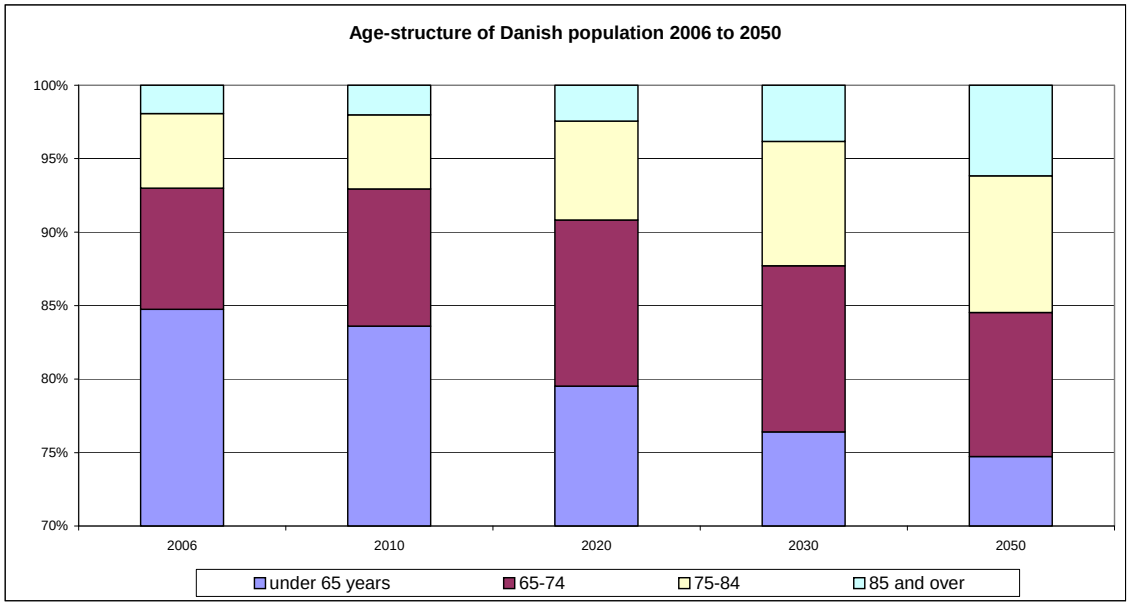
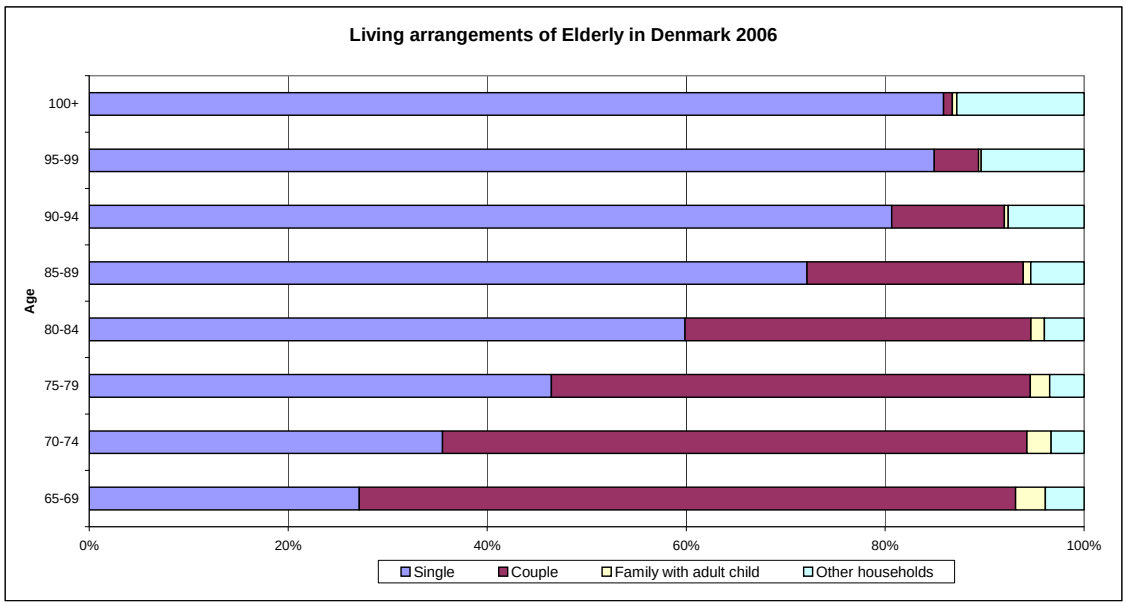
Figure 1. Age structure of the Danish population from 2006 to 2050



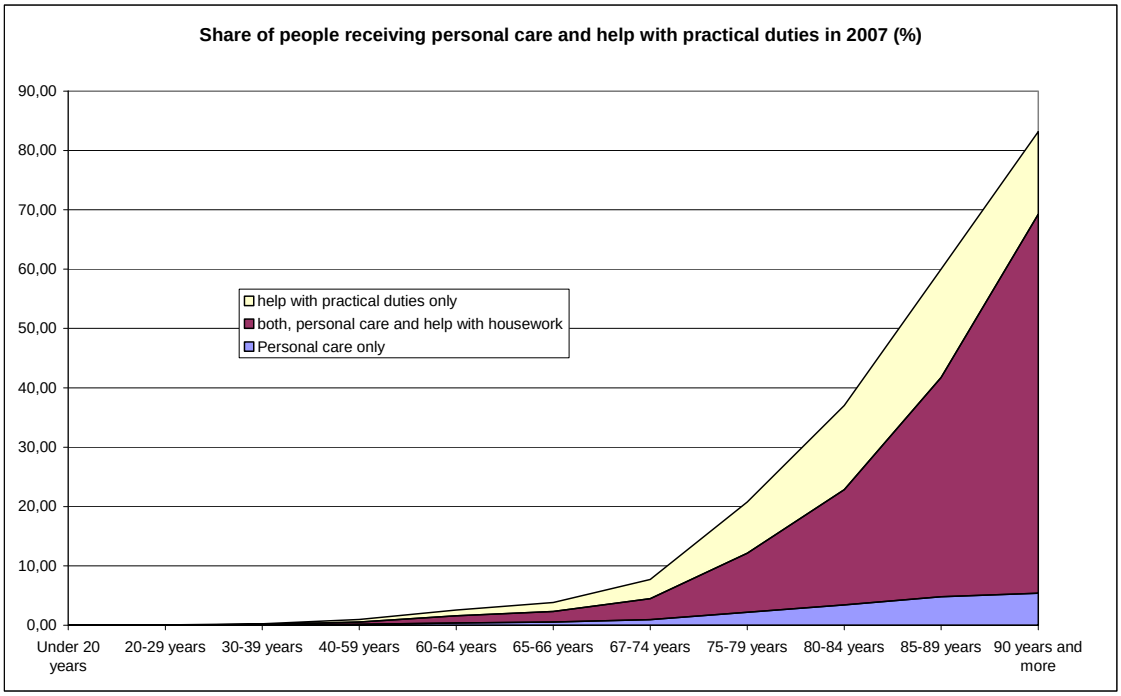
Sources: Statistics Denmark, calculations by DIW Berlin.

Figure 2. Living arrangements of the elderly in Denmark in 2006



Sources: Statistics Denmark, calculations by DIW Berlin.

Figure 3. Share of persons receiving personal care and help with practical tasks in 2007 (%)



Sources: Statistics Denmark, calculations by DIW Berlin.

Table 1. Social expenditure on old age benefits in Denmark in 2005 (million DKK)

	Social expenditure	Financing						
		Public authorities total	Of which Central Government	Employers (contribu-tions, premiums)	The insured (contribu-tions, special taxes)	Financing, other	Total columns 2., 4. and 5.	Transfer to and from funds (7.-1.)
	1.	2.	3.	4.	5.	6.	7.	8.
IV.a Old age								
1. Cash benefits								
A. Retirement pensions	112993	71571	70988	45371	17528	0	134469	21477
Of which								
a. Basic/minimum pension	71437	71437	71018	0	0	0	71437	0
b. Employment pension	6657	52	-113	4425	2467	0	6944	287
c. Supplementary pension	34899	82	82	40946	15061	0	56088	21189
B. Special retirement pensions	29093	3690	2005	-	25403	0	29093	0
C. Partial retirement pension	60	60	60	0	0	0	60	0
D. Other	24	24	0	0	0	0	24	0
Cash benefits, total	142170	75345	73053	45371	42931	0	163647	21477
2. Services								
A. Institutions, etc.	1856	1856	0	0	0	0	1856	0
B. Assistance to carry out daily tasks	25008	25008	3	0	0	0	25008	0
C. Other	1340	1340	101	0	0	0	1340	0
Services, total	28203	28203	104	0	0	0	28203	0
Total IVa.	170374	103548	73157	45371	42931	42350	191850	21477

Source: Social protection in the Nordic Countries 2006.

Table 2. Persons receiving permanent home help at home and in nursing homes and dwellings in Denmark in 2007

Age-groups	People receiving care and help	
	at own home*	in nursing homes and nursing dwellings
Age, total	165669	40959
Under 20 years	139	4
20-29 years	446	6
30-39 years	1803	78
40-59 years	13420	1327
60-64 years	8316	1191
65-66 years	3662	634
67-74 years	23057	3927
75-79 years	27433	5238
80-84 years	35830	8034
85-89 years	32371	10037
90 years and more	19192	10483
65+	141545	38353
80+	87393	28554

*) Including general and other dwellings for the elderly.
Source: Statistics Denmark.

Table 3. Recipients of permanent home help by type of help in Denmark in 2007

Duration hours per week	Total	People receiving			
		only personal help	only practical help	both kinds of help	only personal help or both
	All age-groups				
Total duration	100	12,72	43,98	43,30	56,02
< 2 hours	100	11,18	69,14	19,68	30,86
2-3,9 hours	100	18,17	5,25	76,58	94,75
4-7,9 hours	100	14,31	0,50	85,19	99,50
8-11,9 hours	100	13,14	0,06	86,81	99,94
12-19,9 hours	100	12,18	0,10	87,73	99,90
>=20 hours	100	15,26	0,12	84,62	99,88
	Elderly (65+)				
Total duration	100	11,83	43,29	44,87	56,71
< 2 hours	100	10,49	69,17	20,34	30,83
2-3,9 hours	100	17,21	3,63	79,16	96,37
4-7,9 hours	100	13,18	0,28	86,54	99,72
8-11,9 hours	100	12,09	0,06	87,84	99,94
12-19,9 hours	100	10,37	0,08	89,55	99,92
>=20 hours	100	13,09	0,07	86,84	99,93

Source: Statistics Denmark.

Table 4. Number of recipients of permanent home help by age group in Denmark in 2007

Age-groups	People in need of care receiving				
	Permanent home help total	home help at home			in nursing homes
		help with practical duties only	Personal care only	both, personal care and help with practical duties	
Age, total	206628	72857	21070	71742	40959
Under 20 years	143	21	100	18	4
20-29 years	452	231	102	113	6
30-39 years	1881	1043	317	443	78
40-59 years	14747	6613	2366	4441	1327
60-64 years	9507	3668	1438	3210	1191
65-66 years	4296	1685	602	1375	634
67-74 years	26984	11298	3316	8443	3927
75-79 years	32671	13624	3468	10341	5238
80-84 years	43864	16792	4058	14980	8034
85-89 years	42408	12920	3384	16067	10037
90 years and more	29675	4962	1919	12311	10483
65+	179898	61281	16747	63517	38353
80+	115947	34674	9361	43358	28554

Source: Statistics Denmark.

Table 5. Share of persons receiving personal care and help among the population in Denmark in 2007

Age-groups	People in need of care receiving			
	Permanent home help total	Personal care only	both, personal care and help with housework	help with practical duties only
	Share of people in need of care in population			
Age, total	3,78	0,39	2,06	1,33
Under 20 years	0,01	0,01	0,00	0,00
20-29 years	0,07	0,02	0,02	0,04
30-39 years	0,25	0,04	0,07	0,14
40-59 years	0,97	0,16	0,38	0,43
60-64 years	2,58	0,39	1,20	1,00
65-66 years	3,82	0,54	1,79	1,50
67-74 years	7,72	0,95	3,54	3,23
75-79 years	20,78	2,21	9,91	8,67
80-84 years	37,04	3,43	19,43	14,18
85-89 years	60,01	4,79	36,94	18,28
90 years and more	83,17	5,38	63,88	13,91
65+	21,32	1,98	12,07	7,26
80+	51,58	4,16	31,99	15,43

Table 6. Recipients of permanent home help by duration of help in Denmark in 2007

Duration hours per week	People receiving permanent home help total	help at home total	only personal help	only practical help	both kinds of help	both kinds of help
	Total	Living in their own home				Living in nursing homes*
	All age-groups					
Total duration	100,00	100,00	100,00	100,00	100,00	100,00
< 2 hours	51,10	62,53	54,97	98,32	28,41	4,86
2-3,9 hours	11,16	12,74	18,20	1,52	22,53	4,79
4-7,9 hours	11,08	11,89	13,37	0,14	23,38	7,84
8-11,9 hours	6,35	5,44	5,61	0,01	10,90	10,07
12-19,9 hours	7,74	4,32	4,14	0,01	8,76	21,54
>=20 hours	12,56	3,08	3,70	0,01	6,02	50,90
	Elderly (65+)					
Total duration	100,00	100,00	100,00	100,00	100,00	100,00
< 2 hours	49,69	61,86	54,83	98,84	28,04	4,77
2-3,9 hours	10,95	12,64	18,39	1,06	22,30	4,72
4-7,9 hours	11,28	12,23	13,63	0,08	23,60	7,74
8-11,9 hours	6,66	5,73	5,86	0,01	11,22	10,07
12-19,9 hours	8,19	4,52	3,96	0,01	9,03	21,73
>=20 hours	13,23	3,01	3,33	0,00	5,82	50,96

*) Including nursing dwellings.
Source: Statistics Denmark.

Table 7. Clients in nursing homes and special dwellings for the elderly in Denmark in 2007

Age	Nursing homes	Protected dwellings	Nursing dwellings	Nursing together	General dwellings*	Other dwellings*	Dwellings together	Total
Under 60 years	306	222	1263	1791	2945	1723	4668	6459
60-64 years	334	115	932	1381	1475	587	2062	3443
65-66 years	190	46	515	751	790	284	1074	1825
67-74 years	1114	244	2970	4328	4530	1486	6016	10344
75-79 years	1443	268	3978	5689	4562	1495	6057	11746
80-84 years	2385	362	6403	9150	6027	1855	7882	17032
85-89 years	3091	504	7615	11210	5443	1678	7121	18331
90 and older	3372	481	7405	11258	3439	1135	4574	15832
Total	12235	2242	31081	45558	29211	10243	39454	85012
65 and over	11595	1905	28886	42386	24791	7933	32724	75110

*) For elderly persons.
Source: Statistics Denmark.

Table 8. Age structure of clients in nursing homes and special dwellings for the elderly in Denmark in 2007

Age	Nursing homes	Protected dwellings	Nursing dwellings	Nursing together	General dwellings*	Other dwellings*	Dwellings together	Total
Under 60 years	2,50	9,90	4,06	3,93	10,08	16,82	11,83	7,60
60-64 years	2,73	5,13	3,00	3,03	5,05	5,73	5,23	4,05
65-66 years	1,55	2,05	1,66	1,65	2,70	2,77	2,72	2,15
67-74 years	9,11	10,88	9,56	9,50	15,51	14,51	15,25	12,17
75-79 years	11,79	11,95	12,80	12,49	15,62	14,60	15,35	13,82
80-84 years	19,49	16,15	20,60	20,08	20,63	18,11	19,98	20,03
85-89 years	25,26	22,48	24,50	24,61	18,63	16,38	18,05	21,56
90 and older	27,56	21,45	23,82	24,71	11,77	11,08	11,59	18,62
Total	100	100	100	100	100	100	100	100
65 and over	94,77	84,97	92,94	93,04	84,87	77,45	82,94	88,35

*) For elderly persons.
Source: Statistics Denmark.

Table 9. Places in nursing homes and dwellings for the elderly from 2006 to 2008

Kind of home/dwelling	Places in nursing homes and dwellings		
	2006	2007	2008
Nursing homes	15424	12591	10470
Protected dwellings	2870	2202	2024
Nursing dwellings	32016	32249	34293
General dwellings for elderly persons	26276	29636	30173
Other dwellings for elderly persons	14846	10012	9288
Total	91432	86690	86248

Some municipalities report large deviations between dwellings from year to year and the coupilation is consequently less reliable. The number of dwellings and the number of persons cannot off-hand be compared, since they are compiled differently.

Table 10. Delivered hours of permanent home help per week in Denmark in 2006

Age-groups	People in need of care receiving: Permanent home help total	Personal care	both, personal care and help with housework	help with practical duties only
	Delivered hours of care and help per week			
Age, total	1.113.001	117.511	934.979	60.512
0-64 year	131.497	24.985	95.099	11.413
65-66 years	19.592	3.061	15.024	1.507
67-79 year	279.979	34.657	225.226	20.095
80 year and more	681.934	54.808	599.629	27.497
	People receiving care and help			
Age, total	206.886	20.716	101.181	84.989
0-64 year	28.675	4.185	10.758	13.732
65-66 years	4.283	598	1.699	1.986
67-79 year	62.506	6.763	26.196	29.547
80 year and more	111.422	9.170	62.528	39.724
	Delivered hours per week per person			
Age, total	5,38	5,67	9,24	0,71
0-64 year	4,59	5,97	8,84	0,83
65-66 years	4,57	5,12	8,84	0,76
67-79 year	4,48	5,12	8,60	0,68
80 year and more	6,12	5,98	9,59	0,69

Source: Statistics Denmark.

Table 11. Staff engaged in measures for elderly persons in Denmark in 2006 (full-time equivalent)

Function	Full-time equivalent
Total	99909
Management	447
Administrative work	1942
Ordinary office work	1857
Managerial nursing	2520
Nursing	6359
Physiotherapy etc.	3240
Pedagogical work	1527
Social and health care assistants etc.	26311
Home helpers, social and health workers etc.	45324
Catering and cooking of meals	4121
Cleaning and kitchen help	4367
Caretaker	1895

Source: Statistics Denmark.

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ANCIEN

Assessing Needs of Care in European Nations

FP7 HEALTH-2007-3.2-2

Launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

1) How will need, demand, supply and use of LTC develop?

2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (http://www.ancien-longtermcare.eu).