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GOBIERNO DE ESPAÑA
MINISTERIO DE DERECHOS SOCIALES Y AGENDA 2030

Plan de Recuperación, Transformación y Resiliencia

Case studies on international policy and implementation – Case 10

De-institutionalisation in long-term care for older people in Denmark

Estrategia estatal de desinstitucionalización

Para una buena vida en la comunidad

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September 2023

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Key messages

For half a century, long-term care in Denmark has been provided according to the principles of self-directed life in the community. Over the last decades, drivers for changes in policies have been ageing populations and shortage of staff. The main policy concern today is therefore how to ensure sufficient and high-quality provision of care.

- Long-term care for elderly in Denmark is the responsibility of the 98 municipalities. They organize, finance and, for the most parts, also deliver services.
- The free provision of home care is a central service supporting de-institutionalisation
- Home care includes personal care as well as practical assistance in the home, mainly cleaning.
- Take-up of home care has in recent years declined, and mainly due to policy changes and targeting. This puts more pressure on institutional care.
- The de-institutionalization policy has been strengthened with the introduction of *reablement*, a goal-oriented, cross-disciplinary intervention aiming to maintain functional ability.
- Equally supportive is the evidence-based intervention of preventive visits.
- The long-care system is based on professionalized and formal care work. However, today one in four care workers have no formal care education.
- Working conditions are poor and it is difficult to recruit and retain staff.
- A choice of home care provider has been introduced in order to introduce elements of consumerism but also to forward the quality of care. Today more than one in three use a for-profit home care provider.
- The quality of the services is monitored through the development of quality indicators; most recent indicators focus on outcome quality such as maintenance of functional ability and whether service provision succeeds in avoiding hospitalization.

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Introduction

The foundation for long-term care services for older people in Denmark is the de-centralised public service model. The 98 municipalities are responsible for policy making and for the organisation, financing, and provision of services, resulting in substantial inter-municipal variation in service production, provider-mix and delivery.

Being mainly tax-based, Danish long-term care services are in comparison to other countries relatively affordable (or as is the case for home care entirely free). They are also relatively attractive, of high quality and flexible in the sense that they cater for individual needs. Being based on the principle of universalism, long-term care services are also available for all citizens who have a need for care. Over time, Denmark has therefore established what is by international standards a generous model of care for older people, which is generally used across social classes and without social stigma.

The model also supports gender equality and the facilitation of the dual earner-dual carer model, where men as well as women may participate in unpaid care as well as in paid labour. Many women in fact work as formal care workers in the long-term care sector. Long-term care as a welfare good is generally supported in the population and it is also prioritized politically, being central on the agenda for many political parties. As an example, there is a particular Ministry for Older Citizens, that is in charge of the regulation and overall municipal budgeting.

Long-term care for older people in Denmark is framed not least by the policy of de-institutionalization which was introduced in the early 1970s. The policy favoured care in the home, or so-called community care, over care in an institution. Denmark was one of the first countries internationally to adopt a community care policy (WHO, 2018). This is in order to fulfil the preferences of many older people who wish to remain in their own homes, as well as providing a more cost-efficient alternative to institutional care.

The de-institutionalisation policy is supported by the provision of *Home care services*, which has been relatively generous by international standards, although in recent years increasingly targeted at those with the highest needs. Also supportive is the *Preventive home visit* which is offered on a regular basis to older persons living at home as is the more recently introduced *Reablement interventions* which aims at providing support for the continuation of functional abilities for the older person.

The municipalities set the local quality standards, and de-institutionalisation is a policy goal albeit implicit. A number of national initiatives have focused on the development of *Quality indicators*, the latest with a focus on outcome quality.

However, like other ageing countries, Denmark is struggling with increasing need for long-term care and the availability of resources, both fiscal but to high degree also human resources. Being based on the formal and professionalized delivery of care, the Danish long-term care system requires continued up-take of students in the care educations; however, fewer and fewer young people seem interested in pursuing a career as a formal carer. Some adjustments in service delivery have occurred in the last decades, mainly affecting the provision of home care, where fewer and fewer older people are rewarded this kind of service, with indications of unmet need as a result.

1. De-institutionalisation policy

Denmark introduced the policy principle of de-institutionalisation in the 1970s which meant that home care was prioritized over institutional care and that traditional large institutions with multiple beds in each room were to be phased out. Instead, municipalities were encouraged to build nursing home facilities with individual living spaces that could better accommodate a person-centred approach to care.

This culminated in the 1987 Act on Housing for Older and Disabled People which set a stop for building of traditional hospital-like nursing home institutions. As of then, modern nursing homes (now termed '*plejeboliger'*) were to be built as centres which in addition to common facilities include separate and individual apartments with own facilities such as kitchen/kitchenette, own bathroom and normally also two separate rooms. The apartments also normally include a doorbell and a mailbox, signalling that this is an independent dwelling.

As part of the de-institutionalisation strategy, residents are legally considered as tenants. This means that older people from then on would receive their full pensions. Before, only pocket money would be paid out and the remaining amount would be used for covering the costs of a standardized package of care and services. As part of the new law, older people should now decide whether they want to purchase services such as cleaning, food, and laundry, while care services are part of the standard offer. The vast majority of nursing home residents today live in these modern facilities.

The development towards de-institutionalisation in long-term care for older people was strongly influenced by various reports from the *National Commission on Ageing* in the 1980s. The policy recommendation was here to ensure active care that could facilitate self-care (*hjælp-til- selvhjælp*) in old age, and in this way encourage a more preventive and rehabilitative approach (Boll Hansen et al, 1991). The Commission reports also introduced principles of continuity and normalization, meaning that regardless of need for care, the provision of care should aim at ensuring the continuation of the older person's preferred way of living and ensure that they could remain in their own home for as long as possible (*længst muligt i eget hjem*), which became a popular slogan for de-institutionalisation.

The de-institutionalisation policy stands strong even today in Denmark where 3.3 % of the population 65+ live in a nursing home but can also constitute an expensive solution for the municipalities if intensive care is required. Some municipalities therefore set a maximum number of weekly hours as a standard, for instance 50 hours. If the need for care is above this, they offer a place in a nursing home as an alternative.

2. Organisation

The legal basis of long-term care for frail older people is stipulated in the Social Service Act. It stipulates that provisions of care should enable older people to remain at home as long as it is feasible, in line with the overall policy of de-institutionalisation. The Act also stipulates what kind of social services are offered and which agencies have the

responsibility and/or the obligation of financing, The **Ministry of Older Citizens** has the responsibility of law-making and of drawing up more detailed instructions, circulars or recommendation but the overall principle is that the 98 municipalities are the main authority responsible for planning, organising, providing and regulating social services, including long term care. The five regions are responsible for hospital care.

In general, it is stipulated that the **local municipality** is obliged to provide the necessary care for frail older people and decide on the form of provisions. Implementation of policies is closely followed from central government. Likewise, the annual budget negotiations between the central government and municipalities outline a number of service goals which the municipalities must meet. The municipalities are not bound to provide universal coverage of care but provide services such as home help and nursing home care for older people according to need and local service level.

It is also the municipality which decides whether they see a need for care. Entitlement to both home help and a nursing home place is entirely based on need. A person in need of care is entitled to receive such care, irrespective of age, financial means, income, or family situation. This means that needs assessment should consider the individual situation of the elderly, and not consider whether an adult child, a partner or spouse or other family member would be able to provide the care instead. The municipality is obliged to provide home help services as soon as possible or offer a place in a nursing home or nursing home facility 2 months after initial application at the latest.

3. Financing

Municipalities hold the main role in the financing of long-term care and receive reimbursement through various national state subsidies, block grants and equalization grants. The remainder of the public costs is financed over local income taxes. The equalisation grant evens out local differences in demography, labour market participation and in number of low-income groups. In order to provide an incentive for municipalities to expedite the transfer from hospitals to the community for patients who are ready to be discharged, a special municipal charge was introduced in 2007. This serves as a fine for those municipalities who cannot provide care in the community, resulting in longer hospital stays. The initiative has proven effective and also has an indirect effect for the de-institutionalisation strategy, as older people receive the adequate community services faster.

Since the late 2000s, the average expenditure per person 65+ in the municipalities has fluctuated somewhat but overall tends to decrease, reflecting both the general increase in functional ability but most likely also the change to reablement (see further down) and consequent cuts in home care.

The de-institutionalisation strategy is also facilitated by the lack of user fees for the use of home help, and this is regardless of number of delivered hours. In all other Nordic countries, the user is charged for home care services according to income level. In contrast, residents in nursing homes pay for rent, medication, laundry and for the use of services, up to a max. ceiling of 10-20 % of income depending on the municipality. Residents in nursing homes do, however, not pay for what can be considered home help

services, including help with domestic tasks and personal care, such as bathing and getting dressed, as this is free of charge. As mentioned above, the resident maintains his or her pension and financial means. It is possible to receive rent subsidy. Nevertheless, the rent can be considerable. In total, user payment constitutes 5% of total expenditure on long-term care in Denmark, which is the lowest in the Nordic region; e.g. in Finland, users fees constitute 17% of total costs (Eurostat, 2020).

4. Delivery

The de-institutionalisation policy is not affected by the provider type. All providers should ensure to facilitate self-care in order for the older person to remain living in the community. However, it is more an implicit policy and practice principle and is not controlled nor formally enacted. Depending on the form of care, there are different ways of organising the delivery.

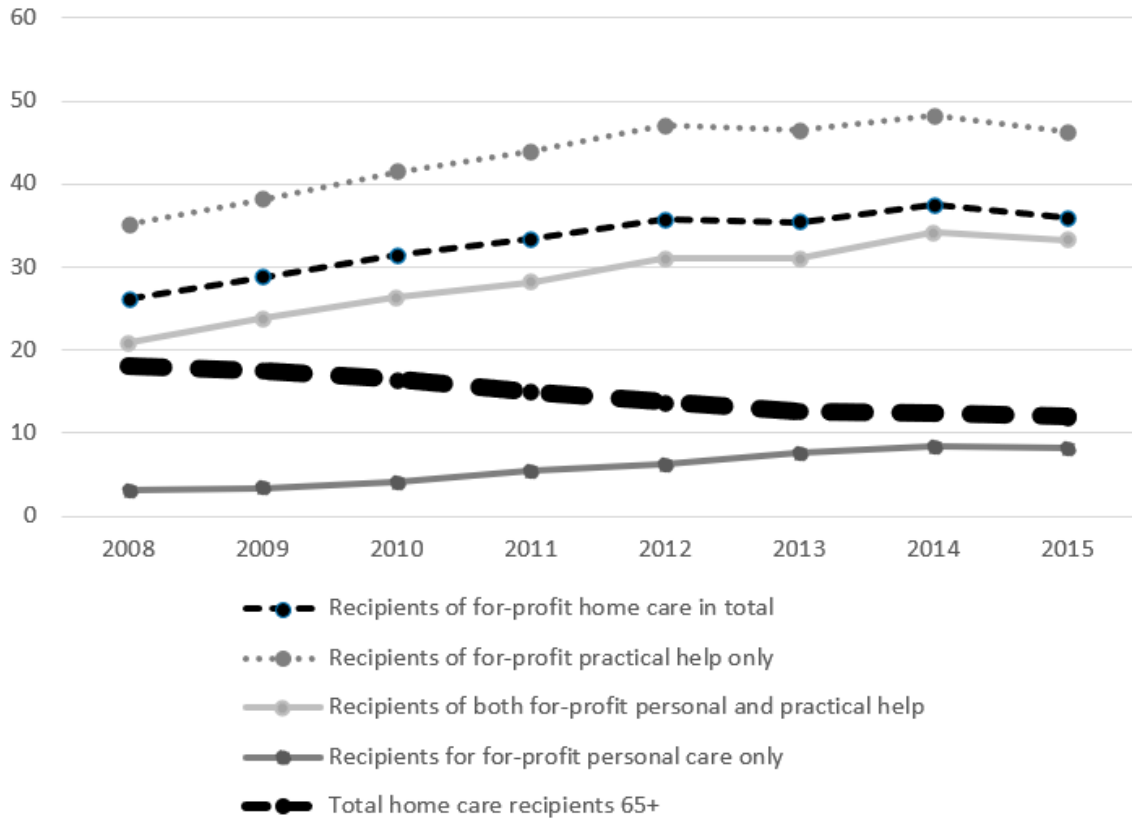
For home care, there is a free choice of provider. The 2003 Law on Free choice of Provider (*Frit valg af leverandør*) made every municipality obliged to ensure that users had a choice of more than one provider of home care, basically introducing a quasi-market in care giving users choice between public and for-profit providers. Non-profit providers are not involved in provision of home care services. The main reason for the introduction of the free choice was to stimulate a market situation where users via their choice of provider would contribute to the development of care quality.

Whether a user chooses to make use of home care services from a public or for-profit provider, the service package is identical, there is the same assessment procedure, and no user fees are involved. However, only those using a for-profit provider can purchase supplementary services through their service provider, something which the municipalities have argued leaves them in a poorer competitive situation. Indirectly, it may also create equity problems, as some users can afford to top-up services, while those who cannot need to rely on the allocated services, which have decreased in intensity and quality over time. Regardless, for-profit providers must, within the same sum of money, provide the same basic services but can otherwise try to perform better in terms of procedures such as communication, customer relations, hours of delivery, continuity of staff etc.

Over time more and more older people have chosen a for-profit provider of home care (See Figure 1) and a mixed market of care has thus been realised. Comparable data only go as far back as 2008 but shows that at that time only one in four used a for-profit provider (26%). Over time, it is consistently those with practical care only who make use of a for-profit provider (from 35 % in 2008 of all home care users with this type of care, to 46% in 2015). However, over time also the frailest users, and thus those using personal care, have increasingly favoured a for-profit provider. Among these users, the proportion using a private, for-profit provider has risen among those with combinations of personal care and practical assistance (from 21% in 2008, to 33 % in 2015 of all home care recipients with this type of care) as well as those with personal care only (from 3 % in 2008, to 8 % in 2015). The figure thus shows an impressive and ongoing increase over time which is however discontinued somewhat from 2013, where it levels out. This is

presumably due not least to a number of bankruptcies in the for-profit sector in later years. As of today, 32% users of home care choses a private, for-profit provider.

Figure 1 - Home care recipients overall of 65+ and use of for-profit provider in total and according to type of assistance in %, 2008-2015



Source: Statistics Denmark, tables AED12 and AED06.

The principles of competition do very much apply when the older person has to choose a service provider. As for free choice of provider in home care services, according to the regulations in the Act on Social Services, the local authority is legally bound to encourage for-profit providers to operate. In comparison to other countries, such as Sweden where private equity funds are involved in the provision of care (Erlandsson et al, 2013), Danish for-profit providers are relatively small and mainly operate on a regional basis.

To ensure that qualified for-profit providers have the opportunity to deliver care, the local authority is required to determine and promulgate the quality standards that providers must meet. According to current regulations, the local authority can enable free choice of providers and access for private for-profit providers under one of the following two models:

- **Competition by tendering (*Udbudsmodellen*):** In the 'competition by tendering'-model (*udbudsmodellen*) under the Free choice legislation, the local authority puts one or more home care services in one or more service districts or in the entire municipality out to tender. Following a competitive tender process, the Act on Social Services requires the local authority to contract with at least two

qualified providers and with the providers who offer the best terms, based on price. The municipal provider is able to participate in the tender process as well, however, it can only continue as a provider if the local authority submits one of the best bids. This means that the municipal provider may risk losing its role as a service provider to a private for-profit provider with a better tender submission. In reality, and as illustrated in Figure 1, one in three service users choose the municipal provider, especially for the provision of personal care. The 'competition by tendering' model allows for a competitive pricing environment; that is, the providers who tender for the services set the prices themselves. When the tendering process does not result in at least two providers, the following 'competition by endorsement'-model must be chosen instead. This is the model most often used.

- **Competition by endorsement (*Godkendelsesmodellen*):** The competition by tendering model may not appeal to local authorities because they run the risk of being excluded from service provision. As an alternative the 'competition by endorsement' model (*godkendelsesesmodellen*) is available as part of the Free Choice legislation. The competition by endorsement model was until 2013 the most often used model. If the local authority chooses to make use of the 'endorsement' model, the local authority determines and promulgates the price and quality requirements that private for-profit providers of personal care and practical assistance need to meet. The price set by the local authority must reflect actual average long-term costs of delivery, and must include costs for administration, rent, wages and so on. Under this model, the local authority is obligated to endorse and contract with every private for-profit provider that meets the requirements on price and quality. Private for-profit providers that meet the requirements and contract with the local authority then operate on equal terms as the municipal provider, although only private for-profit providers are, as mentioned above, able to offer extra services for a fee.

It is up to the individual for-profit providers to decide whether they want to be endorsed for the delivery of both personal care and practical assistance. If a for-profit provider is endorsed to deliver one or both of these services, the provider must be willing to deliver services to all citizens in the municipality and cannot decide to provide services only to, for example, citizens with higher incomes.

The law on free choice does not apply to nursing homes, so municipalities are not obliged to contract out these services or to offer a choice of provider but can opt to do so. Marketisation of nursing home services via user choice is, instead, facilitated by the Law on Independent Nursing Homes (*Lov om friplejeboliger*) which was enacted in January 2007. The aim of the legislation was to increase choice for users of nursing home care, and to introduce more variation in service delivery through competition between various providers. This includes the possibility of buying additional services which nursing home providers are allowed to offer. The spectrum of nursing home providers includes values-based foundations, non-profit providers, for-profit providers, and municipal providers.

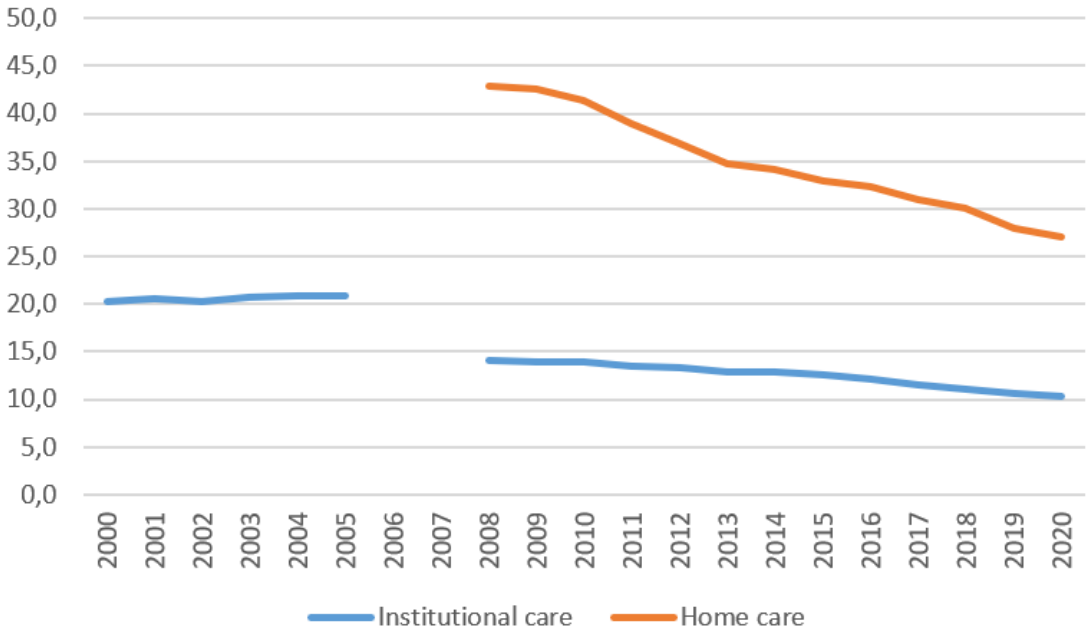
5. Home care

The main service to support the de-institutionalisation policy is the municipally provided home care which offers help with personal care and domestic tasks in the home of the older person. Services are provided mainly by formally trained care workers, with one year or more level of training.

Home care in Denmark is rewarded on the basis of individual need, ideally not considering possible assistance from family members outside the household. As such, is it an individualized and universal care service. The service includes help with housekeeping and personal care, i.e. instrumental activities of daily living (IADL) task such as cleaning, laundering, bed making, and in some cases shopping also, and various activities of daily living (ADL) tasks such as assistance with toileting, dressing, bathing and hair combing. Psychological intervention may also be part of the provision of home help, e.g. time may be set of for the home helper to comfort an elderly who has lost a spouse or otherwise is in a life crisis.

Where home care services have constituted the core social care provision in Denmark, not least due to the policy paradigm of de-institutionalisation, considerably fewer older people in Denmark over time receive home care services. Since 2008, there has been a substantial reduction in the number of recipients aged 65+. This is despite a general increase in the older population in the same period. Figure 2 presents this change: 27 per cent among the 80+ receive home care services today, where the proportion was 43 per cent in 2008. In comparison, the proportion of older people 80+ living in institutional care has not increased. There is also a considerable decline in the average number of hours delivered (not shown in figure).

Figure 2: Older persons 80+ living in institutional care/sheltered housing or receiving home care, 2000-2020 or most recent year



Sources: OECD Health Care Statistics (n.d.) and NOSOSCO (n.d.). Note: For home care, this includes only those who receive regular home care services. Data on institutional care before 2004 and after 2008 is not directly comparable due to a change in the accounting.

The change in take-up of home care is no doubt due to better health and functional ability among both age groups, as described previously. However, self-reported health surveys do not report a similar increase in the health situation, neither among the 65+, nor the 80+ (Lauritzen, 2012). This drop in provision may also be partly attributed to the new reablement policy of offering 'active' training instead of traditional 'passive' care. Also, the change quite likely reflects changes in service standards as most municipalities have cut down on especially hours for cleaning (Rostgaard and Matthiessen, 2019 and 2020).

One of the changes in the take-up of home help has also been the polarisation of resources, whereby more users get only a little help and more get more help, i.e. a practise of combined intensification and spreading of resources. This is not a nationally formulated strategy but has been the applied practise by local governments to keep up with demand. As a result, many older people receive help with domestic tasks only fortnightly or only every third week and often of a duration of only ½ hour (ibid), compared to the early 1990s where it was not unusual to receive cleaning several times a week (Hansen et al, 2002). Help has in this way for some users of practical assistance become more symbolic as it is not possible to provide much help within this time span. This development is not inducive for the continuation of the de-institutionalisation policy.

6. Reablement

Recent changes in long term care supporting the de-institutionalisation policy have especially been related to the introduction of reablement (*Hverdagsrehabilitering*) in home care services as it enables older persons to stay longer in the community.

The introduction of reablement takes its roots in structural changes. Since 2007, the responsibility for services with regards to recovery and chronic phases lies with the 98 municipalities and not the five regions, who instead remained responsible for primary health only. This stimulated an interest in a more preventive but also recovery approach to home care and resulted in the introduction of reablement. The reablement policy as practiced in Denmark offers an approach to needs and frailty in old age that breaks with former models of "passive" long-term care. Reablement is also practised in the United Kingdom and Australia (Aspinal et al, 2015; Rostgaard et al, 2023) but is most widely applied at a national level in Denmark and is since 2015 part of the legislation, and an exemplary model of reablement to inspire local practice has been developed (Socialstyrelsen, 2013).

Instead of providing permanent home care, persons who hold 'potential' for such intervention will be offered a short-term training intervention of what is often 3-12 weeks and provided as an inter-disciplinary team cooperation between care worker, home nurse, occupational therapist, and other relevant professionals. The reablement team meets up regularly at an interdisciplinary case conference to discuss the clients and overall coordinate their work.

The focus for the intervention is on capacities, and, in particular, physical capacities, although mental and social capacities are also in focus. Reablement is "*the result, of a person who has regained, developed or maintained his/her functional ability, to an extent which is in accordance to the persons perception of what is an independent and meaningful life*" (Socialstyrelsen, 2013, p. 5).

More specifically, it consists usually a short-term intervention (3-12 weeks) in the home of the older person, where the focus is on training daily function in order to re-gain or maintain capacities. It is given as a supplement or more often as a replacement to traditional home care. Common areas of focus are helping the older person re-gaining skills in dressing, using the stairs, washing, and preparing meals. But there are also examples of a more holistic approach, such as focusing on social as well as physical capacity.

All interventions should ideally be based on outcome goals that matter to the older person, not to the care worker and in this way the outcome is assessed according to whether the older persons' goal has been met. Often, however, these goals reflect just as much the municipality's interest in reducing services, especially cleaning services. The overall aim is to increase independence and quality of life for the older person as well as reducing costs.

Approximately 80% of older people who apply for the usually permanent home care services are given reablement interventions instead of traditional home care. However, actual effectiveness is not measured, neither nationally nor locally, but there is a strong

political and practice focus on how in particular reablement models may bring about results in the sense that older people become independent of care, and several local evaluations have been conducted, at times as a comparison across municipalities (see e.g. Petersen et al, 2017), but not as randomized or case-controlled designs (for more information on the outcomes of reablement, see also Rostgaard et al, 2023). Municipalities in Denmark report of an expected success rate of around 60% in regard to self-sufficiency post-intervention. There are also no bonus systems in place for the most efficient providers.

7. Preventive home visits

Another intervention which has in fact been tested for effectiveness also in terms of de-institutionalisation, is the preventive home visit offered to older people. The preventive visit has been introduced after several randomised controlled trial studies proved this service cost-efficient in that it reduces the risk of becoming hospitalised or admitted to a nursing home, and proved to have a positive effect on mortality also (e.g. Vass et al, 2007).

Since 1 July 1996, municipalities have been obliged to conduct a preventive home visit for older people 80+, and from 1 July 1998 this included older people aged 75+. With improvements in functional ability the age limit was recently raised again to 80+. Persons 65 years and older who are in poor health or otherwise considered in need will however still be offered such a visit. Some municipalities offer the visit from the age of 65 years for older persons with non-Danish origin, as they have often had more strenuous work lives. The municipal board can also decide to make exceptional visits in relation to the death of a spouse, serious illness, or discharge from hospital.

The visits are to be offered according to need, although at least twice a year. The visit is conducted on acceptance by the older person by a municipally-employed assessor, who must have thorough knowledge of general social as well as health issues. The meeting takes place in the older person's home and should allow the older person and the assessor to evaluate the need for help and care in order that older persons can make use of their own resources, maintain full functional abilities as long as possible, and enhance their social network. Visits may also be made to older people living in nursing homes if the municipal board decides so.

8. Human resources

The qualification of the various professionals is given in the educational structure and the certification system. Formally educated care workers are most often either social care and health helpers or social care and health assistants. The educational program for becoming a Social Care and Health Helper (*SOSU-hjælper*) consists of a 19-month training programme, which is focused on the provision of practical assistance. It includes a 20-week introductory basic course. The remainder of the program is a mix of practical training periods and school study, for example: Three school study periods, a total of 24 weeks, and two practical training periods, a total of 31 weeks.

Another training program is the 20 months Social and Health Care Assistant education (SOSU-assistant), which is also focused on the provision of personal care. This is to be taken on top of the SOSU-helper training. The SOSU-assistant training is a mix of practical training periods and school study, for example: Four school study periods lasting a total of about 32 weeks, and three practical training periods lasting a total of about 48 weeks.

As mentioned earlier, the self-care principle is well integrated in policy as well as practice, albeit at times more implicit, but it supports the de-institutionalisation policy in facilitating that the older person should remain independent and able to live in their home for as long as possible. For this purpose, the curriculum for both social care assistants and helpers include a module on health promotion, prevention and reablement.

The goal is that all persons working with care should have taken at least the basic qualification program of a SOSU-helper but an increasing number of staff work in the sector without formal qualifications. Today only three out of four members of staff have formal qualifications in care.

The tasks performed by care workers in the long-term care sector consist of both basic services such as cleaning but also more sophisticated tasks such as wound dressing and handling of medication. As Table 1 shows, over time care staff in both home care and institutional care spend increasing time on especially documentation and much less time on what can be termed social activities, such as drinking a cup of coffee with an older person. Care workers are also much less likely to spend their time on cleaning tasks, a consequence of the decline in older people who receive home care for this task.

Table 1: Care tasks, care staff in home help and nursing home, 2005 and 2015

	2005 Home help	2015/6 Home help	2005 Institutional care	2015/6 Institutional care
Carry out the following work tasks several times a day:				
Cleaning	17,7	4,43***	2,2	0,5**
Shopping	0,9	0,8	1,5	0,2**
Personal care	54,4	58,5	61,3	67,6**
Performs heavy lifts	36,7	39,3	55,9	62,9**
Administrative tasks such as documentation	10,2	43,5***	14,0	55,1***
Assists an older person on a walk or errand	0,5	1,4	3,4	5,0
Drinks a cup of coffee or the like with an older person	3,7	0,8**	16,4	9,3***
Hands out prescribed medication	-	7,2	-	9,0
Gives injections	-	8,9	-	5,8

Source: Rostgaard and Matthiessen, 2016a.

The social care services is a work sector which attracts women in particular. In a survey among care workers organized in the trade union FOA, women's share of care workers was 96% in home care and 98% in nursing homes. Ageing of the society is a concern also affecting the demographics among care workers and is a concern not least because many care workers retire early. Members of the trade union FOA more often are awarded early retirement pension than employees working in other sectors. As an example of rising average age, home care workers were on average 49.5 years in 2015, compared to 44.6 years in 2005.

With shortage of staff, many municipalities have sought directly to recruit care workers among the migrant population. 6% of care workers in home care and 10% of care workers in nursing homes are today of non-Danish origin. Overall, 13% of home care workers are employed in the private for-profit sector and 11% of the care workers in nursing homes are working in a private for-profit nursing home (Rostgaard and Matthiessen, 2016a). More recently, many municipalities attempt to recruit care workers from abroad, offering basic education and language courses, as well as housing.

Several research reports confirm that the quality of the work environment has been affected by the change in care tasks and the reduction in intensity and quality of care (e.g. NFA 2007a, 2007b and 2007c; Rostgaard and Matthiessen, 2016; Tufte and Borg, 2007).

Regardless, a 2015 survey among staff members organized in FOA, showed that staff still found their work highly meaningful (3 out of 4), but a large, and increasing, share of care workers were concerned about organizational change and felt pressured for time. They also to an increasing degree experienced that they could not develop in their job, that the manager did not have time to guide them and that they had little time to discuss with colleagues. This meant that 4 in 10 care workers seriously considered quitting their job (Rostgaard and Matthiessen, 2016a).

The introduction of reablement in home care does, however, show positive tendencies in regards to the care workers' working conditions. Among those care workers that work with reablement on a regular basis, the abovementioned symptoms of poor working conditions are less prominent (Rostgaard and Matthiessen, 2016b).

Staff working in the private for-profit sector, however, seem to have worse working conditions (Rostgaard, 2017). They also to a higher degree report that they stand alone with the responsibility to organize their daily work schedule and there are fewer opportunities for daily exchange and knowledge sharing with colleagues than is the case for care workers in the public sector (Rostgaard, 2011).

9. Quality regulation

The regulation of quality of long-term care is mainly the responsibility of the local municipality. This is a consequence of the large degree of de-centralization. The Social Service Act does not contain any specific quality stipulations that prescribe how the local municipalities should frame or even assess quality of care. Therefore, the municipalities are not obliged to deliver a special standard package of care services but provide services such as home help and nursing home care for older people according to need and local level of services which defines the volume and quality of the services delivered. It is also largely up to the municipalities to consider what is adequate quality of long-term care. The appointed Social Welfare Committees in each municipality supervise local provision of social services. The service portfolio is controlled locally through the application of so-called quality declarations that specifies the local level of services. This informs users, their family but also assessors and care workers about the local standard of services. This extensive liberty of the local authorities implies some variations in quality and quantity of care between the local municipalities.

There are however a number of ways which national regulations influence the local quality of long-term care. As mentioned, the Social Service Act stipulates that services should be supportive of the de-institutionalisation policy. A quality item is also to deliver personalized services and to include the older person in decision-making. In home care, the law also specifically stipulates that care delivery should support the older person in becoming independent of services as is the goal in reablement.

Quality of care has been in particular focus since the launch of a Quality reform in 2007, where quality was operationalized as 1. user perceived quality, 2. professional quality and 3. organizational quality. At the time, it was decided to systematically document user perceived quality of long-term care, although it was not well-coordinated. This means that the Ministry of Internal Affairs as well as the Ministry of Older Citizens has individually conducted their own national surveys bi-annually, based on a representative sample of users of long-term care.

The survey from the Ministry of Social Affairs is focused on home care users. The survey includes 28 questions of which 13 are mandatory and focus on user satisfaction with personal care, practical assistance, meals-on-wheels, care staff, practical matters, free choice, and overall assessment of quality. The questionnaire is available for the local municipalities and the Association of Local Municipalities recommends the municipalities to conduct local surveys. Until 2020, they also recommended municipalities to publish their results online at a specially developed portal, *Tilfredshedsportalen.dk*, in order to bench-mark municipalities. However, only a minority of municipalities used it, and it has been closed down in order to develop a digital solution that is more user friendly, for users as well as municipalities.

The national survey conducted by the Ministry of Older Citizens consists of 20-43 questions and focus on overall user satisfaction with the quality of care, stability, continuity of care staff, reablement, awareness of the free choice and awareness of flexibility in the provision of care. It is conducted among home care users and residents in nursing homes.

The results of this survey are used to feed into the 23 quality indicators on care (*Ældredokumentation*) available from Statistics Denmark that report on efficiency and use of resources. The indicators are also based on reporting from the municipalities, including the number of users of home care and the services they receive. Although the indicators report on user satisfaction, these indicators are mainly focused on process quality (Statistics Denmark, 2020 A new initiative from 2019 aims at developing 3-5 overall quality indicators that more focus on outcomes, including indicators on number of admissions to hospital, users' functional ability, as well as quality of life and satisfaction (Sundheds – og Ældreministeriet, 2019)

Concluding remarks

Long-term care for older people in Denmark is generally generous, with affordable, attractive and flexible services. Over the last decades, long-term care has developed and matured, and is today an important factor in most people's lives over the life course. Overall, Denmark has maintained a relatively high level of service provision when

accounted for the share of older people receiving long-term care services. However, provision of care is decreasing, best illustrated by the decline in the proportion of older people receiving home care. As the population is ageing, the Danish long-term care system is severely challenged by lack of resources, financially but especially so regarding the recruitment and retainment of staff in a care model where care work is expected to be professionalized and formal.

Regardless, de-institutionalization is still the main foundation for policies and practice in long-term care. This principle has shaped the Danish approach for half a century now and is visible in the policies which have been implemented since. Home care is provided according to the principle of self-care and this has only been strengthened with the introduction of reablement. Reablement has meant a fundamental change to the requirements and obligations of both user and care worker. Services are today short-term only and the aim is to make the user fully or partly independent of care. For many care workers, the introduction of reablement has made the work more meaningful: they interact much more with the older person, they deliver personalized care and they most often experience with the older person a considerable improvement in functional ability.

De-institutionalisation is also facilitated by the preventive home visit. This intervention has proven effective in identifying needs early on and preventing them from developing to the degree that the older person can no longer remain in the home but require institutional care. Being an implicit principle, de-institutionalisation is not incorporated as specific quality goal, but the recent development of various quality indicators indicates that not only the input and process but also the outcome of long-term care service provision will be followed more closely in the future, including how care services may contribute to maintaining functional ability and avoid hospitalisation.

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